January 1, 2024 – December 31, 2024

Your Health and Drug Coverage under the CCA One Care Medicare-Medicaid Plan

Member Handbook Introduction

This handbook tells you about your coverage under CCA One Care through December 31, 2024. It explains healthcare services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports provide the care you need at home and/or in the community and may reduce your chances of going to a nursing facility or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

CCA One Care (Medicare-Medicaid Plan) is offered by Commonwealth Care Alliance, Inc. When this *Member Handbook* says "we," "us," or "our," it means Commonwealth Care Alliance, Inc. When it says, "the plan" or "our plan," it means CCA One Care.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week. This call is free.

ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística gratuitos. Llame al 866-610-2273 (TTY 711), de 8 a 20 horas, 7 días a la semana. La llamada es gratuita.

You can get this document for free in other formats, such as large print, formats that work with screen reader technology, braille, or audio. Call 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week. The call is free.

We will keep your request for alternative formats and special languages on file for future mailings. Please contact Member Services at 866-610-2273 (TTY 711) to change your preferred language and/or format.

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-610-2273 (TTY 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-610-2273 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-610-2273 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-610-2273 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-610-2273 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-610-2273 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-610-2273 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-610-2273 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-610-2273 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-610-2273 (телетайп 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-610-2273 (رقم هاتف الصم والبكم 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-610-2273 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-610-2273 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-610-2273 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-610-2273 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-610-2273 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-610-2273 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Gujarati: અમારી આરોગ્ય અથવા દવાની યોજના વિશે તમને હોય તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે મફત દુભાષિયા સેવાઓ છે. દુભાષિયા મેળવવા માટે, અમને ફક્ત 1-866-610-2273 (TTY 711) પર કોલ કરો. અંગ્રેજી/ગુજરાતી બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. આ એક મફત સેવા છે.

Lao/Laotian: ພວກເຮົາມີບໍລິການລ່າມແປພາສາໂດຍບໍ່ເສຍຄ່າເພື່ອຕອບທຸກຄໍາຖາມທີ່ທ່ານອາດມີກ່ຽວກັບແຜນສຸຂະພາບ ຫຼື ແຜນຢາຂອງພວກເຮົາ. ເພື່ອຂໍລ່າມແປພາສາ, ພຽງໂທຫາພວກເຮົາທີ່ເບີ 1-866-610-2273 (TTY 711). ຈະມີຜູ້ທີ່ເວົ້າພາສາອັງກິດ/ລາວຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການບໍ່ເສັຍຄ່າ.

Cambodian: យើងមានសេវាបកប្រែផ្តាល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំនួរណាមួយដែលអ្នកអាចមានអំពីគម្រោងសុខភាព ឬថ្នាំរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តាល់មាត់ សូមហៅទូរសព្ទមកយើងតាមរយៈលេខ 1-866-610-2273 (TTY 711) ។ នរណាម្នាក់ដែលនិយាយភាសាអង់គ្លេស/ភាសាខ្មែរអាចជួយអ្នកបាន។ នេះគឺជាសេវាកម្មដែលឥតគិតថ្លៃ។

Disclaimers

- Commonwealth Care Alliance (CCA) One Care (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and the Commonwealth of Massachusetts MassHealth (Medicaid) program to provide benefits of both program to enrollees. Enrollment in the plan depends on contract renewal.
- Limitations and restrictions may apply. For more information, call Member Services or read the CCA One Care Member Handbook. This means you may have to pay for some services and that you need to follow certain rules to have CCA One Care pay for your services.
- The List of Covered Drugs (formulary), pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.
- Benefits may change on January 1 of each year.
- Coverage under CCA One Care is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about CCA One Care, a health plan that covers all your Medicare and MassHealth services, and your membership in it. It also tells you what to expect and what other information you will get from CCA One Care. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook***.**

Table of Contents

A. Welcome to CCA One Care

CCA One Care is a One Care: MassHealth plus Medicare plan. A One Care plan is made up of healthcare providers, hospitals, pharmacies, providers of Long-term Services and Supports (LTSS), mental health providers, substance use disorder providers, community based organizations that can assist with health related social needs, and other health care providers. In a One Care plan, a Care Partner will work with you to develop a plan that meets your specific health needs. A Care Partner will also help you manage all your providers, services, and supports. They all work together to give you the care you need.

CCA One Care was approved by the Commonwealth of Massachusetts and CMS (the Centers for Medicare & Medicaid Services) to provide you services as part of One Care.

One Care is a program run by Massachusetts and the federal government to provide better healthcare for people who have both Medicare and MassHealth (Medicaid). This pilot program lets the state and federal government test new ways to improve how you get your Medicare and MassHealth healthcare services.

CCA One Care is a not-for-profit integrated care system. We aim to provide the best possible person-centered care to the members we serve—adults of all ages with complex needs.

CCA One Care aims to help members enjoy the best possible quality of life through better health and greater independence. We look for new and better ways to fill important gaps in care. CCA One Care members have a voice in the decisions affecting their care. Our care teams work with members and their families, providers, and caregivers to develop truly personalized care plans that address medical, behavioral health, and social support needs.

B. Information about Medicare and MassHealth

B1. Medicare

Medicare is the federal health insurance program for:

- some people under age 65 with certain disabilities;
- people 65 years of age or older; **and**
- people with end-stage renal disease (kidney failure).

B2. MassHealth

MassHealth is the name of the Massachusetts Medicaid program. MassHealth is run by the federal government and the state. MassHealth helps people with limited incomes and resources pay for long-term services and supports and medical costs. It also covers extra services and drugs that are not covered by Medicare.

Each state has its own Medicaid program. That means that each state decides:

- what counts as income and resources,
- who qualifies for Medicaid in that state,
- which services are covered, **and**
- what those services cost.

States can decide how to run their own Medicaid programs as long as they follow the federal rules.

Medicare and Massachusetts must approve CCA One Care each year. You can get Medicare and MassHealth services through our plan as long as:

- you are eligible to participate in One Care;
- we offer the plan in your county; **and**
- Medicare and Massachusetts approve the plan.

Even if our plan stops operating, this will not affect your eligibility for Medicare and MassHealth services.

C. Advantages of the One Care Plan

You will now get all your covered Medicare and MassHealth services from CCA One Care. This includes prescription drugs. **You do not have to pay extra to join this health plan.**

CCA One Care will help make your Medicare and MassHealth benefits work better together and work better for you. Here are some of the advantages of having CCA One Care as your health plan.

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a Care Team made up of people you choose. A Care Team is a group of people that will get to know your needs and work with you to help you create and carry out an Individualized Care Plan (ICP). Your Care Team will talk with you about the services that are right for you.
- You will have a Care Partner who will work with you, the health plan, and your Care Team to make sure you get the care you need.

- You can also choose to have a Long-term Supports (LTS) Coordinator. Long-term services and supports are for people who need help doing everyday tasks like taking a bath, getting dressed, making food, and taking medicine.
- An LTS Coordinator will help you find and get the right LTSS and/or other community-based or behavioral health services.
    - Both the Care Partner and LTS Coordinator work with your Care Team to make sure you get the care you need.
- You will be able to take charge of your own care with help from your Care Team and Care Partner.
- The Care Team and Care Partner will work with you to come up with an Individualized Care Plan (ICP) specially designed to meet your health needs. They will help you get the right services and organize your care. The Care Team will be in charge of managing the services you need. For example:
    - Your Care Team will make sure that your healthcare providers know about all your medicines so they can reduce any side effects.
    - Your Care Team will make sure that all your doctors and other providers get your test results.
    - Your Care Team will help you get appointments with doctors and other providers who can help you with any disability accommodations you need.

D. CCA One Care's service area

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

We do not currently service Dukes or Nantucket counties. CCA One Care is only for people who live in our service area.

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8, Section J for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.); **and**

- have both Medicare Part A and Medicare Part B and are eligible for Part D; **and**
- are eligible for MassHealth Standard or MassHealth CommonHealth and are aged 21 to 64 years at the time of enrollment; **and**
- are a United States citizen or are lawfully present in the United States; **and**
- are not enrolled in a MassHealth Home and Community-based Services (HCBS) waiver; **and**
- have no other health insurance.

F. What to expect when you first join a health plan

If CCA One Care is a new plan for you, you can keep using your healthcare providers and getting your current services for 90 days or until your comprehensive assessment and Individualized Care Plan (ICP) are complete. This is called the Continuity of Care period. If you are taking any Medicare Part D prescription drugs when you join our plan, you can get a temporary supply. We will help you to transition to another drug if necessary.

Within the first 90 days of your enrollment in the plan, you will get an in-person comprehensive assessment. After the assessment, you and your Care Team will work together to develop your ICP.

