January 1 – December 31, 2023

Evidence of Coverage:

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

This document gives you the details about your Medicare and MassHealth (Medicaid) healthcare, long-term care, home and community-based services and prescription drug coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 866-610-2273. (TTY users should call 711). Hours are 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.)

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

Commonwealth Care Alliance, Inc. When it says “plan” or “our plan,” it means CCA Senior Care Options.)

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

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

Benefits may change on January 1, 2024.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

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

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2023 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in CCA Senior Care Options, which is a specialized Medicare Advantage Plan (Special Needs Plan)

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 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) healthcare and your prescription drug coverage through our plan, CCA Senior Care Options.

CCA Senior Care Options is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special healthcare needs. CCA Senior Care Options is designed for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from MassHealth (Medicaid) with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare healthcare services. MassHealth (Medicaid) also provides other benefits to you by covering healthcare 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. CCA Senior Care Options will help manage all of these benefits for you, so that you get the healthcare services and payment assistance that you are entitled to.

CCA Senior Care Options 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) healthcare coverage, including your prescription drug coverage long-term care, home and community-based services.

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.

Section 1.2 What is the Evidence of Coverage document about?

This **Evidence of Coverage** document tells you how to get your Medicare and MassHealth (Medicaid) medical care, long-term care, and/or home and community-based services, and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words "coverage" and "covered services" refer to the medical care, long-term care, and home and community-based services and services and the prescription drugs

available to you as a member of CCA Senior Care Options.

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** document.

If you are confused, concerned, or just have a question, please contact Member Services.

Section 1.3 Legal information about the Evidence of Coverage

This **Evidence of Coverage** is part of our contract with you about how CCA Senior Care Options 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 CCA Senior Care Options between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the benefits of CCA Senior Care Options after December 31,

2023. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve CCA Senior Care Options each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and both Medicare and the Commonwealth of Massachusetts renew their approvals of the plan.

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

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

You have both Medicare Part A and Medicare Part B

-- **and** -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.

-- **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 be:

- 65 years of age or older
- Enrolled in MassHealth Standard (Medicaid)
- Not have any other comprehensive health insurance coverage that meets a basic benefit standard, other than Medicare.
- Living at home or in a long-term-care facility (The member cannot be inpatient at a chronic or rehabilitation hospital or reside in an intermediate care facility for people with intellectual disabilities.)

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

Please note: If you lose your 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 during a period of deemed continued eligibility).

Section 2.2 What is MassHealth (Medicaid)?

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 MassHealth (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people

with SLMB are also eligible for MassHealth (Medicaid) benefits (SLMB+).)

Section 2.3 Here is the plan service area for CCA Senior Care Options

CCA Senior Care Options 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 these counties in Massachusetts*:* Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.

If you plan to move to a new state, you should also contact MassHealth and ask how this move will affect your MassHealth (Medicaid) benefits. Phone numbers for MassHealth (Medicaid) are in Chapter 2, Section 6 of this document.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. 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.

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.

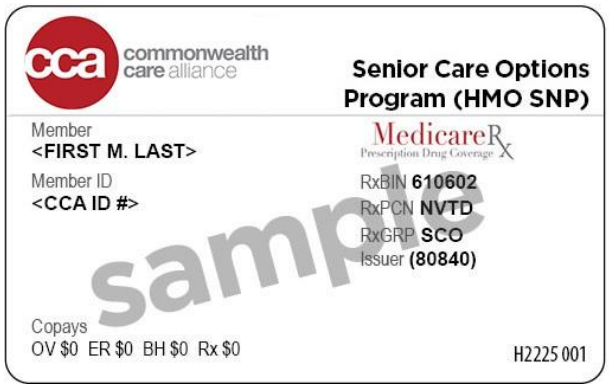
Section 2.4 U.S. Citizen or Lawful Presence

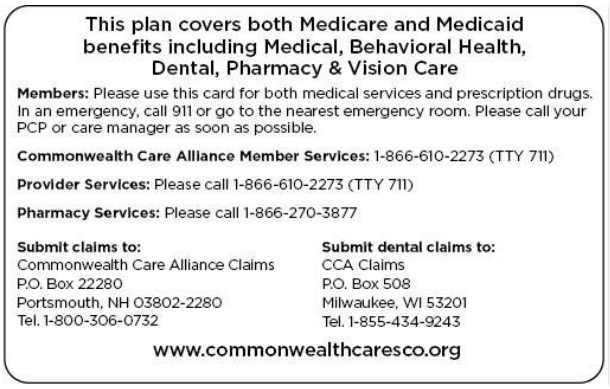
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify CCA Senior Care Options if you are not eligible to remain a member on this basis. CCA Senior Care Options must disenroll you if you do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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. 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 CCA Senior Care Options 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 Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 Provider and Pharmacy Directory

The **Provider and Pharmacy Directory** lists our network providers, pharmacies, and durable medical equipment suppliers. **Network providers** are the doctors and other healthcare professionals, medical groups, pharmacies, durable medical equipment suppliers, hospitals, and other

healthcare facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which CCA Senior Care Options authorizes use of out-of-network providers.

The **Provider and Pharmacy Directory** lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the **Provider and Pharmacy Directory** to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the **Provider and Pharmacy Directory**, you can get a copy from Member Services. You can also find this information on our website at www.ccama.com.

Section 3.3 The plan's List of Covered Drugs (Formulary)

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

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

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website at www.ccama.com or call Member Services.

SECTION 4 You have no out-of-pocket costs as a member of CCA Senior Care Options

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

Section 4.1 Plan premium

Special Note: All references to “premiums” and “premium changes” in this Section 4 are to Medicare premiums. As a member of CCA Senior Care Options, your Medicare premiums are paid by MassHealth (Medicaid) and will not change.

You **do not** pay a separate monthly plan premium for CCA Senior Care Options.

Section 4.2 Monthly Medicare Part B Premium

Many 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 Standard (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most CCA Senior Care Options 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. This includes your premium for Part B. It may also include a

premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you are dual-eligible, the Part D late enrollment penalty (LEP) doesn't apply as long as you maintain your dual-eligible status, but if you lose status you may incur LEP. Some members are required to pay a Part D late enrollment penalty. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.

- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
    - **Note:** The following are **not** creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage,

if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2022, this average premium amount was $33. This amount may change for 2023.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $33, which equals $4.62. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.

- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your

income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 Keeping your plan membership record (centralized enrollee record) up to date

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 healthcare providers, 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**. Senior Care Options members have $0 cost-sharing amounts. 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)). To be eligible for CCA Senior Care Options, you cannot have any comprehensive health insurance other than Medicare.
- 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 (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Services.

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.

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

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

- By phone: at 1-800-841-2900 (TTY 1-800-497-4648)
- By fax: at 1-857-323-8300
- By mail: Health Insurance Processing Center

P.O. Box 4405
Taunton, MA 02780

SECTION 6 How other insurance works with our plan

Other insurance

Special note: This section may not apply to you because enrollment in CCA Senior Care Options is restricted to members who do not have any other comprehensive health insurance.

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. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical, such as separate dental or vision coverage, 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.

CHAPTER 2:
Important phone numbers and resources

SECTION 1 CCA Senior Care Options contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

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

Method	Member Services – Contact Information
CALL	866-610-2273 Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday. October 1 to March 31: 8 am to 8 pm, 7 days a week. Member Services also has free language interpreter services available.
TTY	711 (MassRelay) Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday.October 1 to March 31: 8 am to 8 pm, 7 days a week.
FAX	617-426-1311
WRITE	Commonwealth Care Alliance, Inc. Member Services Department 30 Winter Street Boston, MA 02108
WEBSITE	www.ccama.org

How to contact us when you are asking for a coverage decision or appeal 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 or 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 asking for coverage decisions or appeals about your medical care or 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 Appeals for Medical Care or Part D prescription drugs – Contact Information
CALL	866-610-2273 Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday.October 1 to March 31: 8 am to 8 pm, 7 days a week. Member Services also has free language interpreter services available.
TTY	711 (MassRelay) Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday. October 1 to March 31: 8 am to 8 pm, 7 days a week.
FAX	857-453-4517
WRITE	Commonwealth Care Alliance, Inc. Appeals and Grievances Department 30 Winter Street Boston, MA 02108
WEBSITE	www.ccama.org

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. 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))**.

Method	Complaints about Medical Care – Contact Information
CALL	866-610-2273 Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday. October 1 to March 31: 8 am to 8 pm, 7 days a week. Member Services also has free language interpreter services available.
TTY	711 (MassRelay) Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday. October 1 to March 31: 8 am to 8 pm, 7 days a week.
FAX	857-453-4517
WRITE	Commonwealth Care Alliance, Inc. Appeals and Grievances Department 30 Winter Street Boston, MA 02108

Method	Complaints about Medical Care – Contact Information
MEDICARE WEBSITE	You can submit a complaint about CCA Senior Care Options directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. 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 Requests – Contact Information
CALL	866-610-2273 Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday. October 1 to March 31: 8 am to 8 pm, 7 days a week. Member Services also has free language interpreter services available.
TTY	711 (MassRelay) Calls to this number are free. **Hours of operation:** April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday. October 1 to March 31: 8 am to 8 pm, 7 days a week.
FAX	617-426-1311
WRITE	Commonwealth Care Alliance, Inc. Member Services Department 30 Winter Street Boston, MA 02108
WEBSITE	www.ccama.org

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.
TTY	1-877-486-2048 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Method	Medicare – Contact Information
WEBSITE	www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in Massachusetts.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provides Medicare eligibility status information.
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about CCA Senior Care Options:

Method	Medicare – Contact Information
	• **Tell Medicare about your complaint:** You can submit a complaint about CCA Senior Care Options 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 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 and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 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 (**S**erving the **H**ealth **I**nsurance **N**eeds of **E**veryone).

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on "**Talk to Someone**" in the middle of the homepage
- You now have the following options
  - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
  - Option #2: You can select Massachusetts from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to Massachusetts.

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

SECTION 4 Quality Improvement Organization

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 healthcare professionals who are 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 healthcare, 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 9 am to 5 pm, Monday to Friday 11 am to 3 pm, Saturday to Sunday. 24-hour voicemail service is available. Translation services are available for beneficiaries and caregivers who do not speak English.
TTY	711 (MassRelay)
WRITE	KEPRO 5700 Lombardo Center Dr., Ste. 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. 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 8:00 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.

Method	Social Security – Contact Information
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 MassHealth (Medicaid)

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 MassHealth (Medicaid) benefits (QMB+).)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for MassHealth (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 Standard (Medicaid) 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) healthcare services. MassHealth (Medicaid) also provides other benefits to you by covering healthcare services, including long-term care, home and community-based services, and some prescription drugs, that are not usually covered under Medicare. CCA Senior Care Options will help manage all of these benefits for you so that you can get the healthcare services and payment assistance that you are entitled to.

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

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

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 9 am to 4:30 pm, Monday to Friday
TTY	711 (MassRelay) 339-224-6831 (Videophone for deaf and hard of hearing)
WRITE	25 Kingston St, 4th FL Boston, MA 02111 info@myombudsman.org
WEBSITE	www.myombudsman.org

The LTC Ombudsman Program helps people get information about nursing homes and helps to resolve

problems between nursing homes and residents or their families.

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

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 – Contact Information
CALL	1-800-243-4636 9 am to 5 pm, Monday to Friday
TTY	711 (MassRelay) MassOptions works with telephonic interpreter for the deaf, hard of hearing and speech impaired who wants to communicate with us.
WEBSITE	www.massoptions.org 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 Standard (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 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- 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 a process for 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. Senior Care Options members have a $0 cost-sharing amount for prescription drugs.

- Call Member Services for more information or help.
- 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.

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 on the ADAP formulary qualify for prescription cost-sharing assistance through the Community Research Initiative. The program is called the Massachusetts HIV Drug Assistance Program (HDAP).
Note: To be eligible for the ADAP operating in

Massachusetts , 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 change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call or write:

Community Research Initiative/HIV Drug Assistance Program
529 Main Street, Suite 301
Boston, MA 02129

Phone: 800-228-2714

Fax: 617-502-1703

Email: info@crine.org

Website: www.crine.org/hdap

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

regarding your benefits from the Railroad Retirement Board, contact the agency.

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 *not* free.
WEBSITE	rrb.gov/

SECTION 9 You can get assistance from the Nurse Advice Line

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

Method	Nurse Advice Line – Contact Information
CALL	866-610-2273 Calls to this number are free. Available 24 hours a day, 7 days a week. Free interpreter services are available.
TTY	711 (MassRelay) Calls to this number are free. Available 24 hours a day, 7 days a week.

SECTION 10 You can get assistance from Senior Agencies

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

- **Aging Services Access Points** Aging Services Access Points (ASAPs) are one-stop entry points for all of the services and benefits available to seniors in Massachusetts. These agencies provide information, applications, direct services, and referrals.
- **Councils on Aging / Senior Centers** Councils on Aging (COAs) are local volunteer organizations that offer information and direct services to seniors, their caregivers, and other people with aging issues. COAs are part of the local government, and work with other senior agencies and city/town departments to provide social, recreational, health, safety, and educational programs for seniors in their communities.
- **MassOptions.org** is a website where seniors and their families can get information about programs and services for the elderly in Massachusetts. It is a service of the Massachusetts Executive Office of Health and Human Services.

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

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

Method	Aging Services of North Central Massachusetts – Contact Information
CALL	800-734-7312 9 am to 5 pm, Monday to Friday
TTY	978-514-8841 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.agingservicesma.org

BayPath Elder Services, Inc. offers home care and related services enabling people to live independently and

comfortably in their homes while promoting their well-being and dignity. **Service Area:** Ashland, Dover, Framingham, Holliston, Hopkinton, Hudson, Marlborough, Natick, Northborough, Sherborn, Southborough, Sudbury, Wayland, and Westborough.

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

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

Method	Boston Senior Home Care – Contact Information
CALL	617-451-6400 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	617-451-6404 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.Bshcinfo.org

Bristol Elder Services, Inc. provides and advocates for community-based services that promote independence and dignity for all elders and disabled individuals. **Service area:** Attleboro, Berkley, Dighton, Fall River, Freetown, Mansfield,

North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, and Westport.

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

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

Method	Central Boston Elder Services, Inc. – Contact Information
CALL	617-277-7416 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	844-495-7400 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.centralboston.org

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

Method	Coastline Elderly Services, Inc. – Contact Information
CALL	508-999-6400 8 am to 5 pm, Monday to Friday Calls to this number are **not** free.

TTY	508-994-4265 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.coastlinenb.org

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

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

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

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

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

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

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

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

Greater Springfield Senior Services, Inc. is a private nonprofit organization dedicated to maintaining a quality of life for older adults, caregivers, and persons with disabilities.

Service area: Agawam, Brimfield, East Longmeadow, Hampden, Holland, Longmeadow, Monson, Palmer, Springfield, Wales, West Springfield, and Wilbraham.

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

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

Method	HESSCO – Contact Information
CALL	800-462-5221
TTY	800-462-5221

	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.hessco.org

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

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

Minuteman Senior Services helps seniors and people with disabilities live in the setting of their choice by engaging community resources and supporting caregivers. **Service area:** Acton, Arlington, Bedford, Boxborough, Burlington,

Carlisle, Concord, Harvard, Lexington, Lincoln, Littleton, Maynard, Stow, Wilmington, Winchester, and Woburn.

Method	Minuteman Senior Services – Contact Information
CALL	888-222-6171 9 am to 5 pm, Monday to Friday
TTY	711 (MassRelay) 1-800-439-2370 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.minutemansenior.org

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

Method	Lifepath – Contact Information

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

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

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

Old Colony Elder Services supports the independence and dignity of older adults and individuals with disabilities by providing essential information and services that promote

healthy and safe living. **Service Area:** Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Kingston, Lakeville, Marshfield, Middleboro, Pembroke, Plymouth, Plympton, Rockland, Stoughton, Wareham, West Bridgewater, and Whitman.

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

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

Method	SeniorCare, Inc. – Contact Information
CALL	866-927-1050

TTY	978-282-1836 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.seniorcareinc.org

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

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

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

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

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

Method	Springwell, Inc. – Contact Information
CALL	617-926-4100 9 am to 5 pm, Monday to Friday Calls to this number are **not** free.
TTY	617-923-1562 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	www.springwell.com

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

Method	Tri-Valley – Contact Information
CALL	800-286-6640 8:30 am to 5 pm, Monday to Friday
TTY	508-949-6654

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

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

Method	**West Mass Elder Care – Contact Informatio**
CALL	800-462-2301 8 am to 5 pm, Monday to Friday
TTY	800-875-0287 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Website	www.wmeldercare.org

CHAPTER 3:
Using the plan for your medical and other covered services

OMB Approval 0938-1051 (Expires: February 29, 2024)

SECTION 1 Things to know about getting your medical care and other services 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, equipment, prescription drugs, 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 **(Medical Benefits Chart, what is covered)**.

Section 1.1 What are "network providers" and "covered services"?

- **"Providers"** are doctors and other healthcare professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other healthcare facilities.
- **"Network providers"** are the doctors and other healthcare professionals, medical groups, hospitals, and other healthcare 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, healthcare services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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, CCA Senior Care Options must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare as noted in Chapter 4.

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the

services, supplies, equipment, 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) who is 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, 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 healthcare 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 Medical Benefits Chart in Chapter 4.
    - Prior authorization is not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

  - Note: In your first 90 days with our plan or until your Individualized Care Plan is complete, you can keep seeing your current providers, at no cost to you, if they are not a part of our network. This is called the Continuity of Care (COC) period. During the COC period, your care partner will contact you to help you find providers in our network. After the COC period, we will no longer cover your care if you choose to see out-of-network providers.

- **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. This means that you will have to pay the provider in full for the services furnished. **Here are three exceptions***:*
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. We also cover up to one hundred thousand dollars ($100,000) per calendar year in emergency care and urgently needed services if you're traveling outside the United States and its territories. 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 but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider. The plan must authorize care you receive from an out-of-network provider before you seek care. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network healthcare provider, 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 or when your provider for this service is temporarily unavailable or inaccessible.

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

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. CCA Senior Care Options 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 the plan is required for some of your services before you receive them. Your PCP/care team works closely with the plan to arrange for these services when necessary. These services are identified in the Medical Benefits Chart in the next chapter (**Medical 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.

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 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 Member Services.

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

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

- Routine women's healthcare, 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, COVID-19 vaccinations, 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 are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

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

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

A specialist is a provider who provides healthcare 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 CCA Senior Care Options, 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 and Pharmacy Directory to locate facilities in the plan's network. The most up-to-date Provider and Pharmacy Directory is located on our website at www.ccama.org.

If you recently received a diagnosis for a serious or terminal illness, your care partner, primary care provider or specialist may recommend the 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 the plan is required for certain 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 Medical 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 healthcare professional for any covered services within the network. You may also obtain a second opinion 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. You must receive authorization for any services 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. If your healthcare provider or specialist leaves 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 healthcare providers 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 healthcare 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 find out your healthcare provider or specialist is leaving your plan, please contact us so we can

assist you in finding a new provider to manage your care.

- 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 a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 8.

Section 2.4 How to get care from out-of-network providers

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, including family planning services, from an out-of-network provider. 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 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

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 your loss of life, loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. 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:

- **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. You do not need to use a network healthcare provider. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.

- **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. To notify us, call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week from October 1 to March 31. From April 1 to September 30, Member Services is available 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, 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 hundred thousand dollars ($100,000) 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 Medical Benefits Chart in Chapter 4.

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The healthcare providers 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 follow-up care to be sure your condition continues to be stable. Your healthcare providers will continue to treat you until your healthcare providers contact us and make plans for additional care. Your follow-up care will be covered by our plan. 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.

What to do if you have a behavioral health emergency

In a behavioral health emergency, you should go to the nearest emergency room. You will be evaluated by a crisis

team that will assist in finding you an appropriate facility for care. No prior authorization is required for this type of emergency within the U.S. and its territories. To learn more, see the Medical Benefits Chart in Chapter 4, Section 2.1.

You can also contact the Massachusetts Emergency Services Program (ESP) at 1-877-382-1609. ESP provides behavioral health crisis assessment, intervention, and stabilization services, 24 hours a day, seven days per week, and 365 days a year. ESP includes three services:

1. Mobile Crisis Intervention (MCI) services for adults – these services are available 24 hours a day, seven days a week, as follows: from 7 a.m. to 8 p.m. at all ESP community-based locations, and from 8 p.m. to 7 a.m. at residential programs and hospital emergency departments.
2. Emergency Services Program (ESP) community-based locations – hours vary based on location. For details, go to http://www.masspartnership.com/pdf/MBHPESPDirectory.pdf.
3. Community crisis stabilization (CCS) services for people age 18 and older – these services are available 24 hours a day, seven days a week. For details, go to

http://www.masspartnership.com/pdf/MBHPESPDirectory.pdf.

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 healthcare provider 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.

However, after the healthcare provider 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

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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 Member Services at 866-610-2273 (TTY 711) if you have urgent care needs 24 hours a day, 7 days a week. We will connect you with our Nurse

Advice Line which is available 24 hours a day. We have registered nurses and behavioral health clinicians who will assist you with your medical, behavioral health, or substance use symptoms.

All urgent care and symptomatic office or home visits are available to you within 48 hours, so you will be evaluated either in an office or in your home. All non-symptomatic office visits are available to you within 14 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 hundred thousand dollars ($100,000) per calendar year. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Section 3.3 Getting care during a disaster

If the Governor of Massachusetts, 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.medicare.gov/what-medicare-covers/getting-care-drugs-in-disasters-or-emergencies for information on how to obtain needed care during a disaster.

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 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?

CCA Senior Care Options covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service.

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"?

A clinical research study (also called a "clinical trial") is a way that healthcare providers and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, 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 any Medicare-approved clinical research study, you do not need to tell us or 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, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the 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

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.

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 or services provided only to collect data, and not used in your direct healthcare. 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 visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) 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.

SECTION 6 Rules for getting care in a "religious non-medical healthcare institution"

Section 6.1 What is a religious non-medical healthcare institution?

A religious non-medical healthcare 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 healthcare institution. This benefit is provided only for Part A inpatient services (non-medical healthcare services).

Section 6.2 Receiving Care from a Religious Non-Medical Healthcare Institution

To get care from a religious non-medical healthcare 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 healthcare 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 CCA Senior Care Options inpatient hospital coverage, there is no coverage limit to this benefit. You pay nothing for your authorized services. For more information, please see the Medical Benefits Chart in Chapter 4 of this **Evidence of Coverage**.

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?

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 CCA Senior Care Options, 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, we can rent certain durable medical equipment for short term use. However, you may acquire ownership of rented DME items 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 Medical 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. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage CCA Senior Care Options 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 CCA Senior Care Options or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins

again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what is covered)

OMB Approval 0938-1051 (Expires: February 29, 2024)

SECTION 1 Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of CCA Senior Care Options. 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 Medical Benefits Chart to find out what is covered

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

The Medical Benefits Chart on the following pages lists the services CCA Senior Care Options covers. Part D prescription drug coverage is in Chapter 5. The services

listed in the Medical 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, equipment, and Part B prescription drugs) **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 unless it is emergent or urgent care or unless your plan has given you authorization. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered **only** if your PCP 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 Medical Benefits Chart in italics.

Other important things to know about our coverage:

- You are covered by both Medicare and MassHealth (Medicaid). Medicare covers healthcare 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, over-the-counter drugs, home and community-based services, dental services, or other MassHealth (Medicaid)-only services.
- 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 2023 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.

- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- As a CCA Senior Care Options member, some benefits are covered by Medicare and some are covered by MassHealth (Medicaid). We integrate all of your benefits for you. The benefit chart reflects all covered services.
- If you are within our plan's one-month period of deemed continued eligibility, we will continue to provide all plan-covered Medicare benefits.

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

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill. See "Help with Certain Chronic Conditions" in the Medical Benefits Chart.
    - Chronic alcohol and other drug dependence
    - Autoimmune disorders
    - Cancer
    - Neurologic disorders

  - Chronic and disabling behavioral health conditions
  - Dementia
  - Cardiovascular disorders
  - Diabetes mellitus
  - Chronic heart failure
  - End-stage liver disease
  - End-stage renal disease
  - Severe hematologic disorders
  - HIV/AIDs
  - Chronic lung disorders
  - Stroke
  - Chronic kidney disease (CKD)
  - Physical disabilities
  - Musculoskeletal conditions
  - Developmental disabilities
  - Vision and hearing disorders
  - Other chronic conditions
- Please contact us to find out exactly which benefits you may be eligible for.