In this section, we provide more information about the process for the comprehensive assessment and Individualized Care Plan (ICP). At the beginning of those first 90 days of your enrollment, you will receive a call from our CCA One Care onboarding specialist welcoming you to our plan. Once your information is confirmed, you will also be contacted by trained nurse to complete the comprehensive assessment. You, your family member, caregiver, or anyone you appoint to participate in your care will meet with the nurse at your home or another place you choose. They will review your history and health so that we can work with you to plan your health goals and service needs. The comprehensive assessment will include:

- A medical evaluation of your health status, including immediate needs and current services, health conditions, medications and past medical history containing functional status and physical well-being
- Lifestyle and social information, including accessibility requirements, equipment needs environmental considerations
- An evaluation of your need for long-term care services and supports, including assessment of your needs to help you live independently or safely in the community and to help you understand what choices for long-term services and supports may be best for you
- Preferences and goals

- And other topics based on our discussion

If you use or need long-term services and supports in the community (such as day habilitation, adult foster care, or personal care assistance), you can choose a long-term supports (LTS) coordinator to meet with you and help evaluate your health and wellness needs. The LTS coordinator will be part of your care team and will tell you about the different kinds of services available and help find the best long-term services and programs for you.

Once your assessment is completed, you and if you choose, your family, caregiver, or another appointed representative, and your care team will work together to develop an Individualized Care Plan (ICP) to address your health and support needs, reflecting your personal preferences and goals. This means that some of the services you get now may change.

After the first 90 days, you will need to use doctors and other providers in the CCA One Care network. A network provider is a provider who works with the health plan. Refer to Chapter 3, Section D for more information on getting care from provider networks.

G. Your Individualized Care Plan (ICP)

After your comprehensive assessment, your Care Team will meet with you to talk about the health services you need and want. Together, you and your Care Team will make your Individualized Care Plan (ICP).

Your ICP lists the services you will get and how you will get them. It includes the services that you need for your physical and behavioral healthcare and long-term services and supports. The providers you use and medications you take will be a part of your ICP. You will be able to list your health, independent living and recovery goals, as well as any concerns you may have and the steps needed to address them.

Your One Care plan will work with you at all times and will work with your family, friends, and advocates if you choose. You will be at the center of the process of making your ICP.

Every year, your Care Team will work with you to update your ICP in case there is a change in the health services you need and want. Your ICP can also be updated as your goals or needs change throughout the year.

H. CCA One Care monthly plan premium

You will not pay any monthly premiums to CCA One Care for your health coverage.

If you pay a premium to MassHealth for CommonHealth, you must continue to pay the premium to MassHealth to keep your coverage.

Members who enter a nursing facility may have to pay a Patient Paid Amount to keep your MassHealth coverage. The Patient Paid Amount is the member's contribution to the cost of care in the facility. MassHealth will send you a detailed notice should you be expected to pay a Patient Paid Amount.

I. The Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week. You can also refer to the *Member Handbook* at www.ccama.org/onecare.

The contract is in effect for the months you are enrolled in CCA One Care between January 1, 2024 and December 31, 2024.

J. Other important information you will get from us

You should have already gotten a CCA One Care Member ID Card, information about how to access the *Provider and Pharmacy Directory*, and information about how to access the *List of Covered Drugs*.

J1. Your CCA One Care Member ID Card

Under our plan, you will have just one card for your Medicare and MassHealth services, including LTSS and prescription drugs. You must show this card when you get any services or prescriptions. Here is a sample card to show you what yours will look like:

If your card is damaged, lost, or stolen, call Member Services right away at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week. We will send you a new card.

As long as you are a member of our plan, you should not use your red, white, and blue Medicare card or your MassHealth card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your CCA One Care Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy* Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the CCA One Care network. While you are a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* at any time by calling Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week. You can also refer to the *Provider and Pharmacy Directory* at www.ccama.org or download it from this website.

Both Member Services and the website can give you the most up-to-date information about our network providers, including primary care providers, specialists, hospitals, durable medical equipment suppliers, network pharmacies, skilled nursing facilities, and other providers.

Definition of network providers

- CCA One Care's network providers include:
    - doctors, nurses, dentists, and other healthcare professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan;
    - home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or MassHealth;
    - long-term supports and services; **and**
    - behavioral health diversionary services.

Network providers have agreed to accept payment from our plan for covered services as payment in full. You will not have to pay anything more for covered services.

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.

- You must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

For more information or to get a copy of the *Provider and Pharmacy Directory*, call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs* or *Formulary*. We call it the "Drug List" for short. It tells which prescription drugs are covered by CCA One Care.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5 for more information on these rules and restrictions.

Each year, we will send you information about how to access the Drug List. To get the most up-to-date information about which drugs are covered, visit www.ccama.org or call 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

J4. The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the *Explanation of Benefits* (or EOB).

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. Chapter 6 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services.

K. How to keep your centralized enrollee record up to date

You can keep your centralized enrollee record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your centralized enrollee record to know what services and drugs you get and how much they cost**. Because of this, it is very important that you help us keep your information up to date.

Let us know if any of these situations applies to you:

- changes to your name, address, or phone number
- you get other health insurance coverage, like coverage from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation

- any liability claims, such as claims from an automobile accident
- admission to a nursing facility or hospital
- care in an out-of-area or out-of-network hospital or emergency room
- change in who your caregiver (or anyone else responsible for you) is
- you are part of or become part of 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 information changes, please let us know by calling Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

K1. Privacy of personal health information (PHI)

The information in your centralized enrollee record may include personal health information (PHI). Laws require us to keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8, Section D.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about CCA One Care and your healthcare benefits. You can also use this chapter to get information about how to contact your Care Partner and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. How to contact CCA One Care Member Services

CALL	866-610-2273 This call is free. **Hours of operation:** 8 am to 8 pm, 7 days a week. We have free language interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it. **Hours of operation:** 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

A1. When to contact Member Services:

- questions about the plan
- coverage decisions about your healthcare
  - A coverage decision about your healthcare is a decision about:
    - your benefits and covered services, **or**
    - the amount of your health services we will cover.
  - To learn more about coverage decisions, refer to Chapter 9, Section D.
- appeals about your healthcare
  - an appeal is a way to ask us to change a coverage decision.
  - To learn more about making an appeal, refer to Chapter 9, Section D.
- complaints about your healthcare

- You can call Member Services to make a complaint about us or any provider. A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to Section H below).
- If your complaint is about a coverage decision about your healthcare, you can make an appeal by calling Member Services. (Refer to the section above.)
- You can also send a complaint about CCA One Care right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx or call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- To learn more about making a complaint about your healthcare, refer to Chapter 9.
- You can also call My Ombudsman for help with **any** complaints or to help you file an appeal. (Refer to section I for My Ombudsman's contact information.)

- coverage decisions about your prescription drugs
  - A coverage decision about your prescription drugs is a decision about:
    - your benefits and covered prescription drugs, **or**
    - the amount we will pay for your prescription drugs.
  - This applies to your Part D drugs, MassHealth prescription drugs, and MassHealth over-the-counter drugs. Within the **"Drug List"**, Dual Demonstration Plan (DP) means the item is covered under your MassHealth benefits. MassHealth covered drugs are labeled with a DP in the third column of the "Drug list".
  - For more on coverage decisions about your prescription drugs, refer to Chapter 9, Section F.
- appeals about your prescription drugs
  - To learn more about making an appeal about your prescription drugs, refer to Chapter 9, Section F.
- complaints about your prescription drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.

- If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
- You can send a complaint about CCA One Care right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx or call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- For more information on making a complaint about your prescription drugs, refer to Chapter 9, Section 10.

- questions about payment for healthcare, medical supplies or prescription or over-the-counter drugs you already paid for
  - For more information about paying a bill you got or to ask us how to pay you back for services or prescription drugs, refer to Chapter 7.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9 for more on appeals.

B. How to contact your Care Partner

A Care Partner is the person who works with you, the health plan, and your care team to make sure you get the care you need. When you become a member of our plan, a Care Partner will be assigned to you. Please refer to Chapter 3, Section C for more information about Care Partners and how you can change your Care Partner if they are not right for you.

CALL	866-610-2273. This call is free. **Hours of operation:** 8 am to 8 pm, 7 days a week. Member Services also has free language interpreter services available.
TTY	711 This call is free. This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it. **Hours of operation:** 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

B1. When to contact your Care Partner

- questions about your healthcare
- questions about getting medical services, behavioral health services, and long-term services and supports (LTSS)
- questions about getting help with food, housing, employment, and other health-s
- questions about your Individualized Care Plan (ICP)
- questions about approvals for services that your providers have requested
- questions about the benefits of Flexible Covered Services and how they can be requested

C. How to contact the Nurse Advice Call Line

CCA One Care provides you with around the clock access to an on-call skilled healthcare professional if you need medical or behavioral health information and advice. When you call, a registered nurse or behavioral health clinician or equivalent, will answer your general health and wellness-related questions. They have access to your Individualized Care Plan (ICP) 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, mental health, and substance use questions.

CALL	866-610-2273 This call is free. The Nurse Advice Line is available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it. The Nurse Advice Line is available 24 hours a day, 7 days a week.

C1. When to contact the Nurse Advice Call Line

- questions about your health

D. How to contact the on-call behavioral health clinician

Through the Nurse Advice Line, we can connect you to a behavioral health clinician for help with mental health or substance use symptoms.

CALL	866-610-2273 This call is free. The Nurse Advice Line offers behavioral health support and is available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it. The Nurse Advice Line offers behavioral health support and is available 24 hours a day, 7 days a week.

D1. When to contact the on-call behavioral health clinician

- you need help during a mental health crisis
- you need help during a substance use disorder crisis

E. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance advice to people with Medicare. In Massachusetts, the SHIP is called SHINE (Serving the Health Insurance Needs of Everyone).

SHINE is not connected with any insurance company or health plan.

CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	1-800-439-2370 (Massachusetts only) This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it.
WRITE	Call the number above for the address of the SHINE program in your area.
EMAIL	SHINE@state.ma.us
WEBSITE	www.mass.gov/health-insurance-counseling

E1. When to contact SHINE

- Questions about your Medicare health insurance
    - SHINE counselors can answer your questions about changing to a new plan and help you:
        - understand your rights;
        - understand your plan choices;
        - make complaints about your healthcare or treatment; **and**
        - fix problems with your bills.

F. How to contact Medicare

Medicare is a federal health insurance program. It covers some people under age 65 with disabilities; people 65 years of age or older; and people with end-stage renal disease (ESRD—permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS).

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov/ This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, healthcare providers, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

G. How to contact MassHealth

MassHealth helps with the cost of medical care and long-term services and supports for people with limited incomes and resources.

You are enrolled in Medicare and in MassHealth. If you have questions about the help you get from MassHealth, the contact information is below.

CALL	1-800-841-2900
TTY	711 This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it.
WRITE	MassHealth Customer Service 55 Summer Street Boston, MA 02110
E-MAIL	membersupport@mahealth.net
WEBSITE	www.mass.gov/masshealth

H. How to contact My Ombudsman

My Ombudsman is an independent program that can help you if you have questions, concerns, or problems related to One Care. You can contact My Ombudsman to get information or assistance. My Ombudsman's services are free. My Ombudsman's staff:

- Can answer your questions or refer you to the right place to find what you need.
- Can help you address a problem or concern with One Care or your One Care plan, CCA One Care. My Ombudsman's staff will listen, investigate the issue, and discuss options with you to help solve the problem.
- Help with appeals. An appeal is a formal way of asking your One Care plan, MassHealth, or Medicare to review a decision about your services. My Ombudsman's staff can talk with you about how to make an appeal and what to expect during the appeal process.
- You can call or write My Ombudsman. Please refer to the My Ombudsman website or contact them directly for updated information about location and walk-in hours.

CALL	1-855-781-9898 (Toll Free)
MassRelay and Videophone (VP)	Use 7-1-1 to call 1-855-781-9898 This number is for people who are deaf, hard of hearing, or speech disabled. Videophone (VP): 339-224-6831 This number is for people who are deaf or hard of hearing.
WRITE	My Ombudsman 25 Kingston Street, 4th floor Boston, MA 02111
E-MAIL	info@myombudsman.org
WEBSITE	www.myombudsman.org

I. How to contact the Quality Improvement Organization (QIO)

Massachusetts has a Quality Improvement Organization (QIO) called KEPRO. This is a group of doctors and other healthcare professionals who help improve the quality of care for people with Medicare. The QIO is not connected with our plan.

CALL	1-888-319-8452
TTY	1-855-843-4776 This number is for people who are deaf, hard of hearing, or speech disabled. You must have special telephone equipment to call it.
WRITE	KEPRO QIO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609
WEBSITE	www.keprogio.com

I1. When to contact the QIO

- Questions about your healthcare
    - You can make a complaint about the care you got if you:
        - have a problem with the quality of care;
        - think your hospital stay is ending too soon; **or**
        - think your home healthcare, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

Chapter 3: Using the plan's coverage for your healthcare and other covered services

Introduction

This chapter has specific terms and rules you need to know to get healthcare and other covered services with CCA One Care. It also tells you about your Care Partner, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information about "services," "covered services," "providers," and "network providers"

Services include medical care, behavioral healthcare, long-term services and supports, supplies, prescription and over-the-counter (OTC) drugs, equipment, and others. Covered services are any of these services that our plan pays for. Covered services are listed in the Benefits Chart in Chapter 4, Section D.

Providers are doctors, nurses, behavioral health clinicians, and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you healthcare services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment as full payment.

B. Rules for getting your healthcare and long-term services and supports (LTSS) and other services covered by the plan

CCA One Care covers services covered by Medicare and MassHealth. This includes behavioral health, long-term services and supports (LTSS), and prescription and over-the-counter (OTC) drugs.

CCA One Care will pay for the healthcare and services you get if you follow the plan rules listed below. To be covered by our plan:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D of this handbook).
- The care must be **medically necessary**. Medically necessary means that the services are reasonable and necessary:
    - For the diagnosis and treatment of your illness or injury; **or**
    - To improve the functioning of a malformed body part; **or**
    - Otherwise medically necessary under Medicare law
    - In accordance with Medicaid law and regulation and per MassHealth, services are medically necessary if:
        - They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction,

threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**

- There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive. The quality of medically necessary services must meet professionally recognized standards of healthcare, and medically necessary services must also be supported by records including evidence of such medical necessity and quality.

If you have questions about if a service is medically necessary or not, you can contact Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.The call is free.

- You must have a **primary care provider (PCP)** that is in our plan network (a network PCP). As a plan member, you must choose a network provider to be your PCP.
  - To learn more about choosing a PCP, refer to page 36.
  - In most cases, our plan must give you approval before you can use someone that is not your PCP or use other providers outside of the plan's network. This is called a **prior authorization**. If you don't get approval in advance, CCA One Care may not cover the services. You don't need a referral or prior authorization to use certain specialists, such as women's health specialists. For more information about services that require an authorization, refer to the Benefits Charts in Chapter 4.
  - You do not need a referral from your PCP or prior authorization from the plan for emergency care or urgently needed care. You can also get other kinds of care without having a referral from your PCP. To learn more about this, refer to page 37.
  - **Note:** In your first 90 days with our plan or until your Individualized Care Plan (ICP) is complete, you can keep going to 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, our 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 use out-of-network providers.
- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. But sometimes this rule does not apply, for example:

- The plan covers emergency or urgently needed care from an out-of-network provider. To learn more about what emergency or urgently needed care means, refer to Section I, page 44.
- If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. You must obtain approval in advance (prior authorization) from CCA One Care before you seek care from an out-of-network provider. In this situation, we will cover the care. To learn about getting approval to use an out-of-network provider, refer to Section D, page 39.
- The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
- If you need family planning services, you may get those services from any One Care plan provider or from any MassHealth contracted Family Planning Services Provider. For more information about family planning services, refer to Chapter 4, Section D.
- When you first join the plan, you can continue going to the providers you use now for the Continuity of Care (COC) period defined in Chapter 1 on page 9, and also in Chapter 12. The COC is for 90 days or until your Individualized Care Plan (ICP) is completed. During the 90 days or until your assessment and your Individualized Care Plan (ICP) are complete, CCA One Care will contact you to help you find providers in our network. You also may contact Member Services if you need help finding providers in our network. After 90 days or when your assessment and Individualized Care Plan (ICP) are complete, we will no longer cover your care that is provided by out-of-network providers unless we agreed to do so for a longer period as part of your Individualized Care Plan (ICP) or another exception as described above applies.

C. Care Coordination

C1. What care coordination is

Care coordination includes developing your Individualized Care Plan (ICP), supporting you in your care plan goals and checking in with you, your Care team, and other providers about your care and how it is going. A C**are Partner** helps to coordinate all your services in order to make sure you get what you need.

The Care Partner is the main contact person for you (the Enrollee) with your health plan to help you use your MassHealth and Medicare benefits to get the care and services you need. This

includes helping you get additional benefits through your health plan that you may not have been able to get before joining One Care. Your Care Partner will work with you to make sure your health plan knows what you need and how you want to get your services and will help you with questions you have about getting care. Your Care Partner can also help connect you with community resources. Working with you and your care team, your Care Partner will help you make an Individualized Care Plan (ICP) that will be updated if your needs and preferences change over time.

Everyone who enrolls in a One Care plan also has the right to have an independent Long-term Supports (LTS) Coordinator on their care team.

An LTS Coordinator will work with you as a member of your care team to find resources and services in your community that can support your wellness, independence, and recovery goals. These services are sometimes called long-term services and supports (LTSS). LTS Coordinators may also be able to help you access behavioral health resources and services.