🍏 You will see this apple next to the preventive services in the benefits chart.

Medical 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. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible.

Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); and • **not associated with surgery**. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	You pay $0.

Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: **Continued on next page**	

Acupuncture for chronic low back pain (continued) • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Prior authorization is not required for services provided by a network provider.	

Services that are covered for you	**What you must pay** when you get these services
Acupuncture Our plan covers supplemental acupuncture benefits through Medicare and MassHealth (Medicaid) in addition to the Medicare covered services above. The plan covers up to 36 visits total per calendar year unless authorized differently by the plan. The 36 sessions are **not in addition to the 20 covered sessions above** if you are receiving acupuncture services for lower back pain. Prior authorization is not required for services provided by a network provider.	

Services that are covered for you	**What you must pay** when you get these services
Adult day health 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.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
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.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
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.	You pay $0. ***Prior authorization is required.***

Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Our plan also covers emergency services, including emergency transportation, and urgently needed care outside the United States and its territories up to one hundred thousand dollars ($100,000) per	You pay $0. ***Prior authorization is required for non-emergency ambulance services.***

Services that are covered for you	**What you must pay** when you get these services
calendar year. See **Emergency** and **Urgent Care** sections later in this chart for more information. For more information about non-emergency transportation services covered by the plan under the MassHealth (Medicaid) benefit, see **Transportation** section listed later in this chart.	

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. **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. Prior authorization is not required for services provided by a network provider. **Annual wellness visit reward** An annual wellness visit or an annual physical exam qualifies for one $25 reward per year after you've completed the visit. Routine PCP	You pay $0. There is no coinsurance, copayment, or deductible for the annual wellness visit. If you've received a qualifying exam from your PCP, you can receive up to one $25 reward on your Healthy Savings card per calendar year upon provider billing CCA for the service.

visits, like a follow-up or sick visit, don't qualify for the reward. Earned rewards will be added to your Healthy Savings card for use at approved OTC network retailers. To earn this reward, you must have an annual wellness visit or an annual physical exam. Either annual visit type is longer than routine PCP visits. During an annual wellness visit or an annual physical exam, you and your provider will review your overall health in detail. Your provider must bill CCA for your exam in order for your reward to be processed and applied to your Healthy Savings card. Your reward can be used at in-network OTC retailers (not independent pharmacies) to purchase allowed items excluding firearms, alcohol or tobacco. Covered once every calendar year.	

Services that are covered for you	**What you must pay** when you get these services
🍎 **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. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	**What you must pay** when you get these services
🍏 **Breast cancer screening (mammograms)** Covered services include: • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months The plan may also cover additional screenings and clinical exams when medically necessary under the MassHealth (Medicaid) benefit. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	**What you must pay** when you get these services
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 healthcare provider's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay $0. ***Prior authorization is required.***

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 provider (PCP) to help lower your risk for cardiovascular disease. During this visit, your PCP may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
🍏 **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. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	**What you must pay** when you get these services
🍏 **Cervical and vaginal cancer screening** Covered services include: • 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 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. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation The plan also covers routine care, office visits and radiology services under the MassHealth (Medicaid) benefit. ***The plan covers 36 chiropractic visits per calendar year unless authorized differently by the Plan.*** Prior authorization is not required for services provided by a network provider.	You pay $0.

Services that are covered for you	**What you must pay** when you get these services
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.	You pay $0. ***Prior authorization is required.***

Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within	You pay $0. There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

Services that are covered for you	**What you must pay** when you get these services
48 months of a screening sigmoidoscopy Prior authorization is not required for services provided by a network provider.	
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.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
Continuous nursing services/private duty nursing Continuous, specialized skilled nursing services. These services are covered by our plan under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
Custodial care (long-term nursing home 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. The plan also helps with transition back to community. CCA Senior Care Options does not pay for personal services such as TV, etc. while you are in custodial care. Custodial care is covered by our plan under the MassHealth (Medicaid) benefit.	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). ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
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.	You pay $0. ***Prior authorization is required.***

Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover these services under the MassHealth (Medicaid) benefit: <u>Preventive/Diagnostic:</u> • Preventive care such as cleanings • Routine exams • X-rays <u>Restorative:</u> • Fillings • Crown* • Replacement Crown* • Endodontic Therapy (root canals) * <u>Periodontics:</u> • Scaling and root planning • Periodontal Maintenance	You pay $0.

<u>Prosthodontics (removable):</u> • Complete dentures • Partial dentures* • Relines and adjustments of complete dentures <u>Implant Services:*</u> • Implants are covered for maximum of 2 implants per arch (upper and lower) per year, for a maximum total of 4 implants per year. **Continued on next page**	

Dental services (continued) <u>Oral and Maxillofacial Surgery:</u> • Extractions (removal of teeth) • Biopsy and soft tissue surgery* • Alveoplasty • Bone grafting* **** Prior authorization may be required for services listed and additional services.*** Frequency limitations apply. This list is not a guarantee of coverage. These services are covered without prior authorization: • Complete dentures • Routine exams and x-rays • Preventive services including cleanings • Restorative fillings • Complete dentures and relines • Non-surgical extractions	

Services that are covered for you	**What you must pay** when you get these services
• Emergency Care • Preventive cleanings and routine exams & x-rays are covered twice per calendar year • Other limitations may apply. In the event that clinical input is necessary to determine whether a course of treatment is appropriate, CCA Senior Care Options reserves the right to have a dental expert review the treatment plan your dentist has proposed. Services requiring authorization must be sent directly to the CCA dental benefit administrator, Skygen, by your treating network dental provider for review.	

Services that are covered for you	**What you must pay** when you get these services
🍎 **Depression screening** We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. The plan also covers additional services and screening under the MassHealth (Medicaid) benefit. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	**What you must pay** when you get these services
🍎 **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. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • 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.	You pay $0. Prior authorization is not required for diabetes self-management training, diabetic services, and other diabetic supplies provided by a contracted provider. ***Prior authorization is required for glucometers and therapeutic continuous glucose monitors (CGMs).***

• Diabetes self-management training is covered under certain conditions. The plan may also cover additional services under the MassHealth (Medicaid) benefit. Our plan contracts with Abbott Diabetes Care and LifeScan, preferred vendors to supply glucometers and test strips to our diabetic members. These products include: FreeStyle Freedom Lite® meters, Precision Xtra® meters, FreeStyle Lite® test strips, Precision Xtra® test strips, Precision Xtra® Beta Ketone test strips, OneTouch Ultra2® Glucose System, OneTouch Ultra Mini® Meter, OneTouch Verio Flex® Meter, OneTouch Verio IQ® Meter, OneTouch Ultra® Test Strips, and OneTouch Verio® Test Strips. **Continued on next page**	***Certain diabetic test strips may require a prior authorization under specific circumstances*** **.**

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services, and supplies (continued) Some restrictions may apply. You can obtain a new glucometer and test strips by requesting a new prescription from your provider to fill at your local pharmacy. You can also call LifeScan at 1-800-227-8862 or visit www.lifescan.com. Or call Abbott Diabetes Care at 1-800-522-5226 or visit www.AbbottDiabetesCare.com. For more information, please call Member Services.	

Diversionary behavioral health services The plan covers community-based behavioral healthcare 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: • Medically monitored inpatient withdrawal management, including withdrawal management for dual diagnosis (also known as acute treatment services) (ASAM Level 3.7) • Behavioral emergency services, including emergency screening services program, short-term crisis counseling, medication management crisis and specializing services (also known as emergency services program (ESP))	You pay $0.

• Clinically managed population-specific high intensity residential services* (refer to the Note below) (ASAM Level 3.3) • Clinical stabilization services (CSS) (ASAM Level 3.5) • Community crisis stabilization (CSS) • Community support program (CSP) • Community support program for chronically homeless individuals (CSP-CHI) • Intensive outpatient program (IOP) • Partial hospitalization program (PHP) • Psychiatric day treatment • Structured outpatient addiction program (SOAP) • Recovery support navigator • Recovery coach • Residential rehabilitation services (RRS) • Programs for assertive community treatment (PACT) • Transitional support services (TSS) for substance use disorders* (refer to the Note below) **Continued on next page**	

Diversionary behavioral health services (continued) You have the option of getting these services through an in-person visit or by telehealth (virtual care). *** Note:** These services may not be available at the beginning of the plan year through CCA Senior Care Options. If you have questions, please contact us. See **Outpatient behavioral healthcare** section listed later in this chart for more information about additional behavioral health services. CCA also offers a substance use program for members who are experiencing or are at risk for developing opioid use disorder or any other substance use disorder. In addition to providing coverage for certain addiction services, we provide targeted clinical support. Our network of providers and the benefits we offer provide services such as detoxification, intensive outpatient	

Services that are covered for you	**What you must pay** when you get these services
treatment, structured addiction outpatient program, acupuncture, and medication-assisted treatments. If you need support with opioid use disorder or any other substance use disorder, talk to your care partner. Prior authorization is not required for services provided by a network provider.	

Durable medical equipment (DME) and related supplies (For a definition of “durable medical equipment,” see Chapter 11 as well as Chapter 3, Section 7 of this document.) Covered items include but, are not limited to: Personal Emergency Response Systems (PERS), wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME 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. The most recent list of suppliers is also	You pay $0. ***Limits may apply to certain DME.*** ***Prior authorization may be required.***

available on our website at www.ccama.org. Generally, CCA Senior Care Options covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to CCA Senior Care Options and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your healthcare provider to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your healthcare provider, you can ask him or her to refer you for a second opinion.) To check if a certain item is covered, please call Member Services.	

Services that are covered for you	**What you must pay** when you get these services

Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. 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 services may be furnished by network providers or by out-of-network providers when network	You pay $0. 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 ***or*** you must have your inpatient care at the out-of-network hospital authorized by the plan.

Services that are covered for you	**What you must pay** when you get these services
providers are temporarily unavailable or inaccessible. 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 hundred thousand dollars ($100,000) per calendar year. This is a supplemental benefit covered under our plan. See Chapter 3 for more information about emergency care. Prior authorization is not required.	

Services that are covered for you	**What you must pay** when you get these services
Gender reassignment/affirmation The plan covers gender reassignment services. Services may include the following: mastectomy, breast augmentation, hysterectomy, salpingectomy, oophorectomy, or genital reconstructive surgery. Services and procedures that are consider cosmetic and reversal of gender reassignment surgery are not covered. For more information or help, please speak with your care team.	You pay $0. ***Prior authorization is required.*** ***Your provider will be required to submit your medical records for review.***
Grocery shopping and delivery These services are covered by our plan under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
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.	You pay $0. ***Prior authorization is required.***

🍎 Health and wellness education programs The plan covers Medicare preventive services. These services are listed separately within this Medical 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 and living well at home resources • Complex Care Self-Management programs for chronic obstructive pulmonary disease (COPD), diabetes, and heart failure • Motivational interviewing • Access to Nurse Advice Line 24 hours a day, 7 days a week (see	You pay $0.

Chapter 2, for more information on accessing Nurse Advice 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 speak to your care team. **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. ○ Martial arts centers ○ Gymnastics facilities **Continued on next page**	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 are responsible for all charges over

Health and wellness education programs (continued)
 	
• Participation in group and/or instructional fitness classes in-person or online, such as:
  ○ Tai Chi, yoga, and Pilates
  ○ Dance classes
  ○ Health programs, including those at a YMCA (for classes and programs associated with an additional fee)
  ○ Instructional fitness such as golf, tennis, or swimming lessons
  ○ Sports activities
• Activity tracker, e.g., Fitbit, Apple watch, etc. (limit of one per member per year)
• Memory fitness activities that are goal oriented and are a formal program.
• Weight management programs, such as Weight Watchers and Jenny Craig, or hospital-based programs.
	$250 per calendar year.
	
	Reimbursement requests for a prior year must be received by CCA Senior Care Options no later than March 31, 2024.