LTS Coordinators do not work for One Care plans. They come from independent community organizations and are experts in areas like independent living, recovery, and aging. This means that they can work for you and help you advocate for your needs.

You can choose to have an LTS Coordinator work with you as a full member of your care team at any time. This is a free service for you.

The LTS coordinator can help assess your needs and provide recommendations for the long-term services and supports that may be best for you. Such services might include, as examples, personal care attendants (PCA), cleaning services, day habilitation, adult day health, adult foster care and group adult foster care, peer support, non-medical transportation, and many other types of support.

Your LTS coordinator will also act as an advocate on your behalf when making requests to your Care Partner for service approval. Once services are approved, your LTS coordinator will work as a liaison between you, your providers, and care team to help coordinate and manage your Individualized Care Plan (ICP).

LTS coordinators work for community agencies such as Independent Living Centers (ILCs), Recovery Learning Centers (RLCs), and Aging Services Access Points (ASAPs). Once you enroll with CCA One Care, we will call you to schedule a time to meet and do a comprehensive assessment. As a part of that assessment, you will be offered a referral for an LTS coordinator. Should you accept the referral, we will arrange to have the LTS coordinator meet with you and help evaluate your long-term services and support needs.

C2. How you can contact your Care Partner or Long-term Supports (LTS) Coordinator

If you need to contact your Care Partner or LTS coordinator, please call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

C3. How you can change your Care Partner

You may request a change in your Care Partner if they are not right for you. If you need more information or help changing your Care Partner, please call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

D. Care from your primary care provider, specialists, other network providers, and out-of-network providers

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of "PCP," and what a PCP does for you

What a PCP is

Your primary care provider (PCP) is the doctor or other provider that you use first for most health problems. They make sure you get the care you need to stay healthy. They will work with your care team. They also may talk with other doctors and providers about your care and may refer you to them.

CCA One Care 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. These can include Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) as listed in our network.

What types of providers may be a PCP

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.

The role of a PCP

- **Coordinating covered services** Your PCP, along with the other members of your care team, is responsible for coordinating all your medical care. Your care team may consist of your PCP, Care Partner, long-term services coordinator (LTS coordinator or LTSC), and others if necessary.

- **Assists in making decisions about prior authorization (approval before you can get a service)** Approval in advance (prior authorization) from CCA One Care is required for certain services before you receive them. Your PCP works closely with Commonwealth Care Alliance to arrange for these services when necessary. For a full list of services that require prior authorization, please refer to the Benefits Charts in Chapter 4, Section D. While some services do not require a prior authorization, we always encourage you to speak with your PCP and care team to make sure you receive all appropriate services.

Once you are enrolled, your Care Partner, PCP, and anyone else you choose to have involved as part of your care team, such as a caregiver, will work with you to develop an **Individualized Care Plan (ICP)** to address your health and support needs, reflecting your personal needs and goals. You and your care team will reassess your needs at least annually, but more frequently if necessary. Your Care Partner will always communicate with you to confirm any changes.

Your choice of 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, a physician assistant, or a women's health specialist. In your first 90 days in our plan, an onboarding specialist will work with you to choose a PCP if you do not have one. If you do not identify a current PCP or select a PCP within 90 days of enrollment, we will assign a PCP to you. You may call Member Services if you need more information or wish to change your PCP at 866-610-2273 (TTY711), 8 am to 8 pm, 7 days a week.

Option to change 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. We will help you find a new PCP if the one you have leaves our network. We will work with you to help identify how soon you are able to transition to the new PCP.

If your PCP leaves our network, we will let you know by mail or phone. Your Care Partner and Member Services will help you choose another PCP so that you may continue to get covered services. For more information or help, please call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

D2. Care from specialists and other network providers

A specialist is a provider who provides healthcare 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 problems.

- Orthopedists care for patients with bone, joint, or muscle problems.

Primary care providers (PCPs) have certain specialists they use for referrals. However, 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 and if they are in our network. You may change your PCP within our network if you want to see a specialist to whom your current PCP cannot refer you. For more information about changing your PCP, see **Changing your PCP** section earlier 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 One Care, 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** at www.ccama.org to locate facilities in the plan's network.

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

Prior authorization (approval in advance) from CCA One Care is required for certain services before you receive them. Your PCP/care team works closely with CCA One Care to arrange for these services when necessary. For a full list of services that require prior authorization, please see the Benefits Charts in Chapter 4, Section D. While some services do not require a prior authorization, we always encourage you to speak with your PCP and care team to make sure you receive all appropriate services.

D3. What to do when one of your providers leaves our plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

- We will help you select a new qualified provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. The care you receive from out-of-network provider must be authorized by CCA One Care before you seek care.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make a complaint. Refer to Chapter 9 for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please call Member Services for more information or help at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

D4. How to get care from out-of-network providers

You must get your care from network providers. Usually, the plan will not cover care from a provider who does not work with CCA One Care. There are a few exceptions to note:

- The plan covers emergency or urgently needed care from an out-of-network provider anywhere in the United States and its territories. To learn more about what emergency or urgently needed care means, refer to Section I in this chapter.
- If you need care that our plan covers, and our network providers cannot provide it for you, then you can receive the care from an out-of-network provider. The care you receive from out-of-network provider must be authorized by CCA One Care before you seek care. In this situation, we will cover the care at no cost to you.
- The plan covers out-of-network care in unusual circumstances. The care you receive from out-of-network provider must be authorized by CCA One Care before you seek 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 timely as warranted by your medical condition.
  - Your PCP/care team determines that a non-network provider can best provide the service or transitioning you to another provider could endanger life, or cause suffering or pain, or significantly disrupt the current course of treatment.
- The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
- If you need family planning services, you may receive those services from any CCA One Care network provider or from any MassHealth contracted Family Planning Services Provider.
- When you first join the plan, you can continue seeing the providers you see now for 90 days or until your Individualized Care Plan (ICP) is complete. During the 90 days or until assessment and your Individualized Care Plan (ICP) are completed, CCA One Care will contact you to help you find providers in our network. After 90 days or when your assessment and Individualized Care Plan (ICP) are complete, we will no longer cover your care that is provided by out-of-network providers unless we agreed to do so for a longer period as part of your Individualized Care Plan (ICP*)* or another exception as described above applies.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare or MassHealth.

- We cannot pay a provider who is not eligible to participate in Medicare or MassHealth.
- If you use a provider who is not eligible to participate in Medicare or MassHealth, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare or MassHealth.

E. How to get long-term supports and services (LTSS)

Long-term services and supports (LTSS) are non-medical services that help people live independently in the community. Examples of LTSS include personal care, homemaking, companion, day programs, adult foster care, and transportation amongst others. To get long-term services and supports, you will need approval in advance (prior authorization) from PCP/Care Team or Commonwealth Care Alliance. Your PCP/care team works closely with CCA One Care to arrange for these services when necessary.

Your long-term supports (LTS) coordinator and/or Care Partner will talk to you and discuss what different types of services are available and which might be right for you. Your Care Partner or LTS coordinator will also help you find an appropriate provider and arrange for these services to be provided to you.

Please refer to the Benefits Charts in Chapter 4, Section D for more information on covered services and prior authorization requirements.

F. How to get behavioral health services

What behavioral health services are

Behavioral health services are a wide-variety of services that can support mental health and substance use needs you may have. Such support is broadly defined to include emotional, social, educational, vocational, peer support and recovery services, in addition to more traditional psychiatric or medical services. Such services may be provided in the community, or where needed, in your home, day program or another place that is most comfortable for you.

Our plan also covers community-based behavioral healthcare services that are referred to by MassHealth as "behavioral health diversionary services." These are services you may be able to use instead of going to the hospital or a facility for some behavioral health needs. These services are also available to support your successful transition from the hospital into the community.

Please refer to the Benefits Charts in Chapter 4, Section D for more information, a list of covered behavioral health and diversionary services, and prior authorization requirements.

How to get behavioral health services

You can discuss the various behavioral health services available with your Care Partner and other members of your care team, including your LTS coordinator. Your Care Partner/LTS coordinator will support you in identifying resources in the community and help you access appointments or schedule an assessment.

Your care team may also include community health workers or behavioral health clinicians that will work with your Care Partner to ensure that you have all the support you need to stay well and remain in the community. A CCA behavioral health clinician can provide additional support to the extent needed, including help through crisis situations and transitions from hospitals or other services.

Most outpatient behavioral health services do not require approval in advance (prior authorization); however, some diversionary services and limited number of outpatient services may require authorization. Your Care Partner/care team will work with you to identify necessary services and to obtain authorization as needed. If your Care Partner is not available, there is a

24-hour team who can assist with authorization of services. If you need any help, please call 866-610-2273 (TTY 711) 24 hours a day, 7 days a week.

CCA One Care also provides you with around the clock access to an on-call behavioral health clinician through the Nurse Advice Line. If you're feeling depressed or experiencing mental health or substance use symptoms, call 866-610-2273 (TTY 711), 24 hours a day, 7 days a week.

All members who request behavioral health support and need services are eligible for behavioral health services. Please see the Benefits Charts in Chapter 4, Section D, for more information on behavioral services and prior authorization requirements.

G. How to get self-directed care

G1. What self-directed care is

Self-directed care recognizes that the individual is knowledgeable about his or her own care needs, and the individual is empowered and accountable for his or her own care; and places an emphasis on environmental change and quality of life. Self-directed care emphasizes the ability of you, as a consumer, to:

- Advocate for your own needs
- Make choices about what services would best meet those needs
- Monitor the quality of those services

The self-directed model for personal care services is called the personal care attendant (PCA) program. In this model, personal care attendants are recruited, hired, trained, supervised, and, if necessary, fired by the consumer. You do not have to worry about paying the bills yourself in this model. CCA One Care will do that on your behalf.

G2. Who can get self-directed care

If you meet the functional and clinical eligibility for personal care services, you may choose to self-direct these services through the personal care attendant (PCA) program. The amount of services you are eligible for will be approved by your care team and will be based upon standards that are consistent with the criteria set by MassHealth regulations. Support and skills training are provided by personal care management agencies, under contract with CCA One Care, to provide information to members about what is involved in self-direction, and to obtain any skills necessary to manage their own services, including the recruitment, hiring, training, supervision, and firing of personal care attendants. CCA One Care will work with the "fiscal intermediary" to pay the bills for these services under the plan. In self-directed care, you do not have to take care of the payment yourself.

G3. How to get help in employing personal care providers (if applicable)

You can ask your Care Partner or LTS coordinator to help you access resources to employ personal care attendants. They will connect you with a personal care management agency that can provide skills training to assist with employment functions. The personal care management agency will work with you to develop the skills necessary to oversee the employment of personal care attendants and engage in collaborative problem-solving.

G4. How to request that a copy of all written notices be sent to care team participants the member identifies

Please call Member Services for more information at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week**.**

H. How to get dental and vision services

Dental Care Services

Our plan provides access to dental benefits that includes preventive, restorative, and emergency oral healthcare. Your coverage includes up to two cleanings per calendar year and routine bite-wing X-rays every calendar year.

You must go to a network dental provider for all covered dental services.

Some services may require approval in advance (prior authorization) by CCA One Care. Your dentist will need to submit a prior authorization directly to Skygen, our dental benefit administrator.

Vision Services

The plan covers professional care of the eyes for purposes of preventing, diagnosing, and treating all pathological conditions. They include eye examinations, prescriptions, and glasses and contact lenses.

We cover routine eye exams for members once per benefit year from ophthalmologists or optometrists who are part of our network. We also cover one pair of base lenses (single, bifocal and trifocal) and frames up to $125. Once you have received an eye exam from a provider, bring your vision prescription to a participating VSP provider and you'll receive savings on eyewear.

Approval in advance (prior authorization) is not required for outpatient vision services provided by a network provider. Limitations and authorization requirements for frames may apply. Please see Benefits Charts in Chapter 4, Section D for more information on covered vision care and limitations that may apply.

To find a participating vision provider, use our Provider and Pharmacy Directory on our website at www.ccama.org.

You can also call VSP for assistance at 855-492-9028 (TTY 711), 8 am to 8 pm, 7 days a week

For questions about your dental, please call Member Services at 866-610-2273 (TTY711), 8 am to 8 pm, 7 days a week.

I. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

I1. Care when you have a medical emergency

Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use 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. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license.
- **As soon as possible, make sure that you tell our plan 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. However, you will not have to pay for emergency services because of a delay in telling us. Please call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week**.**

Covered services in a medical emergency

You may get covered emergency care whenever you need it, anywhere in the United States or its territoriesIf you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4, Section D.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

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

Neither our plan nor Medicare covers emergency care or any other care that you get outside the United States and its territories.

What to do if you have a behavioral health emergency

Behavioral health emergencies include feelings of wanting to hurt oneself and/or someone else. If you are experiencing a behavioral health emergency, you may call 911 for assistance or go to the nearest hospital emergency room as is the case for medical emergencies.

You also have the choice of calling the psychiatric emergency service program that is in your area. Many individuals throughout the state have used this service as opposed to going to a hospital emergency room and believe this to be better choice. In some situations, though not all, the emergency service program staff may come to your home or see you at a designated urgent care site.

CCA One Care also has a 24-hour behavioral health clinician on call should you need support or resources for mental health or substance use symptoms. Please call the Nurse Advice Line at 866-610-2273 (TTY 711) to speak to our behavioral health clinician, 24 hours a day, 7 days a week.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care, but the healthcare provider may say it wasn't really an emergency. As long as it was reasonable for you to think your health was in serious danger, we will cover your care.

However, after the healthcare provider says it was not an emergency, we will cover your additional care only if:

- you use a network provider, **or**
- the care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

I2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but still needs to be taken care of right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

- you get this care from a network provider, **and**
- you follow the other rules described in this chapter.

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care that you get from an out-of-network provider.

Please consider the following options when you need urgent care:

1. Call your primary care provider (PCP). Your PCP can review your concerns and advise on what to do next.
2. Check for urgent care centers near your home. Some centers may have walk-in visits available. If you need help finding an urgent care center, call Member Services for help at: 866-610-2273.
3. Call the CCA Nurse Advice Line at 866-610-2273. It's your 24 hours, 7 days a week connection to our clinical team of nurses and behavioral health clinicians whenever you have an unexpected health issue.
4. Speak to your CCA care team. Your care team is here to support your medical or behavioral health needs.

5. Request an in-home visit from instED. InstED can provide urgent care services in the comfort and convenience of your home. When you call instED, a nurse will review your concerns and coordinate a visit with a paramedic. Contact instED by calling 833-946-7833 or by visiting their website at www.insted.us to request a visit for your urgent medical care needs.

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

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care that you get from any provider.

Our plan does not cover urgently needed care or any other care that you get outside the United States.

I3. 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 CCA One Care.

Please visit our website for information on how to obtain needed care during a declared disaster: www.ccama.org

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

J. What to do if you are billed directly for services covered by our plan

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If you have paid for your covered services or if you have gotten a bill for covered medical services, refer to Chapter 7 to learn what to do.

J1. What to do if services are not covered by our plan

CCA One Care covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to Chapter 4, Section D), **and**
- that you get by following the plan's rules.

If you get services that aren't covered by our plan, **you will have to pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us verbally or in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to pay for a medical service it doesn't usually pay for. It also tells you how to appeal a decision about a service. You may also call Member Services to learn more about this at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

K. Coverage of healthcare services when you are in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way for healthcare providers to test new types of healthcare or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study that you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way, you can continue to get care from our plan not related to the study.

If you want to participate in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

You do need to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your Care Partner should contact Member Services to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- 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 that is part of the research study, **and**
- treatment of any side effects and complications of the new care.

If you are part of a study that Medicare has **not approved**, you will have to pay any costs for being in the study.

K3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (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 (people who have difficulty hearing or speaking) should call 1-877-486-2048.

L. How your healthcare services are covered when you get care in a religious nonmedical healthcare institution

L1. Definition of a religious nonmedical healthcare institution

A religious nonmedical healthcare institution is a place that provides care that you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, then we will cover care in a religious nonmedical healthcare institution.

This benefit is only for Medicare Part A inpatient services (nonmedical healthcare services).

L2. Getting care from a religious nonmedical healthcare institution

To get care from a religious nonmedical healthcare institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

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

To be covered by our plan, the care you get from a religious nonmedical healthcare institution must meet the following conditions.

- The facility providing the care must be certified by Medicare.
- Services are limited to nonreligious aspects of care.
- If you get services in a facility, the following applies:
  - The services must be for a medical condition that we would cover as inpatient hospital care or skilled nursing facility care.
  - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

There is no coverage limit to this benefit. For more information on inpatient hospital coverage, please see the Benefits Charts in Chapter 4, Section D.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of CCA One Care, you usually will not own DME that you rent, no matter how long you rent it.

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 this section, we discuss situations when DME will be rented or purchased for you.

In Medicare, people who rent certain types of DME own it after 13 months.

If your need for durable medical equipment is temporary, CCA One Care can rent certain durable medical equipment for short term use. However, you may acquire ownership of rented durable medical equipment item as long as you have a long-term need for the item, and it is authorized. You pay nothing for your covered services, including durable medical equipment. Authorizations rules may apply. Please refer to the Benefits Charts in Chapter 4, Section D for more information on durable medical equipment. Call Member Services to learn about the requirements at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

Even if you had the DME for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.