• Fitness equipment, such as free weights, like dumbbells or kettlebells; cardio equipment like a treadmill, elliptical, stationary bike, or rowing machine; resistance bands, or other items that can be used in the home to support health and fitness goals. **The wellness allowance does not cover:** • The purchase of food in conjunction with a weight management program. • This benefit does not cover costs for pre-packaged meals/foods, books, videos, scales, or other items or supplies. ○ Some other fitness and health related items may be covered under the OTC Card benefit, such as blood pressure cuffs, food scales, pulse oximeters and activity trackers. **Continued on next page**	

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs (continued) To obtain this reimbursement, you must submit a completed CCA 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 www.ccama.org. Send the completed form with any required documents to the address shown on the form. If you have any questions, call Member Services. Prior authorization is not required for services provided by CCA Senior Care Options or a network provider.	

Healthy Savings card to purchase certain Medicare approved over-the-counter (OTC) items and healthy food You receive a CCA Healthy Savings card with an allowance of $285 that is applied at the beginning of each calendar quarter (every three months) to purchase Medicare-approved OTC items like hand sanitizer, masks, first aid supplies, toothbrushes, and cold medicine without a prescription at OTC network retailers. **Members without chronic illness** can only use the Healthy Savings card towards the purchase of Medicare-approved items. **Members with chronic illnesses** can use the Healthy Savings card for the purchase of healthy food products like the Supplemental Nutrition Assistance Program (SNAP) benefit including	You pay $0 for covered items up to $285 per quarter. If the cost of the Medicare approved OTC or healthy food items exceeds the quarterly benefit limitation of $285 per quarter, you are responsible for the remainder of the costs.

fresh food boxes or prepared meals at OTC network retailers. Please see "**Help with Certain Chronic Conditions**" within the Medical Benefits Chart for more information. Chronic diseases are generally conditions that require ongoing medical attention or limit activities of daily living. The condition is diagnosed by a licensed medical professional, including your primary care provider and similar providers. Purchases made with the Healthy Savings card for Medicare OTC items and/or healthy foods can only be used at in-network retailers. For a list of retailers in your area, visit www.mybenefitscenter.com with your Healthy Savings card number or contact Member Services. **Continued on next page**	

CCA Healthy Savings card to purchase certain Medicare approved over-the-counter (OTC) items and healthy food (continued) For questions regarding Medicare-approved OTC items and healthy foods visit www.ccama.org or contact Member Services. For more information about OTC drugs covered under the MassHealth (Medicaid) benefit, see **Outpatient drugs** section listed later in this chart. Prior authorization is not required for covered Medicare OTC items and/or healthy food approved items purchased from a network retailer. Prior authorization is not required for members with chronic illnesses to use the Healthy Savings card towards the purchase of healthy foods.	

Hearing services **<u>Non routine hearing:</u>** 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. The plan also covers the following **<u>routine hearing services</u>** under the MassHealth (Medicaid): • Routine hearing exams and tests • Hearing aids including evaluations for fitting hearing aids, repairs, and replacements Prior authorization is not required for routine hearing exams, evaluations, repairs, and replacements provided by a network provider.	You pay $0. Non-routine hearing: You must use a CCA contracted provider. Routine hearing: You must use a NationsHearing provider to be covered for this benefit. ***Prior authorization is required for hearing aids costing more than $500.***

Services that are covered for you	**What you must pay** when you get these services
The plan uses NationsHearing as the benefit administrator for hearing services, including exams and hearing aids. Please contact NationsHearing at 877-277-9196 (TTY 711) for questions about your hearing services benefit.	

Help with Certain Chronic Conditions
 	
CCA Senior Care Options benefits include the following additional services:
 	
• Food and produce allowance for members diagnosed with a chronic condition.
  ○ Qualifying members will have access to this allowance through their CCA Healthy Savings OTC quarterly allowance of $285 at contracted retailers.
• Identity theft protection for members diagnosed with a chronic condition
  ○ Identity theft protection offers monitoring of your personal information to detect signs of fraud. They help you recover your identity and reimburse for costs you may have due to identity theft.
	You pay $0

○ Qualifying members can sign up for identity theft protection through our partner, ID Watchdog, from Equifax. Information about ID Watchdog and how to sign up can be found on the CCA Partners page of our website: www.ccama.org/ ○ Members must use ID Watchdog (Equifax) to be covered for this benefit. ○ Once you enroll, you are enrolled until the end of the current plan year. If you opt to disenroll, you cannot reenroll until the next year. ○ You can contact Equifax by calling 866-513-1518. **Continued on next page**	

Help with Certain Chronic Conditions (continued) Chronic conditions include: chronic alcohol and other drug dependence, autoimmune disorders, cancer, neurologic disorders, chronic and disabling behavioral health conditions, dementia, cardiovascular disorders, diabetes mellitus, chronic heart failure, end-stage liver disease, end-stage renal disease, severe hematologic disorders, HIV/AIDs, chronic lung disorders, stroke, chronic kidney disease (CKD), physical disabilities, musculoskeletal conditions, developmental disabilities, vision and hearing disorders, and more. Chronic diseases are generally conditions that require ongoing medical attention or limit activities of daily living. The condition is diagnosed by a licensed medical professional, including your primary care provider, nurse practitioner and similar providers.	

Services that are covered for you	**What you must pay** when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Services that are covered for you	**What you must pay** when you get these services
Homemaker 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 typically provided by agencies. These agencies are called personal care agencies or home care agencies. Homemaker services are covered by our plan under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
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.	You pay $0. ***Prior authorization is required.***

Home health agency care Prior to receiving home health services, a healthcare provider must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home healthcare benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	You pay $0. ***Prior authorization is required***.

Services that are covered for you	**What you must pay** when you get these services
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.	

Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You pay $0. ***Prior authorization is required***.

Hospice care You are eligible for the hospice benefit when your healthcare provider and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice provider can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care <u>For hospice services and for services that are covered by Medicare Part A</u>	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 for by Original Medicare, not CCA Senior Care Options. You pay $0.

or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: 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, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). **Continued on next page**	

Hospice care (continued) For services that are covered by CCA Senior Care Options but are not covered by Medicare Part A or B: CCA Senior Care Options 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. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 (**What if you're in Medicare-certified hospice**). **Note:** If you need non-hospice care (care that is not related to your	

terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit. 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 palliative care program as well as end of life care. The CCA palliative care program focused on relieving pain, stress, and other uncomfortable symptoms for people living with serious illness. The program is designed for our members, their caregivers, and healthcare providers with active involvement of the care team. For more information, see Palliative Care in the Medical Benefits Chart, and discuss with your care team. **Continued on next page**	

Services that are covered for you	**What you must pay** when you get these services
Hospice Care (continued) Prior authorization is not required for services provided by a network provider or the member's elected hospice organization.	

Immunizations Covered Medicare Part B services include: • 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 • COVID-19 vaccine • 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. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

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 healthcare provider'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. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units)	You pay $0. If you get **authorized** inpatient care at an out-of-network hospital after your emergency condition is stabilized, you pay nothing. ***Prior authorization is required, except for inpatient substance use and emergency admissions.***

Services that are covered for you	**What you must pay** when you get these services
• Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use services **Continued on next page**	

Inpatient hospital care (continued) • 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 CCA Senior Care Options provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange	

or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services **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.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) 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 https://www.medicare.gov/sites/default/files/2021-10/11435-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.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient behavioral healthcare Covered services include behavioral healthcare 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 behavioral health services provided in a psychiatric unit of a general hospital under Medicare. The plan covers your inpatient stay in a psychiatric hospital beyond the Medicare limit under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required, except for inpatient substance use and emergency admissions.***
Laundry Our plan covers laundry services under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required.***

Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your healthcare provider. We cover 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. The plan may cover medical nutrition therapy for members who do not meet	You pay $0. There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	**What you must pay** when you get these services
the Medicare benefit criteria under the MassHealth (Medicaid) benefit. Prior authorization is not required for services provided by a network provider.	

Services that are covered for you	**What you must pay** when you get these services
🍎 **Medicare Diabetes Prevention Program (MDPP)** MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. 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. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for the MDPP benefit.

Medicare Part B prescription drugs 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	You pay $0. ***Prior authorization may be required for Medicare Part B drugs.***

fracture that a healthcare provider 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 **Continued on next page**	

Medicare Part B prescription drugs (continued) 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.ccama.org We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. You pay nothing for your Part D prescription drugs covered by our plan.	

Services that are covered for you	**What you must pay** when you get these services
Most specialty drugs are limited to a 30-day supply. To check if a certain drug is covered, please call Member Services.	
🍏 **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 provider or practitioner to find out more. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Prior authorization is not required for services provided by a network provider.	You pay $0.

Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • 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. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are	You pay $0. ***Prior authorization may be required for outpatient diagnostic tests and therapeutic services and supplies.*** ***For example, specialized imagining and specialized screening tests (i.e., genetic testing) may require a prior authorization.***

Services that are covered for you	**What you must pay** when you get these services
covered beginning with the first pint used • Genetic testing – services provided accordingly with Medicare and MassHealth (Medicaid) guidance • Other outpatient diagnostic tests For more information, please speak with your care partner or call Member Services. In the event that clinical input is necessary to determine whether a course of treatment is appropriate, CCA Senior Care Options reserves the right to have an expert review the proposed treatment plan or request.	

Outpatient drugs Our plan covers prescription drugs under Medicare Part D. See Chapter 5 for more information on Medicare Part D drug benefit. 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: • 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 or visit our website www.ccama.org. Additionally, our plan covers Healthy Savings card to purchase certain	You pay $0. Prior **a**uthorization may be required for certain outpatient medications**.**

Services that are covered for you	**What you must pay** when you get these services
Medicare-approved over-the-counter items. For more information about the Healthy Savings card allowance, see **Healthy Savings card to purchase certain Medicare approved over-the-counter (OTC) items and healthy food** section listed earlier in this chart.	

Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and may pay the costs for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you	You pay $0.

Services that are covered for you	**What you must pay** when you get these services
are not sure if you are an outpatient, you should ask the hospital staff. 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 https://www.medicare.gov/sites/default/files/2021-10/11435-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.	

Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Behavioral healthcare, including care in a partial-hospitalization program, if a healthcare provider 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	You pay $0. ***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***

• Certain drugs and biologicals that you can't give yourself **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. Senior Care Options members have $0 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. **Continued on next page**	***require a prior authorization.***

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued) For more information, discuss with your care team or contact Member Services. In the event that clinical input is necessary to determine whether a course of treatment is appropriate, CCA Senior Care Options reserves the right to have an expert review the proposed treatment plan or request.	

Outpatient behavioral healthcare The plan provides behavioral healthcare and substance use benefits that are no more restrictive than the requirements or limitations that we apply to medical, surgical, and community supports benefits. This is required under the Mental Health Parity and Addiction Equity Act. The plan covers the following services under the Medicare benefit: Behavioral 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 behavioral healthcare professional as allowed under applicable state laws. Under the MassHealth (Medicaid) benefit, the plan covers additional outpatient care provided by licensed behavioral health counselors and licensed independent clinical social	You pay $0. ***Prior authorization is required for neuropsychological testing, psychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation (rTMS), and esketamine.***

workers. Services include but are not limited to: • 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 • Urgent outpatient services • Dialectical behavioral therapy (DBT) **Continued on next page**	

Services that are covered for you	**What you must pay** when you get these services
Outpatient behavioral healthcare (continued) You have the option of getting these services through an in-person visit or by telehealth. The plan also covers community-based behavioral healthcare 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 **Diversionary behavioral health services** section listed earlier in this chart.	

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Prior authorization is not required for services provided by a network provider.	You pay $0.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance use services Under the Mental Health Parity and Addiction Equity Act, we provide behavioral healthcare and substance use benefits that are no more restrictive than the requirements or limitations that we apply to medical, surgical, community, and support benefits. The plan covers additional services under the MassHealth (Medicaid) benefit including but not limited to: • Ambulatory detoxification (Level II. d) • Acupuncture treatment • Methadone maintenance/opioid replacement therapy	You pay $0. ***Prior authorization is required for acupuncture treatment after 36 sessions.***

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. Senior Care Options members have $0 cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." For more information, please speak to your care partner or contact Member Services.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
Over-the-counter (OTC) medications Please see Outpatient drugs section of this chart.	You pay $0. Prior authorization may be required for certain OTC medications.