M2. DME ownership when you switch from One Care to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage plans in Chapter 12. You can also find more information about them in the *Medicare & You 2024* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan; **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan**, those Original Medicare or Medicare Advantage plan payments do not count toward the payments you need to make after leaving our plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or a Medicare Advantage plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services CCA One Care covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you what services CCA One Care covers. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, and information about what you pay for drugs is in Chapter 6, Section C. This chapter also explains limits on some services.

With CCA One Care, you pay nothing for the covered services in this chapter as long as you follow the plan's rules. Refer to Chapter 3, Section B for details about the plan's rules. This Covered Services List is for your general information only. Please call CCA One Care for the most up to date information. MassHealth regulations are one of the factors that control the services and benefits available to you. To access MassHealth regulations:

- Go to MassHealth's website at www.mass.gov/masshealth; **or**
- Call MassHealth Customer Service at 1-800-841-2900, TTY: 1-800-497-4648 (for people who are deaf, hard of hearing, or speech disabled), Monday through Friday from 8:00 AM – 5:00 PM.

If you need help understanding what services are covered, call your Care Partner. Please call Member Services to contact your Care Partner at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

A1. During public health emergencies

If the Governor of Massachusetts, the U.S. Secretary of Health and Human Services, or the President of the United States declares a public health emergency in your geographic area, you are still entitled to care from CCA One Care.

Please speak to your Care Partner or call Member Services for information on how to obtain needed care during a declared emergency.

During a declared emergency, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

B. Rules against providers charging you for services

We do not allow CCA One Care providers to bill you for covered services. You should never get a bill from a network provider for covered services. If you do, refer to **Chapter 7** or call Member Services.

C. Our plan's Benefits Charts

The Benefits Charts in Section D tell you which services the plan covers. The charts list and explain the covered services.

We will pay for the services listed in the Benefits Charts only when the following rules are met. You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and MassHealth covered services must be provided according to the rules set by Medicare and MassHealth.
- The services (including medical care, behavioral healthcare, Long-term Services and Supports, other services, supplies, and equipment) must be medically necessary. Medically necessary means you reasonably need the services to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice and that there is no other similar, less expensive service suitable for you.
- You get your care from a network provider. A network provider is a provider who works with CCA One Care. In most cases, the plan will not cover care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- Some of the services listed in the Benefits Charts are covered only if your care team, doctor, or other network provider gets approval from us first. This is called prior authorization (PA). Covered services that need PA are marked in the Benefits Charts in bold and italic type.
- Some of the services in the Benefits Charts are covered only if you and your care team decide that they are right for you and they are in your Individualized Care Plan (ICP).

D. The Benefits Charts

General services that our plan covers	What you must pay
Abdominal aortic aneurysm screening The plan covers a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get an order for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. Prior authorization is not required for services provided by a network provider.	$0
Abortion services Prior authorization is not required for family planning services provided by in-network or MassHealth providers.	$0

General services that our plan covers	What you must pay
Acupuncture for chronic low back pain The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. **Additonal Acupuncture Coverage** Our plan covers acupuncture under the MassHealth benefit in addition to the Medicare covered services above. The plan covers up to 36 visits total per calendar year through MassHealth 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.	$0

General services that our plan covers	What you must pay
Adult day health services The plan covers services from adult day health providers at an organized program. These services may include the following: • nursing services and health oversight • therapy • assistance with activities of daily living • nutritional and dietary services • counseling services • activities • case management • transportation ***Prior authorization is required.***	$0
Adult foster care services The plan covers services from adult foster care providers in a residential setting. These services may include the following: • assistance with activities of daily living, instrumental activities of daily living, and personal care • supervision • nursing oversight ***Prior authorization is required.***	$0
Alcohol misuse screening and counseling The plan covers alcohol-misuse screening. If you screen positive for alcohol misuse, the plan covers counseling sessions with a qualified primary care provider or practitioner in a primary care setting.	$0

General services that our plan covers	What you must pay
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are **not** emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. *Emergency ambulance services are not covered outside the United States and its territories.* Prior authorization is not required for in-network and out-of-network emergency ambulance services. ***Prior authorization is required for non-emergency transportation. See the Transportation section later in this chart for more information.***	$0
Audiologist services The plan covers audiologist (hearing) exams and evaluations. See "Hearing services" later in this section for more information on hearing services and hearing aids. Prior authorization is not required for services provided by a network provider.	$0
Bone-mass measurement The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will also cover a healthcare provider looking at and commenting on the results. Prior authorization is not required for services provided by a network provider.	$0

General services that our plan covers	What you must pay
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women ages 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.	$0
Cardiac (heart) rehabilitation services The plan covers cardiac-rehabilitation services, such as exercise, education, and counseling. Members must meet certain conditions with a doctor's order. The plan also covers **intensive** cardiac rehabilitation programs, which are more intense than standard cardiac rehabilitation programs. ***Prior authorization is required.***	$0
Cardiovascular (heart) disease risk-reduction visit (therapy for heart disease) The plan covers visits with your primary care provider (PCP) to help lower your risk for heart disease. During this visit, your PCP may: • discuss aspirin use • check your blood pressure • give you tips to make sure you are eating well Prior authorization is not required for services provided by a network provider.	$0

General services that our plan covers	What you must pay
Cardiovascular (heart) disease testing The plan covers blood tests to check for cardiovascular disease once. These blood tests also check for defects due to high risk of heart disease. Prior authorization is not required for services provided by a network provider.	$0
Cervical and vaginal cancer screening The plan covers pap tests and pelvic exams. Prior authorization is not required for services provided by a network provider.	$0
Chiropractic services The plan covers adjustments of the spine to correct alignment, office visits, and radiology services. The plan covers up to 36 visits total without prior authorization per calendar year unless authorized differently by the plan. Additional visits can be approved if it aligns with your Individualized Care Plan (ICP).	$0

General services that our plan covers	What you must pay
Colorectal-cancer screening • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	$0

General services that our plan covers	What you must pay
Community health center services The plan covers services from a community health center. Examples include the following: • office visits for primary care provider and specialists • OB/GYN and prenatal care • pediatric services, including EPSDT • health education • medical social services • nutrition services, including diabetes self-management training and medical nutrition therapy • tobacco-cessation services • vaccines not covered by the Massachusetts Department of Public Health (MDPH) For more information about vaccines, please see Chapter 6, Section D. Prior authorization is not required for services provided by a network provider.	$0
Counseling to stop smoking or tobacco use As a preventive service, the plan covers counseling on attempts to quit. The plan covers up to 16 visits total per calendar year unless authorized differently by the plan. Prior authorization is not required for services provided by a network provider.	$0

General services that our plan covers	What you must pay
Day habilitation services The plan covers a program of services offered by day habilitation providers if you qualify because you have an intellectual or developmental disability. At this program, you develop a service plan that includes your goals and objectives and the activities to help you meet them. These services may include the following: • nursing services and healthcare supervision • developmental-skills training • therapy services • life skills/adult daily living training ***Prior authorization is required.***	$0

Dental services The plan covers preventive, restorative, and emergency oral health care. Non-routine dental (Medicare covered) We pay for some dental serviceswhen the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. We cover these services under the MassHealth benefit: <u>Preventive/Diagnostic:</u> • Preventive 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 <u>Prosthodontics (removable):</u> • Complete dentures • Partial dentures • Immediate dentures (once per lifetime) • Relines and adjustments of complete dentures <u>Prosthodontics (fixed)</u>: • Implants, 2 anterior implants per arch when needed to support a complete denture <u>Oral and Maxillofacial Surgery:</u> • Extractions (removal of teeth) • Biopsy and soft tissue surgery • Alveoplasty Bone grafting **These services are covered without prior authorization:** • Routine exams and x-rays • Preventive services including cleanings • Restorative fillings	$0

General services that our plan covers	What you must pay
• Non-surgical periodontal services (cleanings and maintenance) • Complete dentures and relines (after 6 months of initial placement) • Partial dentures and relines (after 6 months of initial placement) • Non-surgical extractions • Emergency care ***Prior authorization is required for all other services.*** • Preventive cleanings and periodic oral evaluations are covered two times per calendar year. • Complete and partial dentures are covered once every five years. Other limitations may apply. • Crowns are limited to coverage once every five years. Other limitations may apply. • Additional coverage is based on medical necessity. • Benefit limitations apply for certain dental services. In the event that clinical input is necessary to determine whether a course of treatment is appropriate, CCA One Care reserves the right to have a dental expert review the treatment plan your dentist has proposed. Services requiring authorization must be sent directly by your treating network dental provider to the plans dental benefit administrator, Skygen, for review. For more information, please call Member Services.	
Depression screening The plan covers depression screening. The screening must be done in a primary care setting that can give follow-up treatment. Prior authorization is not required for services provided by a network provider.	$0
Diabetes screening The plan covers diabetes screening (includes fasting glucose tests). Prior authorization is not required for services provided by a network provider.	$0

Diabetic self-management training, services, and supplies The plan covers the following services for all people who have diabetes or pre-diabetes (even if they don't use insulin): • Supplies to monitor your blood glucose, including the following: ○ A blood glucose monitor ○ Blood glucose test strips ○ Lancet devices and lancets ○ Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, the plan covers the following: ○ Therapeutic custom-molded shoes (including inserts), **or** ○ Depth shoes (including non-customized removable inserts) The plan will also cover fitting the therapeutic custom-molded or depth shoes. • In some cases, the plan covers training to help you manage your diabetes. For more information, please call Member Services. 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 Precision Neo® Meter, FreeStyle Precision Neo® Test Strips, FreeStyle Lite® Meter, FreeStyle Freedom Lite® Meter, FreeStyle Lite ® Test Strips, FreeStyle® Lancets, Freestyle® Test Strips, Freestyle InsuLinx ® Test Strips, Precision Xtra ® Meter, Precision Xtra® Test Strips,Precision Xtra Beta Ketone® Test Strips, OneTouch Ultra 2® Meter, OneTouch Ultra Mini® Meter, OneTouch Ultra ® Test Strips, OneTouch Verio® Meter, OneTouch Verio® Reflect Meter, OneTouch Verio® Flex Meter, OneTouch Verio® Test Strips, OneTouch Delica® Lancets, OneTouch Delica® Plus Lancets, OneTouch Delica® Ultrasoft Lancets.	$0

General services that our plan covers	What you must pay
Diabetic self-management training, services, and supplies (continued) ***Prior authorization is required for glucometers and therapeutic continuous glucose monitors (CGMs). Certain diabetic test strips may require a prior authorization under specific circumstances.*** ***Prior authorization is required for therapeutic custom-molded shoes and depth shoes.*** 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. Prior authorization is not required for diabetes self-management training, diabetic services, and other diabetic supplies provided by a network provider. **This benefit is continued on the next page**	

General services that our plan covers	What you must pay
Durable medical equipment (DME), including related supplies, replacement parts, training, modifications and repairs (For a definition of "Durable medical equipment (DME)," refer to Chapter 12 as well as Chapter 3, Section M of this handbook.) The following items are examples of DME that are covered: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • Personal emergency Response (PERS) Other DME items may be covered, including environmental aids or assistive/adaptive technology. The plan may also cover you learning how to use, modify, or repair your DME item. Your care team will work with you to decide if these other DME items and services are right for you and will be in your Individualized Care Plan (ICP). We cover all medically necessary DME that Medicare and MassHealth usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you. Limits may apply to certain DME. Prior authorization is required non-preferred manufacturers diabetic testing supplies (glucose monitors and test strips) • For assistance in determining authorization requirements or benefit limits, please call Member Services.	$0

General services that our plan covers	What you must pay

Emergency medical care
 	
"Emergency care" means services that are:
• given by a provider trained to give emergency services; **and**
• needed to treat a medical emergency.
 	
A "medical emergency" is a medical condition that anyone with an average knowledge of health and medicine could expect is so serious that if it doesn't get immediate medical attention, it would result in:
• serious risk to your health or to that of your unborn child; **or**
• serious harm to bodily functions; **or**
• serious dysfunction of any bodily organ or part; **or**
• in the case of a pregnant woman in active labor, when:
  ○ there is not enough time to safely transfer you to another hospital before delivery; **or**
  ○ the transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
 	
You may get emergency medical care whenever you need it, anywhere in the United States or its territories.
 	
Emergency care is not covered outside of the United States and its territories.
 	
If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized you must return to a network hospital for your care to continue to be paid for.
 	
You can stay in the out-of-network hospital for your inpatient care *only if the plan approves your continued stay.*
	$0

General services that our plan covers	What you must pay
Family planning services You may choose any provider in the CCA One Care network or a MassHealth provider to get certain family planning services. This means that you can pick any healthcare provider, clinic, hospital, pharmacy, or family-planning office. The plan covers the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, or implants) • Family planning supplies with a prescription (condom, sponge, foam, film, diaphragm, or cap) • Counseling and diagnosis of infertility • Counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (You must be 21 or older, and you must sign a federal sterilization-consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling The plan will also pay for some other family planning services. However, you must use a provider in the plan's network for the following services: • Treatment for medical conditions of infertility (this service does not include artificial ways to become pregnant) • Treatment for AIDS and other HIV-related conditions • Genetic testing For more information, call Member Services. Prior authorization is not required for family planning services provided by in-network or MassHealth providers. ***Prior authorization required for genetic testing.***	

General services that our plan covers	What you must pay
Gender Affirming Care Gender dysphoria describes the serious discontent a person feels about their biological sex and/or gender assigned at birth. The plan covers treatment for gender dysphoria, including gender reassignment services. Services may include the following: hormone therapy, mastectomy, breast augmentation, hysterectomy, salpingectomy, oophorectomy, or genital reconstructive surgery. Services and procedures that are considered cosmetic and reversal of gender reassignment surgery are not covered. For more information or help, please contact your Care Partner. ***Prior authorization required.***	$0
Group adult foster care The plan covers services provided by group adult foster care providers for members who qualify. These services are offered in a group-supported housing environment and may include the following: • assistance with activities of daily living, instrumental activities of daily living, and personal care • supervision • nursing oversight • care management • ***Prior authorization required.***	$0

General services that our plan covers	What you must pay
Health and wellness education programs The plan covers all health and wellness education programs covered by Medicare and MassHealth. Covered services include but are not limited to: • Smoking and tobacco use cessation (see also "Counseling to stop smoking or tobacco use" earlier in this section) • Access to our Nurse Advice Line, 24 hours a day, 7 days a week (see Chapter 2, Section C for more information on accessing Nurse Advice Line) • Health education and living well at home resources (see "Community health center services" earlier in this section) • Nutrition education (see also "Community health center services" earlier in this section and "Medical nutrition therapy" later in this section for more information on covered services) • Complex Care Self-Management programs for chronic obstructive pulmonary disease (COPD), diabetes, and heart failure • Kidney disease education services to teach kidney care and help members make informed decision about their care (see also "Renal (Kidney) disease services and supplies" later in this section for more information) Prior authorization is not required for services provided by a network provider.	$0

General services that our plan covers	What you must pay

Hearing services, including hearing aids
 	
The plan covers hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.
 	
The plan also covers the following routine hearing benefits:
• routine hearing exams
• evaluations for fitting hearing aids
• hearing aids
• providing and dispensing hearing aids, batteries, and accessories
• instruction in the use, care, and management of hearing aids
• ear molds
• ear impressions
• loan of a hearing aid, when necessary
 	
The plan uses NationsHearing as the benefit administrator for hearing services, including exams and hearing aids. Members must use NationsHearing to be covered for this benefit.
 	
Please contact NationsHearing at 877-277-9196 (TTY 711) for questions about your hearing services benefit.
 	
Prior authorization is not required for routine hearing exams, evaluations, repairs, and replacements provided by a network provider.
 	
Prior authorization is required for the following:
• *monaural hearing aids costing more than $500 (excluding shipping) per ear.*
• *binaural, cros, bicroshearing aids costing more than $1,000 (excluding shipping) per ear.*
• the replacement of a hearing aid, regardless of the cost of the hearing aid, due to a medical change;
  ○ loss of the hearing aid; or
  ○ damage beyond repair to the hearing aid;
• any replacement of cochlear implant external components.
	$0

General services that our plan covers	What you must pay
HIV screening The plan covers HIV screening exams and HIV screening tests. Prior authorization is not required for family planning services provided by in-network or MassHealth providers.	$0
Hepatitis C Virus (HCV) screening The plan covers HCV screening 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.	$0
Home health agency care The plan covers services provided by a home health agency including: • 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, with certain exceptions) • physical therapy, occupational therapy, and speech therapy • medical and social services • transportation to your care or services • medical equipment and supplies ***Prior authorization is required.***	$0

General services that our plan covers	What you must pay
Home health aide services The plan covers services from a home health aide, under the supervision of a licensed registered nurse (RN) or other professional, for members who qualify. Services may include the following: • simple dressing changes • assistance with medications • activities to support skilled therapies • routine care of prosthetic and orthotic devices • assistance with activities of daily living ***Prior authorization required.***	$0
Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0

Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice provider can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care If you choose to get your hospice care in a nursing facility, CCA One Care will cover the cost of room and board. **Hospice services and services covered by Medicare Part A or B are billed to Medicare.** • Refer to Section F of this chapter for more information. **For services covered by CCA One Care but not covered by Medicare Part A or B:** • CCA One Care will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by CCA One Care's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F. Our plan covers hospice consultation services for a terminally ill person who has not chosen the hospice benefit. **Note:** If you need hospice or non-hospice care, you should call your Care Partner to help arrange these services. Non-hospice care is care that is not related to your terminal prognosis.	$0