Palliative care program CCA Senior Care Options palliative care is care that aims to improve the quality of life for people living with a serious illness. This type of care is focused on relief from the symptoms and stress of a serious illness. When receiving palliative care, you can still receive treatment and therapies meant to improve, or even cure, your medical problems. The program can help you: • Find relief for pain & other symptoms • Manage your medications • Understand your illness and its course • Identify what matters most to you • Get you the right care at the right time • Make plans and decisions • Communicate with your providers • Prepare for future stages	You pay $0.

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

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community behavioral health center, that is more intense than the care received in your healthcare provider's or therapist's office and is an alternative to inpatient hospitalization. Prior authorization is not required for services provided by a network provider.	You pay $0.

Personal care attendant (PCA) Consumer-directed care delivery. A personal care attendant (PCA) is 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. Members are considered the employer of the personal care attendant and are responsible for recruiting, hiring, scheduling, training, and if necessary, firing their personal care attendants. If you are unable to complete any of the responsibilities listed above, you must use an approved surrogate.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
Personal care In addition to the services listed in the **homemaker** section, personal care agencies (also called home care agencies) also provide assistance with bathing, dressing, shampoo/hair combing, foot care (excluding nail cutting), denture care, shaving, toileting, eating, meal prep, ambulating, and transfers. These services are covered by our plan under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required.***

Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or a specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services (virtual care), including: urgently needed services; home health services; primary care provider services; occupational therapy services; individual sessions for behavioral health specialty services; other healthcare professional; individual	You pay $0. If you've received a qualifying exam from your PCP, you can receive up to one $25 reward on your Healthy Savings card per calendar year upon provider billing CCA for the service. ***Prior Authorization is required for: certified ambulatory surgical centers, non-***

sessions for psychiatric services; physical therapy and speech-language pathology services; individual sessions for outpatient substance use. ○ 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. ○ 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. **Continued on next page**	***routine dental care, and services provided by out-of-network providers.***

Physician/Practitioner's Services (continued) ○ Telehealth services to diagnose, evaluate, or treat symptoms of a stroke. ○ Telehealth services for members with a substance use disorder or co-occurring behavioral health disorder, regardless of their location. ○ Telehealth check-ins (for example, by phone or video chat) with your healthcare provider for 5-10 minutes **<u>if</u>**: ▪ You're not a new patient **and** ▪ The check-in isn't 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 healthcare provider, and interpretation and	

follow-up by your healthcare provider within 24 hours if: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your healthcare provider has with other healthcare providers by phone, internet, or electronic health record **if** you're not a new patient • 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.	

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner's Services (continued) • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). For more information on dental services, including prior authorization requirements, please go to the **Dental services** section listed earlier in this Chart. See "Annual Wellness Visit" for details about the annual wellness visit reward for annual physical exams.	

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • 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 The plan also covers podiatric care, including routine foot care, under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required for podiatric surgery and podiatry services provided in a nursing home.***

Services that are covered for you	**What you must pay** when you get these services
Prescription Digital Therapeutics The plan covers reSET and reSET-O, a 12-week, on demand cognitive behavioral therapy application downloadable to a smartphone. This therapy is indicated for adults being treated in an outpatient treatment program for substance use disorder and opioid use disorder. Treatment with reSET-O should be combined with therapy including transmucosal buprenorphine. Please work with your provider and Senior Care Options Plan to determine if this will work for you. Call the plan's Member Services line for more information.	You pay $0.

Services that are covered for you	**What you must pay** when you get these services
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for an annual PSA test.

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. The plan also covers prosthetic care not covered by Medicare under the MassHealth (Medicaid) benefit. For a detailed list, please discuss with your care team or call Member Services.	You pay $0. ***Prior authorization may be required.***

Services that are covered for you	**What you must pay** when you get these services
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 healthcare provider treating the chronic respiratory disease.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
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 pre-planned for a specified time period. These services are covered by our plan under the MassHealth (Medicaid) benefit. Prior authorization is not required for services provided by a network provider.	You pay $0.

Services that are covered for you	**What you must pay** when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, 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 provider or practitioner in a primary care setting. The plan covers additional services under the MassHealth (Medicaid) benefit. Prior authorization is not required for services provided by a network provider.	You pay $0. There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and 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. **For LDCT lung cancer screenings after the initial LDCT screening***:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or	You pay $0. There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
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.	

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: • 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 Prior authorization is not required for services provided by a network provider.	You pay $0.

🍏 Screening 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 healthcare provider's office.	You pay $0. There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Prior authorization is not required for services provided by a network provider.	

Services to treat kidney disease Covered services include: • 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 healthcare provider, 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, or when your provider for this service is temporarily unavailable or inaccessible) • 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	You pay $0.

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) 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, "**Medicare Part B prescription drugs**." Prior authorization is not required for services provided by a network provider or for dialysis provided by an out-of-network provider when you are temporarily out of the service area.	

Skilled nursing facility (SNF) care (For a definition of “skilled nursing facility care,” see Chapter 11 of this document. Skilled nursing facilities are sometimes called “SNFs.”) 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: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole	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). ***Prior authorization is required.***

blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services **Continued on next page**	

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (continued) 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, if the facility accepts our plan's amounts for payment. • 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	

🍏 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 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. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover 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. The plan also covers additional 8 cessation counseling sessions under the MassHealth (Medicaid) benefit.	You pay $0. There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	**What you must pay** when you get these services
Prior authorization is not required for services provided by a network provider.	
Social and dementia day care 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.	You pay $0. ***Prior authorization is required.***

Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and an order for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • 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	Your cost $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
• 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 SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a healthcare provider.	

Transportation (non-emergency medical) The plan covers transportation you need for medical reasons other than emergencies to approved destinations in the plan's service area. This non-emergency transportation benefit is covered by our plan under the MassHealth (Medicaid) benefit. The plan uses Coordinated Transportation Solutions (CTS) for all non-emergency transportation rides. To contact CTS, please call 855-204-1410 (TTY 711). Transportation must be arranged by CTS to be covered by CCA Senior Care Options. Prior authorization is not required for non-emergency medical transportation.	You pay $0.

Transportation (non-medical purposes) Eight (8) one-way trips per month are provided for non-medical purposes, such as grocery shopping. Trips not used within the month are not rolled over for future use. Trips must be booked at least 72 hours in advance, Monday through Friday, of the expected trip date. If you cannot go on a scheduled ride, you must cancel the ride at least 2 hours before the scheduled pick-up time. If you do not cancel your ride, and you either do not show up or cancel with less than 2 hours' notice, the scheduled ride will count against your eight (8) one-way non-medical trips per month. Mile limitation is applicable. This benefit is covered by the plan under the MassHealth (Medicaid) benefit.	You pay $0. ***Prior authorization is required.***

Services that are covered for you	**What you must pay** when you get these services
The plan uses Coordinated Transportation Solutions (CTS) for all non-emergency transportation rides. To contact CTS, please call 855-204-1410 (TTY 711). Transportation must be arranged by CTS to be covered by CCA Senior Care Options.	

Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Our plan also covers urgently needed care and emergency services,	You pay $0.

Services that are covered for you	**What you must pay** when you get these services
including emergency transportation, outside the United States and its territories up to one hundred thousand dollars ($100,000) per calendar year. This is a supplemental benefit covered under our plan. For more information about urgently needed care, see Chapter 3. Whenever possible, you should inform your PCP and CCA care team when receiving urgent care. Prior authorization is not required for services provided by a network provider.	

Vision care 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 (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older	You pay $0. ***Prior authorization is required for any eyewear or contact lenses beyond the $300 limit.***

• 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 covers additional vision services that are typically not covered under the Medicare and (MassHealth) benefit. The plan pays up to $300 per calendar year for the following items without prior authorization: **Continued on next page**	

Vision care (continued) • Eyeglass frames, or • Contact lenses ○ Contact lenses may be dispensed only upon a written and dated prescription. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to order the prescription and the plan to cover the service under the MassHealth (Medicaid) benefit. The plan also covers vision services under the MassHealth (Medicaid) benefit. Covered services include, but are not limited to: • Routine vision exams	

Services that are covered for you	**What you must pay** when you get these services
• Prescription lenses, which includes base lenses (single, bifocal, trifocal) Designer frames, or contact lenses used for cosmetic purposes, such as colored lenses, are excluded from coverage. Prior authorization is not required for outpatient vision services provided by a network provider. For questions about your vision benefits, call Member Services.	

Services that are covered for you	**What you must pay** when you get these services
🍏 **"Welcome to Medicare" preventive visit** 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. **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 healthcare provider's office know you would like to schedule your "Welcome to Medicare" preventive visit.	You pay $0. There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

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 the plan does not 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.

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 items is covered by the plan under MassHealth (Medicaid) benefits.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: 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 6.3 in this document.)

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
Cosmetic surgery or procedures		✓ • Covered 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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by 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.)

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.)
Full-time nursing care in your home.		✓ May be covered by the plan under the MassHealth

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
		(Medicaid) benefit only when there are no other alternative modes of care available. Prior authorization is required.
Naturopath services (uses natural or alternative treatments).	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
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.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
Orthopedic shoes or supportive devices for the feet		✓ Shoes that are part of a leg brace and are included in the cost of the brace. 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.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.		✓ Covered only if these services or supplies are covered under the MassHealth (Medicaid) benefit.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, 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.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions, including if covered by the plan under MassHealth (Medicaid)
Services considered not reasonable and necessary, according to Original Medicare standards		✓ 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.

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

OMB Approval 0938-1051 (Expires: February 29, 2024)

How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Because you are eligible for MassHealth Standard (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 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 document.)

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your

MassHealth (Medicaid) benefits. The Drug List tells you how to find out about your MassHealth (Medicaid) drug coverage. For more information, call Member Services. You can also visit our website www.ccama.org to find out what drugs are covered by MassHealth (Medicaid).

Section 1.1 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 you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- 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 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 on the plan's Drug List.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Provider and Pharmacy Directory**, visit our website (www.ccama.org), and/or call Member Services.

You may go to any of our network pharmacies.

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 pharmacy in your area, you can get help from Member Services or use the **Provider and Pharmacy Directory**. You can also find information on our website at www.ccama.org.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If

you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

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

To locate other specialized pharmacies, look in your **Provider and Pharmacy Directory** or call Member Services.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as "**mail-order" drugs** in our Drug List.

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 three options:

1. Call Member Services.
2. Visit our website www.ccama.org and view information under 'Member Forms.'
3. Speak with your care team.

If your prescription is delayed, you may contact Costco Pharmacy online at http://pharmacy.costco.com for more information or by phone by calling 800-607-6861. Costco customer service hours are 8 am to 10 pm, Monday to Friday, and 12:30 pm to 5 pm on Saturday. If additional support is required, you may contact CCA Member Services to obtain a medication override at your local pharmacy for a limited supply of medication. Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. If for any reason your mail order is

delayed, please call our Member Services. We will assist you in obtaining the prescription (s) you need.

New prescriptions the pharmacy receives directly from your healthcare provider's office.
After the pharmacy receives a prescription from a healthcare provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14-21 days before your current prescription 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?

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.)

1. Some **retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your **Provider and 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.
2. You may also receive maintenance drugs through our **mail-order program**. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

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. **Please check first with Member Services** to see if there is a network pharmacy nearby.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- 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 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 drugs).
- 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.

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 healthcare providers and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth (Medicaid) benefits. We sent you the MassHealth (Medicaid) over-the-counter (OTC) Drug List. For more information on drugs that are covered by MassHealth (Medicaid), call Member Services. You can also visit our website at www.ccama.org.

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 for the diagnosis or condition for which it is being prescribed.
- **or** -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars.] Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand-name drugs and some biological products.

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.

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 the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 8.
- MassHealth (Medicaid)-covered drugs are not included on the Medicare Drug List (Formulary). We sent you MassHealth (Medicaid) MassHealth over-the-counter (OTC) Drug List. For more information, call Member Services. You can also visit the plan's website (www.ccama.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 provide electronically. (Please note: The Drug List we provide 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 provided Drug List. If one of your drugs is not listed in the Drug List, you should contact Member Services to find out if we cover it.)

2. Visit the plan's website (www.ccama.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.

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 healthcare providers and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If 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.

Please note that sometimes a drug may appear more than once in our drug list. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your healthcare provider, and different restrictions may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

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. Contact Member Services to learn what you or your provider would 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)

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 instead of the brand name drug. However, if your provider has told us the medical reason that the generic drug will not work for you *OR* has written "No substitutions" on your prescription for a brand name drug *OR* 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**." This is put in place to ensure medication safety and help 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 usually 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 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 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

There are situations where there is a prescription drug you are 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.

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 options:

- You may be able to get a temporary supply of the drug.
- 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.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List OR is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan**.**

- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first **90 days** of the calendar year.

- This temporary supply will be for a maximum of 31-day supply*.* If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 31-day supply of medication. The prescription must be filled at a network pharmacy. (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 days and reside in a long-term care facility and need a supply right away**. We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- **For those members who have a level of care transition.** 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 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

For questions about a temporary supply, call Member Services.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may 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.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it 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. 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 tell you about any change prior to the new 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 you 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 can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**.
- **Add or remove a restriction on coverage for a drug**.
- **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, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes were made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan 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 newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. 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). 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.

- 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.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you 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 example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List 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.

- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- 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.

Changes to the Drug List that do not affect you during this plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for 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 restrictions to your use of the drug. We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 8.) If the drug excluded by our plan is also excluded by MassHealth (Medicaid), you must pay for it yourself

(except for certain excluded drugs covered under our enhanced drug coverage).

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 or 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.
- Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your MassHealth (Medicaid) drug coverage. We sent you a MassHealth (Medicaid) over-the-counter (OTC) Drug List. For more information, call Member Services. You can also

visit the plan's website (www.ccama.org) to find out what drugs are covered by MassHealth (Medicaid).

- Non-prescription drugs (also called over-the-counter drugs). Certain over-the-counter drugs are covered for you under your MassHealth (Medicaid) drug coverage.
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms. Certain drugs for relief of cough or cold symptoms are covered for you under your MassHealth (Medicaid) drug coverage.
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. Certain vitamin and mineral products are covered for you under your MassHealth (Medicaid) drug coverage.
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain. Certain vitamin and mineral products are covered for you under your MassHealth (Medicaid) drug coverage.

- 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 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

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

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can 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 prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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 uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your **Provider and Pharmacy Directory** to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member

Services. 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.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are 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 these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your

drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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 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
- Prescriptions for drugs that have ingredients you are allergic to

- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

We have a program that helps make sure members safely use prescription opioids and other frequently overused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several healthcare providers or pharmacies, or if you had a recent opioid overdose, we may talk to your healthcare providers to make sure your use of opioid medications is appropriate and medically necessary. Working with your healthcare providers, if we decide your use of prescription opioid medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid medications from a certain healthcare provider(s)

- Limiting the amount of opioid medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which healthcare providers 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 or with the limitation, you and your prescriber have the right to appeal. If you 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.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

CCA also offers a substance use program for members who are experiencing or are at risk for developing opioid use disorder or any other substance use disorder. In addition to providing coverage for certain addiction services, we provide targeted clinical support. Our network of providers and the benefits we offer provide services such as detoxification, intensive outpatient treatment, acupuncture, and medication-assisted treatments. If you need support with opioid use disorder or any other substance use disorder, talk to your care partner.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and healthcare providers developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, 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. During the review, you can talk about 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 which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your healthcare provider about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctor, pharmacists, and other healthcare providers. Also, keep your medication list up to date and 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. If you have any questions about this program, please contact Member Services.

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 summary called the Part D Explanation of Benefits (the "Part D EOB")

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 have paid. This is called your "**out-of-pocket**" cost. With CCA Senior Care Options, 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. CCA Senior Care Options members are responsible for $0 costs for covered drugs.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a

Part D Explanation of Benefits ("Part D EOB"). The Part D EOB 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 the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 11.2 Help us keep our information about your drug payments up to date

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 every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, 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, give us copies of these receipts Here are examples of when you should give us copies of your drug receipts:
    - 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

  If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 6, Section 2.

- **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. 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. 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 the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. Be sure to keep these reports.

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

OMB Approval 0938-1051 (Expires: February 29, 2024)

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

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 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 medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. 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.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for cost sharing as discussed in the

document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. 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 we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed amounts. Senior Care Options members have $0 cost-sharing amounts. If this provider is contracted, you still have the right to treatment.

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 or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

   - If you pay the entire amount yourself at the time you receive the care, ask us to pay you back. Submit the CCA reimbursement form with proof of payment.

- You may get a bill from the provider asking for payment that you think you do not owe. Before paying the bill, contact Member Services.
  - We will review your bill and if the provider is owed anything, we will pay the provider directly.

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, contact Member Services. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, submit the CCA reimbursement form with proof of payment.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This 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 such as receipts and bills for us to handle the reimbursement.

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

If you go to an out-of-network pharmacy, 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.

Submit the CCA prescription reimbursement form with proof of payment. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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. Submit the CCA prescription reimbursement form with proof of payment.

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 should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Submit the CCA prescription reimbursement form with proof of payment. In some situations, we may need to get more information from your healthcare provider 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 document 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

You may request us to pay you back by sending us a request in writing, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within the timeframes noted below:**

- **Requests for reimbursement for fitness/wellness** must be received by March 31, 2024.
- **All other reimbursement requests** must be submitted within 12 months of the date you received the service or item.

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

- You don't have to use the form, but it will help us process the information faster. Your request must be written, and be signed by you, an authorized representative, or a licensed prescriber. You must include the following information with your request:
    - First and Last Name
    - Member ID

- Date of birth
- Service type:
  - Medical/Behavioral Health
  - Dental
  - Equipment/Supplies
  - Worldwide Emergency Services
  - Transportation
  - Healthy Savings
  - Fitness/Wellness
  - Delivered Meals
  - Vision
- The name of the service/supply provider
- Date(s) of service
- CPT/Diagnosis code
- You must include a copy of the receipt and an itemized bill of services or supplies. Receipts must show:
  - Place and date of purchase
  - Total amount paid and payment method
  - Items/services to be reimbursed
  - Service provider and date of service

  - The receipt or bill should include diagnostic and procedure codes. If an itemized bill is not available, you can submit a statement from the provider/supplier on their letterhead. Both your receipt and your itemized bill must be easy to read. CCA will not honor reimbursement requests for items purchased with gift certificates, gift cards, or pre-paid debit cards. CCA will not reimburse for coupons.
- Either download a copy of the CCA reimbursement form from our website (www.ccama.org) or call Member Services and ask for the form.

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

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

Prescription reimbursement is different from medical services reimbursement. The plan works in partnership with its pharmacy benefit manager (PBM), Navitus Health Solutions (Navitus), to provide Part D prescription

reimbursements. **You must submit your claim to Navitus within 12 months of the date you received the drug.**

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

- You don’t have to use the prescription reimbursement form, but it will help us process the information faster. Your request must be written, and be signed and dated by you, an authorized representative, or a licensed prescriber. You must include the following information with your request:
    - First and last name
    - Telephone number
    - Date of birth
    - Gender
    - Member ID
    - Mailing address
    - The name, address, and telephone number of the pharmacy that filled your prescription
    - Date(s) the prescription was filled
    - Diagnosis code and description
    - Name of medication

  - Prescription number
  - For compound medications, the following information is needed
    - Final form of compound (cream, patches, suppository, suspension, etc.)
    - Time spent preparing drug
    - Compound ingredients
  - National Drug code
  - Quantity
  - Day supply
  - Total volume (grams, ml., each, etc.)
  - Proof of payment
  - Prescriber first and last name
  - Prescriber NPI
  - Original cost of drug
  - Amount primary insurance paid on the drug
  - Member paid amount
- Either download a copy of the prescription reimbursement form from our website (www.ccama.org) or call Member Services and ask for the form.

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

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

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. The letter will let you know how long you have to submit additional information to us. 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, 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.

- 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. We will send you a letter explaining the reasons why we are not sending the payment 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

If you think we have made a mistake in turning down your request for payment or 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. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 8 of this document.

CHAPTER 7:
Your rights and responsibilities

OMB Approval 0938-1051 (Expires: February 29, 2024)

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

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

is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

- Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive healthcare services.
- If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service.
- If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week, from October 1 to March 31. (April 1 to September 30: 8 am to 8 pm, Monday to Friday, and 8 am to 6 pm, Saturday and Sunday.) You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you are treated with respect and recognition of your dignity and your right to privacy

- Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's medical condition, health status, receipt of health services, claims experience, medical history, disability (including behavioral impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence.
- If you want more information or have concerns about discrimination or unfair treatment, please call the U.S. Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.
- If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.
- For more information on how we protect your right to privacy, refer to Section 1.4.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

- You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.
- You have the right to get appointments and covered services from the plan's network of providers **within a reasonable amount of time**. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.
- All urgent care and symptomatic office or home visits are available to you within 48 hours. All non-symptomatic office visits are available to you within 14 calendar days.
- If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 8 tells what you can do.

Section 1.4 We must protect the privacy of your personal health information

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

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that 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.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn’t providing your care or paying for your care, **we are required to get written permission from you or someone you have given legal power to make decisions for you first.**

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - 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; typically, this requires that information that uniquely identifies you not be shared.

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

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

- If you have questions or concerns about the privacy of your personal health information, please call Member Services.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: August 4, 2022

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

We reserve the right to change this Notice and to make the changes effective for all Medical Information we maintain. If we make a material change to the Notice, we will (i) post the updated Notice on our website; (ii) post the updated Notice in each of Our Healthcare Providers'

service locations; and (iii) make copies of the updated Notice available upon request. We will also send Our Health Plan Members information about the updated Notice and how to obtain the updated Notice (or a copy of the Notice) in the next annual mailing to Members. We are required to abide by the terms of the Notice that is currently in effect.

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

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

SECTION 1: Companies to Which This Notice Applies

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

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

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

Our Health Plans

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

Our Healthcare Providers

- Commonwealth Clinical Alliance, Inc.
- Boston's Community Medical Group, Inc. d/b/a CCA Primary Care

- Reliance PO of Michigan, Inc.
- instED™
- Marie's Place

SECTION 2: Information We Collect:

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

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

- We collect information, such as email addresses, personal, financial, or demographic information from you when you voluntarily provide us with such information, such as (but not limited to) when you contact us with inquiries, fill out on-line forms, respond to one of our surveys, respond to advertising or promotional material, register for access to our services or use certain services.

- Wherever CCA collects Medical Information, we make access to this notice available. By providing us with Medical Information, you are consenting to our use of it in accordance with this notice. If you provide information to CCA, you acknowledge and agree that such information may be transferred from your current location to the facilities and servers of CCA and the authorized third parties with whom CCA does business.

SECTION 3: How We Use and Disclose Your Medical Information

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

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

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

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

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

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

Healthcare Operations: We may use and disclose your Medical Information to perform a variety of business activities that allow us to administer the benefits you are entitled to under Our Health Plan and the treatment

furnished by Our Providers. For example, we may use or disclose your Medical Information to:

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

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

Persons Involved in Your Care: We may disclose your Medical Information to a relative, close personal friend or any other person you identify as being involved in your care. For example, if you ask us to share your Medical Information with your spouse, we will disclose your Medical Information to your spouse. We may also disclose your Medical Information to these people if you

are not available to agree and we determine it is in your best interests. In an emergency, we may use or disclose your Medical Information to a relative, another person involved in your care or a disaster relief organization (such as the Red Cross), if we need to notify someone about your location or condition.

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

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

healthcare power of attorney, or a disabled individual's court-appointed guardian.

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

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

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

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

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

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

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

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

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

SECTION 4: Other Uses and Disclosures Require Your Prior Authorization

Except as described above, we will not use or disclose your Medical Information without your written permission ("**authorization**"). We may contact you to ask you to sign

an authorization form for our uses and disclosures or you may contact us to disclose your Medical Information to another person and we will need to ask you to sign an authorization form.

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

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

- **Use and disclosure of psychotherapy notes**: Except for certain treatment, payment, and healthcare operations activities or as required by law, we may only use or disclose your psychotherapy notes if we have your written authorization.

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

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

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

Right to Access to Inspect and Copy: You have the right to inspect (see or review) and receive a copy or summary of your Medical Information we maintain in a "designated record set." If we maintain this information in electronic form, you may obtain an electronic copy of these records. You may also instruct Our Healthcare Providers to send an electronic copy of information we maintain about you in an Electronic Medical Record to a third party. You must provide us with a request for this access in writing. We may charge you a reasonable, cost-

based fee to cover the costs of a copy of your Medical Information. In accordance with the HIPAA Privacy Rule and in very limited circumstances, we may deny this request. We will provide a denial in writing to you no later than 30 calendar days after the request (or no more than 60 calendar days if we notified you of an extension).

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

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

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

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

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

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

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

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

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

SECTION 7: State-Specific Requirements

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

Massachusetts Immunization Information System (MIIS)
Immunization Program

Massachusetts Department of Public Health
305 South Street
Jamaica Plain, MA 02130

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

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

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your covered services and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding

medical services. Chapter 5 provides information about Part D prescription drug coverage.

- **Information about why something is not covered and what you can do about it.** Chapter 8 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 8 also provides information on asking us to change a decision, also called an appeal.
- **Information on your responsibilities as a member of our plan.** You have some responsibilities you must follow as a CCA Senior Care Options member.

Section 1.6 We must support your right to participate with practitioners and providers in making decisions about your care

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

with your healthcare providers about what treatment is best for you, your rights include the following:

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

as a means of coercion, discipline, convenience, or retaliation.

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

- If you want to use a health care proxy to give your instructions, here is what to do:
  - **Get the form.** You can contact Member Services to ask for a form that is provided by Honoring Choices Massachusetts. You can also download a copy of the form from the Honoring Choices Massachusetts website (www.honoringcoicesmass.com).
  - **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document.
  - **Give copies to appropriate people.** A copy of your health care proxy is as valid as the original. You should give a copy of the form to your healthcare provider and to your health care agents. You may want to give copies to close friends or family members. Keep a copy at home.
- If you know ahead of time that you are going to be hospitalized, and you have signed a health care proxy, take a copy with you to the hospital.
  - The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
  - If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

Section 1.7 You have the right to make complaints or appeals about the organization or the care it provides

- If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 8 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.
- You may file an internal appeal directly with our plan. 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.

Section 1.8 You have the right to make recommendations on our member rights and responsibilities policy

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

Section 1.9 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to 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 1-877-486-2048).

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

Section 1.10 How to get more information about your rights

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

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication “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 1-877-486-2048).

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapter 5 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know.
- **Tell your doctor and other healthcare providers that you are enrolled in our plan.** Show your plan

member ID card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other healthcare providers about your health problems. Follow the mutually agreed upon treatment plans and instructions that you and your healthcare providers agree upon.
    - Make sure your healthcare providers know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **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 CCA Senior Care Options 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, you must pay the full cost.

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

CHAPTER 8

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

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 problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are 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. To make things easier, this chapter:

- Uses 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. Knowing which terms to use will help you communicate more accurately to 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 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. 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. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact 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 also 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 get help and information from My Ombudsman

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

- You can call 1-855-781-9898, TTY users should use MassRelay at 711 to call 1-855-781-9898 or use Videophone (VP) at 339-224-6831)
- You can visit the My Ombudsman website (www.myombudsman.org).
- You can email My Ombudsman at info@myombudsman.org

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 decisions and appeals

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)**.

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

Coverage decisions and appeals deal with problems related to your benefits and coverage, including 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 prior to receiving services

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 network provider makes a (favorable) coverage decision for you whenever you receive medical care from them. Or, if you or your provider ask the plan to cover a power wheelchair

and we say yes, this is a (favorable) coverage decision. You or your healthcare provider can also contact us and ask for a coverage decision if your provider 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.

In limited circumstances, a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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, whether before or after a service is received, and you are not satisfied, you can

"appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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 properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, your appeal for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need

to do anything. The Level 2 appeal is conducted by an independent review organization that is not connected to us. The independent review organization will mail you a notice to confirm they received your Level 2 appeal. See Section **6.4** of this chapter for more information about Level 2 appeals for medical services and Part B drugs.

If we do not dismiss your case but say no to all or part of your Level 1 appeal for **Part D drugs**, you will need to ask for a Level 2 appeal. See **Section 7** of this chapter for more information about Level 2 appeals for Part D drugs.

If you are not satisfied with the Level 2 appeal decision, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services**.
- You **can get free help** from the Massachusetts Health Insurance Assistance Program.

- **Your doctor or other healthcare provider can make a request for you.** If your healthcare provider helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.ccama.org.)
    - For medical care, your doctor or other healthcare provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal 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.
    - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **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.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.ccama.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.
    - 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.

- **You also have the right to hire a lawyer.** 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 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”
- **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 healthcare provider 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 only applies to these services: home healthcare, 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. You can also get help or information from government organizations such as your SHIP.

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

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: **Medical Benefits Chart (what is covered**). To keep things simple, we generally refer to “medical care coverage” or “medical care” which 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. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other healthcare provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
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. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home healthcare, skilled nursing facility care, or Comprehensive Outpatient

Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."** A "fast coverage decision" is called an **"expedited determination."**

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may **only ask** for coverage for medical care **you have not yet 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 healthcare provider 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 healthcare provider's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines
  - Explains if your healthcare provider asks for the fast coverage decision, we will automatically give you a fast coverage decision
  - Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- 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 healthcare provider, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This 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.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days** if your request is for a medical item or service. If we 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." We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions

and appeals. See Section 11 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe.

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.

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we 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". (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **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 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."** A "fast appeal" is also called an **"expedited reconsideration."**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 30 days.
A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your healthcare provider will need to

decide if you need a “fast appeal.” If your healthcare provider tells us that your health requires a “fast appeal,” we will give you a fast appeal.

- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.2 of this chapter.

<u>Step 2:</u> Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include 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. You and your healthcare provider may add more information to support your 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 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your healthcare provider.

Deadlines for a "fast appeal"

- For fast appeals, 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.
  - However, if you ask for more time, or if we need 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 take extra days, we will tell you in writing. We can't take extra time 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. Section 6.4 explains the Level 2 appeal 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 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard" appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. 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 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 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." 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 deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage 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 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.

- 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.
- 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

Legal Term
The formal name for the “independent review organization” is the **“Independent Review Entity.”** It is sometimes called the **“IRE.”**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

- 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 208 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.

If your problem is about a service or item Medicare usually covers:

<u>Step 1:</u> The independent review organization reviews your appeal.

- 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

- For the "fast appeal" 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 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.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- For the "standard appeal" 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.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you it's decision in writing and explain the reasons for it.

- **If the independent 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 **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" or "turning down your appeal.") In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 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 explains the process for Level 3, 4, and 5 appeals.

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 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/how-to/how-to-appeal-a-masshealth-decision.

- Hearing requests should be mailed or faxed to:

  Executive Office of Health and Human Services
  Board of Hearings Office of Medicaid

100 Hancock Street, 6th floor
Quincy, MA 02171
Fax: 1-617-847-1204

- We will send the information we have about your appeal to the Board of Hearings. This information is called your “case file.” You have the right to ask us for a copy of your case file. Copies are provided to you free of charge.
- You have a right to give the Board of Hearings additional information to support your appeal.
- At the hearing, you may present yourself or have an authorized representative act on your behalf, or be represented by a lawyer or other representative at your own expense. You may contact a local legal service or community agency to get advice or representation at no cost.

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**.

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.

Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

If you get a bill for Medicaid-covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the

problem. But if you do pay the bill, you can get a refund from that healthcare provider if you followed the rules for getting the service or item.

If you have already paid for a Medicaid 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.

Asking for reimbursement is asking for a coverage decision from us.

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a healthcare provider for a 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. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost within 60 calendar days after we receive your request.
- **If we say no to your request:** 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.

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. For appeals concerning reimbursement, please note:

- 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, you are not allowed to ask for a fast appeal.

- If the independent review organization decides we should pay, we must send you or the provider the payment 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 healthcare provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5.

- **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. We also use the term “drug list” instead of “List of Covered Drugs” or “Formulary.”
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- 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.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **“coverage determination.”**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's **List of Covered Drugs**. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

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.

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering 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.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.**
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List.

Section 7.3 Important things to know about asking for exceptions

Your healthcare provider 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.

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 healthcare provider 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, you can ask for another review by making an appeal.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A “fast coverage decision” is called an **“expedited coverage determination.”**

Step 1: Decide if you need a “standard coverage decision” or a “fast coverage decision.”

“Standard coverage decisions” are made within **72 hours** after we receive your healthcare provider’s statement. **“Fast coverage decisions”** are made within **24 hours** after we receive your healthcare provider’s statement.

If your health requires it, ask us to give you a "fast coverage decision." **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a **drug you have not yet received**. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- 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 a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
    - Tells 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. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decision."

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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the "supporting statement,** which is the medical reasons for the exception. 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.

Step 3: We consider your request and give you our answer.

Deadlines for a "fast coverage decision"

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your healthcare provider's supporting statement. 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.

- **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 healthcare provider'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

- We must give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your healthcare provider's supporting statement. 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.
- **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 request or healthcare provider'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 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
- **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 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."** A "fast appeal" is also called an **"expedited redetermination."**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal".

- 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 6.2 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1

appeal. If your health requires a quick response, you must ask for a "fast appeal."

- **For standard appeals, submit a written request**, or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 866-610-2273 (TTY 711). Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include 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 and your healthcare provider may add more information to support your appeal.

<u>Step 3:</u> 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.

Deadlines for a "fast appeal"

- For fast appeals, 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.
    - 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. **Section 7.6** explains the Level 2 appeal 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 for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. 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 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. **Section 7.6** explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** 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" 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.
- **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.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 Step-by-step: How to make a Level 2 appeal

Legal Term
The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding “at-risk” determination under our drug management program, we will automatically forward your claim to the IRE.

- 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 copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast appeal"

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for "standard appeal"

- For standard appeals, 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 yet received. 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.

<u>Step 3:</u> The independent review organization gives you their answer.

For "fast appeals":

- **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.

For "standard appeals":

- **If the independent review organization says yes to part or all of your 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 says yes to part or all of your 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.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:

- Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. 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.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

<u>Step 4:</u> 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- 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 healthcare provider 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.

During your covered hospital stay, your healthcare provider and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will 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 is decided, your healthcare provider or the hospital staff will tell you.
- 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.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, 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.

If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your healthcare provider. 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.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This 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.

2. **You will be asked to 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.
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, 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 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.

Section 8.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

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.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, call Member Services. Or call Massachusetts Health Insurance Assistance Program, a government organization that provides personalized assistance.

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.

The **Quality Improvement Organization** is a group of doctors and other healthcare professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes

reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

<u>Step 1:</u> Contact the Quality Improvement Organization for Massachusetts and ask for an immediate review of your hospital discharge. You must act quickly.

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 Massachusetts in Chapter 2.

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.**
    - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision 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 8.3** of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your healthcare provider, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services 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.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (“the reviewers”) 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 healthcare provider, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your healthcare provider, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

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, **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.

What happens if the answer is no?

- If the review organization says no, 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.

<u>Step 4:</u> 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 said **no** to 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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision 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.

<u>Step 1:</u> 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.

<u>Step 2:</u> 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.

<u>Step 3:</u> Within 14 calendar days of receipt of your request for a Level 2 appeal, the 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.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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 you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled 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?

Legal Term
A “fast review” (or “fast appeal”) is also called an **“expedited appeal**.**”**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement 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

<u>Step 1:</u> Contact us and ask for a “fast review.”

- **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. Chapter 2 has contact information.

<u>Step 2:</u> 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 see if the decision about when you should leave the hospital was fair and followed all the rules.

<u>Step 3:</u> We give you our decision within 72 hours after you ask for a "fast review".

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are 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 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.

<u>Step 4:</u> If we say *no* to your appeal, your case will automatically be sent on to the next level of the appeals process.

Step-by-Step: Level 2 <u>Alternate</u> appeal Process

Legal Term
The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

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. **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.

- 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 pay you back for our share of the costs of hospital care you 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 that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell you how to start 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 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 This section is only about three services: Home healthcare, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, 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.

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.

Section 9.2 We will tell you in advance when your coverage will be ending

Legal Term
"**Notice of Medicare Non-Coverage."** It tells you 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.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop 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.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, call Member Services. Or call Massachusetts Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other healthcare experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it’s time to stop covering

certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (**Notice of Medicare Non-Coverage**) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for Massachusetts in Chapter 2.

Act quickly:

- 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.

Your deadline for contacting this organization.

- 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 9.4** of this chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term
"**Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") 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 healthcare provider, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

<u>Step 3:</u> 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?

- 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). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home healthcare, 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.

<u>Step 4:</u> If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- 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 a Level 2 appeal.

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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 healthcare, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

Step 1: 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?

- **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 made to your Level 1 appeal.
- 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.

<u>Step 4:</u> 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- 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 9.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, 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

Legal Term
A “fast review” (or “fast appeal”) is also called an **“expedited appeal**.**”**

Step 1: Contact us and ask for a “fast review.”

- **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. Chapter 2 has contact information.

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.

Step 3: We give you our decision within 72 hours after you ask for a “fast review”.

- **If we say yes to your 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 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 healthcare, 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.

<u>Step 4:</u> If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

Legal Term
The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step-by-Step: Level 2 Alternate appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision

should be changed. **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.

<u>Step 1:</u> We 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. **Section 11** of this chapter tells how to make a complaint.)

<u>Step 2:</u> The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- 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 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 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 go on to a Level 3 appeal.

<u>Step 3:</u> If the independent review organization says no to 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- A Level 3 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

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 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. The written response you receive to your Level 2 appeal will explain how to make 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 **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**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide not to appeal, 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. The notice you get will tell you what to do for a Level 4 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.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - 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.
  - 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 may 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 and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

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 **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**. We must **authorize or provide the drug coverage** that was 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. The notice you get will tell you what to do for a Level 4 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**. 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 may 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 will tell you whether the rules allow you to go on to a Level 5 appeal. It 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.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is **only** used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are

examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?

Complaint	Example
Waiting times	• 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? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or healthcare provider’s office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review

Complaint	Example
	organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

- A **"Complaint"** is also called a **"grievance."**
- **"Making a complaint"** is also called **"filing a grievance."**
- "**Using the process for complaints"** is also called "**using the process for filing a grievance."**
- A **"fast complaint"** is also called an **"expedited grievance."**

Section 11.3 Step-by-step: Making a complaint

<u>Step 1:</u> 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.
- 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. We will respond to your complaint in writing.

- You can make the complaint at any time after you had the problem you want to complain about. We will acknowledge your grievance within one business day after we receive it.
- You also have the right to file an expedited complaint which could include a complaint that CCA Senior Care Options refused to expedite an organization determination, coverage determination, reconsideration, or redetermination, or invoked an extension to an organization determination or reconsideration time frame(s). The time frame for CCA Senior Care Options to respond to expedited complaints is within 24 hours of our receipt of your complaint.
- **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.

<u>Step 2:</u> 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.

- **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 in writing.
- **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**.
- **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 include our reasons in our response to you.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization. The** Quality Improvement Organization is a group of practicing doctors and other healthcare experts

paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 11.5 You can also tell Medicare and MassHealth (Medicaid) about your complaint

You can submit a complaint about CCA Senior Care Options directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

You can submit a complaint about CCA Senior Care Options anytime directly to MassHealth (Medicaid). You can do this by calling the MassHealth (Medicaid) Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648), Monday – Friday 8:00 a.m. to 5:00 p.m.

Section 11.6 Complaints about Mental Health Parity

Federal and state laws require that all managed care organizations, including CCA Senior Care Options provide behavioral health services to MassHealth (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. CCA Senior Care Options must provide the same level of benefits for any behavioral health and substance use problems you may have as for other physical problems you may have.
2. CCA Senior Care Options must have similar prior authorization requirements and treatment limitations for behavioral health and substance use services as it does for physical health services.
3. CCA Senior Care Options must provide you or your provider with the medical necessity criteria used by the plan for prior authorization upon your or your provider’s request; and
4. CCA Senior Care Options must also provide you within a reasonable time frame the reason for any denial of authorization for behavioral or substance use services.

If you think that CCA Senior Care Options is not providing

parity as explained above, you have the right to file a Grievance with CCA Senior Care Options. For more information about Grievances and how to file them, please review the section on how to make a complaint earlier in this chapter.

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 am to 5 pm.

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 CCA Senior Care Options.

- 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
  Fax: 617-847-1204

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

- To get the "Fair Hearing Request Form" or for more information about your appeal rights, you may contact the Board of Hearings at 617-847-1200 or 1-800-655-0338. The form is also available at: www.mass.gov/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 CCA Senior Care Options' 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 CCA Senior Care Options. You must tell the Board of Hearings that you wish to continue to receive the service while you are appealing. If you continue to receive services during the Board of Hearings appeal process, you may be responsible for the costs of those services. You may also choose not to continue to receive services during your appeal.

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 Member Services 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 1-866-457-4953

  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 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 Commonwealth Care Alliance, Inc., 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 member 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.**

What to do:

- Be careful!
- Read your paperwork from Commonwealth Care Alliance, Inc. 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 Commonwealth Care Alliance, Inc. can come into your home without your permission.

To learn more, go to www.ccama.org

CHAPTER 9:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in CCA Senior Care Options 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- 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, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and MassHealth (Medicaid)

Most people with Medicare can end their membership only during certain times of the year. Because you have

MassHealth (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.

- Choose any of the following types of Medicare plans:
    - Another Medicare health plan, with or without prescription drug coverage
    - Original Medicare **with** a separate Medicare prescription drug plan
    - Original Medicare without a separate Medicare prescription drug plan

- If you choose this option, 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.

Contact MassHealth (Medicaid) Office to learn about your MassHealth (Medicaid) plan options (telephone numbers are in Chapter 2, Section 6 of this document).

- **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

You can end your membership during the Annual Enrollment Period (also known as the “Annual Open Enrollment Period”). During this time, review your health

and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **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, with or without prescription drug coverage.
  - Original Medicare **with** a separate Medicare prescription drug plan

OR

  - Original Medicare **without** a separate Medicare prescription drug plan.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

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 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make **one** change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and 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.
- **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

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**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. 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 2.1 tells you more about the special enrollment period for people with MassHealth (Medicaid).

- **The enrollment time periods vary** depending on your situation.
- **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. You can choose:
- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare **with** a separate Medicare prescription drug plan

OR

- Original Medicare **without** a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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.

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 MassHealth (Medicaid) and Extra Help.

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Services.**
- Find the information in the **Medicare & You 2023** handbook.

- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our 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:
Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from CCA Senior Care Options when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
Original Medicare **with** a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from CCA Senior Care Options when your new plan's coverage begins.

Original Medicare **without** 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. ○ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll**. Contact Member Services if you need more information on how to do this. • 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 CCA Senior Care Options when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your MassHealth (Medicaid) benefits, contact MassHealth at 1-800-841-2900 (TTY 800-497-4648), Monday to Friday 8 am to 5 pm. You can also get help with question about your MassHealth (Medicaid) benefits from My Ombudsman at 855-781-9898 (videophone (VP) 339-224-6831), Monday to Friday 9 am to 4 pm. 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

Until your membership CCA Senior Care Options ends, and your new Medicare MassHealth (Medicaid) coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**

- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 CCA Senior Care Options must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

CCA Senior Care Options must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you are no longer eligible for MassHealth (Standard) Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and MassHealth Standard (Medicaid).
- If you lose eligibility for MassHealth Standard (Medicaid) benefits, CCA Senior Care Options will continue to provide care as long as you can reasonably be expected to regain your MassHealth Standard

(Medicaid) coverage within one month. We will continue your membership for the remainder of the month in which we receive notification from MassHealth (Medicaid) about your loss of eligibility, along with one additional calendar month. If you regain your MassHealth Standard (Medicaid) coverage during this period, we will not end your membership.

- 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, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you lie 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 call Member Services.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

CCA Senior Care Options is not allowed to ask you to leave our plan for any health-related reason.

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, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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.

CHAPTER 10:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this **Evidence of Coverage** 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. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice of nondiscrimination

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, Inc.® complies with applicable Federal civil rights laws and does not discriminate on the basis of, or exclude people or treat them differently because of, medical condition, health status, receipt of health services, claims experience,

medical history, disability (including behavioral impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence. Commonwealth Care Alliance, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services.

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

creed, public assistance, or place of residence, you can file a grievance with:

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

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

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

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

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

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

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, CCA Senior Care Options, 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

CCA Senior Care Options 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, Inc.

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, Inc., 30 Winter Street, Boston, MA 02108 or call us directly at 866-610-2273 (TTY 711).

SECTION 6 Information upon request

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

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

SECTION 7 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.

SECTION 8 New Technology

We regularly review new procedures, devices, treatments, and drugs to determine if they are safe and effective for members. New technology that are found to be safe and effective are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles, or other payment contributions.

Any device, medical treatment, drug, supply or procedure for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Investigational or unproven therapies are not medically necessary, and are excluded from coverage,

unless they are explicitly covered by Medicare or by CCA's plan documents.

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

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 healthcare services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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 have not 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 partner — one main person who works with you, CCA Massachusetts, and your care providers to make sure that you get the care you need.

Care Team – A team that may consist of your primary care provider (PCP), a nurse practitioner, a registered nurse, a physician assistant, community health worker, 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.

Centralized enrollee record – another term for membership record, which contains your health and demographic information.

Community Health Worker – Community Health Workers assists members managing their social determinants of health (SDOH) by identifying and connecting members to

services and resources within their own communities; with a member-centered-approach that aims to both improve members' health and empower their independence. SDOH includes, but it is not limited to, housing, public assistance [SNAP, SSI Cash Assistance], day programs, fuel assistance, and MassHealth Standard (Medicaid) eligibility.

Complaint — The formal name for "making a complaint" is "filing a grievance." The complaint process is used **only** for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Continuity of Care (COC) — the amount of time you can keep seeing your healthcare providers and getting your current services after you become a member of CCA Senior Care Options. The Continuity of Care period lasts

for 90 days or until your comprehensive assessment and Individualized Care Plan are complete.

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 document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the healthcare 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, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

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 healthcare provider 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, or loss of or serious impairment to a bodily function. 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) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

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 our formulary (a formulary exception), or get a non-preferred drug at a

lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare or a State 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.

Home Health Aide – A person who provides services that do not 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).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. 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.

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.”

Income Related Monthly Adjustment Amount (IRMAA) –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. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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. If you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Integrated Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a

complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Integrated Organization Determination – A decision our plan makes 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 document.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

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. State Medicaid programs vary, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 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 also available for a 3-month period after an individual is first eligible for Medicare.

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 i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) 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**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

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, Special Needs 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.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap

policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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.

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 behavioral 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 pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. 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 for doctors, other healthcare professionals, hospitals, and other healthcare facilities that are licensed or certified by Medicare and by the State to provide healthcare services. "**Network providers**" have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

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 healthcare providers payment amounts established by Congress. You can see any doctor, hospital, or other healthcare 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 does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. 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 that does not have a contract with our plan 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.

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. 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.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

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. 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 healthcare plan for health or prescription drug coverage. CCA Senior Care Options members do not have a premium.

Primary Care Provider (PCP) –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other healthcare provider.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics –Medical devices including, but 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 healthcare experts paid by the Federal government to check and improve the care given to Medicare patients.

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 you must live to join a particular health plan. For plans that limit which healthcare providers and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must 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 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 healthcare for specific groups of people, such as those who have both Medicare and MassHealth (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 – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example,

you need immediate care during the weekend. Services must be immediately needed and medically necessary.

CCA Senior Care Options Member Services

Method	Member Services – Contact Information
CALL	866-610-2273 Calls to this number are free. Hours of operation: April 1 to September 30: 8 am to 8 pm, Monday to Friday and 8 am to 6 pm, Saturday to Sunday. October 1 to March 31: 8 am to 8 pm, 7 days a week. Member Services also has free language interpreter services available.
TTY	711 Calls to this number are free.
FAX	617-426-1311
WRITE	CCA Senior Care Options Member Services 30 Winter Street Boston, MA 02108
WEBSITE	www.ccama.org

SHINE (Serving the Health Information Needs of Everyone) (Massachusetts SHIP)

SHINE is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	SHINE (Massachusetts SHIP) – Contact

	Information
CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	711 (MassRelay) or 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

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