General services that our plan covers	What you must pay
For all members who do not elect Medicare hospice, we offer palliative care services under our Palliative Care Program (the "Program") as well as end-of-life care. The Program is focused on relieving pain, stress, and other uncomfortable symptoms for people living with serious illness. The Program is designed for our members, their caregivers, and providers with active involvement of the CCA One Care care teams. In appropriate cases, CCA One Care contracts with appropriate outside palliative care and hospice agencies to provide services that augment the program. For more information on the Program, please contact your care team.	
Immunizations The plan covers certain vaccines such as: • Pneumonia • Flu shots • 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 • Other vaccines that meet the MassHealth or Medicare Part D coverage rules. Read Chapter 6, Section D to learn more. Prior authorization is not required for services provided by a network provider.	$0
Independent nursing The plan covers care from a nurse in your home. The nurse may either work for a home health agency or may be an independent nurse. ***Prior authorization required.***	$0

General services that our plan covers	What you must pay
Inpatient behavioral healthcare Inpatient services, such as: • inpatient mental health services to evaluate and treat an acute psychiatric condition • inpatient substance use disorder services (ASAM Level 4) • observation/holding beds • administratively necessary day services Under this plan, there is no lifetime limit on the number of days a member can have in an inpatient behavioral healthcare facility. ***Prior authorization is required.***	$0

General services that our plan covers	What you must pay

Inpatient hospital care
 	
The plan covers medically necessary inpatient stays. You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.
 	
The plan covers services including:
• Semi-private room (or a private room if it is medically necessary)
• Meals, including special diets
• Regular nursing services
• Costs of special care units, such as intensive care or coronary care units
• Drugs and medications
• Lab tests
• X-rays and other radiology services
• Surgical and medical supplies
• Appliances, like wheelchairs
• Operating and recovery room services
• Physical, occupational, and speech therapy
• Inpatient substance use disorder services
• Blood, including storage and administration
  ○ The plan covers whole blood, packed red cells, and all other parts of blood. The coverage of whole blood and packed red cells begins with the first pint of blood that you need.
• Physician services
• Transplants, including corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.
  ○ If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant.
 	
This benefit is continued on the next page
	$0

General services that our plan covers	What you must pay
Inpatient hospital care (continued) ○ Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If CCA One Care provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. ***Prior authorization is required except for inpatient substance use and emergency admissions.***	
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • Are aged 50-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer **or** smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider. Prior authorization is not required for services provided by a network provider.	$0
Medical nutrition therapy The plan covers nutritional diagnostic therapy and counseling services to help you manage a medical condition (such as kidney disease). Prior authorization is not required for services provided by a network provider.	$0

General services that our plan covers	What you must pay
Medically necessary non-emergency transportation The plan covers transportation you need for medical reasons other than emergencies to plan approved destinations and confirmed appointment destinations within 50 miles of pick-up location. Rides must be booked 72 hours in advance, 7am to 8pm EST Monday through Friday and 8am to 12pm EST Saturday and Sunday. This non-emergency transportation is covered by our plan under the MassHealth 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 One Care.** ***Prior authorization is required for trips farther than 50 miles from the pickup location.***	$0
Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle. Prior authorization is not required for services provided by a network provider.	$0

Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. CCA One Care will cover the following drugs: • drugs you don't usually give yourself and are injected or infused while you are getting healthcare provider, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • drugs you take using DME (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 • osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a healthcare provider certifies was related to postmenopausal osteoporosis, and cannot inject the drug yourself • 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) • IV immune globulin for the home treatment of primary immune-deficiency diseases Part B Step Therapy Drug Categories: (Note: drugs classes listed below are usually not self-administered by the patient) • Anti-inflammatory • Anti-neoplastic agents (cancer) • Biologics • Colony-stimulating factors • Immunomodulators	$0

General services that our plan covers	What you must pay
This benefit is continued on the next page	
Medicare Part B prescription drugs (continued) View a list of Part B Drugs that may be subject to step therapy on our website: www.ccama.org We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. **Chapter 5 explains the outpatient prescription drug benefit.** It also explains the rules you must follow to have prescriptions covered. Most specialty drugs are limited to a 30-day supply. ***Prior authorization is required.*** For help in determining authorization requirements, please call Member Services.	$0
Nursing facility care The plan covers services at a place that provides care for people who cannot get their care at home but who do not need to be in the hospital. The plan does not pay for personal items such as TV or telephone, etc. ***Prior authorization is required***	$0
Obesity screening and therapy to keep weight down The plan covers counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. Prior authorization is not required for services provided by a network provider.	$0

General services that our plan covers	What you must pay
Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use disorder counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing)	$0
Orthotic services The plan covers braces (non-dental) and other mechanical or molded devices to support or correct the form or function of the human body. ***Prior authorization is required.*** For help in determining authorization requirements, please call Member Services.	$0

Outpatient behavioral health services The plan covers behavioral health services provided by the following providers: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a nurse practitioner • a physician assistant, **or** • any other Medicare-qualified behavioral healthcare professional as allowed under applicable state laws. The plan covers services including: • individual, group, and couples/family treatment • medication visit • diagnostic evaluation • family consultation • case consultation • psychiatric consultation on an inpatient medical unit • inpatient-outpatient bridge visit • acupuncture treatment • opioid replacement therapy • office-based opioid treatment • medication assisted treatment • methadone maintenance • ambulatory detoxification (Level II.d) • psychological testing • urgent outpatient services • dialectical behavioral therapy (DBT) **This benefit is continued on the next page**	$0

General services that our plan covers	What you must pay
Outpatient behavioral health services (continued) • structured outpatient addiction program (SOAP) You have the option of getting these services through an in-person visit or by telehealth. Under the Mental Health Parity and Addiction Equity law, we are required to provide mental 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. *(See also "Community-based behavioral health (diversionary) services that our plan covers" later in this section for more information on behavioral health services.)* ***Prior authorization is required for neuropsychological testing, psychological testing, electroconvulsive therapy, and repetitive transcranial magnetic stimulation (rTMS), esketamine for treatment of resistant depression.***	

General services that our plan covers	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies The plan covers services including: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood. The plan will pay for storage and administration. The coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Genetic testing; services provided in accordance with Medicare and MassHealth guidelines. • Other outpatient diagnostic tests CCA One Care reserves the right to have an expert review the proposed treatment plan or request to determine if a course of treatment is appropriate for you. ***Prior authorization is required for outpatient diagnostic tests and therapeutic services and supplies.*** For example, specialized imagining and specialized screening tests (i.e. genetic testing) may require a prior authorization. For help in determining authorization requirements, please call Member Services.	$0
Outpatient drugs Please read Chapter 5 for information on drug benefits, and Chapter 6 for information on what you pay for drugs. You pay nothing for prescription drugs and OTC items covered by our plan.	$0

General services that our plan covers	What you must pay

Outpatient hospital services
 	
The plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
 	
The plan covers services including:
• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
  ○ Observation services help your healthcare provider know if you need to be admitted to the hospital as an "inpatient."
  ○ Sometimes you can be in the hospital overnight and still be an "outpatient."
  ○ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101
• Labs 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 needed without it
• X-rays and other radiology services billed by the hospital
• Medical supplies, such as splints and casts
• Preventive screenings and services listed throughout the Benefits Chart
• Some drugs that you can't give yourself
 	
CCA One Care reserves the right to have an expert review the proposed treatment plan or request to determine if a course of treatment is appropriate for you.
 	
Prior authorization is required for outpatient surgery.
 	
Prior authorization is required for outpatient diagnostic tests and therapeutic services and supplies. For example, specialized imaging and specialized screening tests may require prior authorization.
 	
For help in determining authorization requirements, please call Member Services.
	$0

General services that our plan covers	What you must pay
Outpatient rehabilitation services The plan covers physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. For more information, please contact your care team. ***Prior authorization is required for physical therapy, occupational therapy, and speech therapy.*** ***Augmentative and alternative communication devices and assistive technology may require a prior authorization.***	$0
Outpatient substance use disorder services The plan covers services including: • Acupuncture • Methadone maintenance • Ambulatory Detoxification (Level II.D) You have the option of getting these services through an in-person visit or by video visit (virtual care or telehealth). Prior authorization is not required for services provided by a network provider, except for after 36 sessions acupuncture treatment. ***Acupuncture used in the treatment of substance use disorder requires prior authorization if the number of visits exceeds 36 in a calendar year.***	$0
Outpatient surgery The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. ***Prior authorization is required.***	$0

General services that our plan covers	What you must pay
Oxygen and respiratory therapy equipment The plan covers services including oxygen systems, refills, and oxygen therapy equipment rental. ***Prior authorization is required.***	$0
Palliative care program Palliative care 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 To enroll in the Palliative Care Program, please speak with your Care Partner. If it is right for your needs, your Care Partner will give you a referral to the program. Prior authorization is not required for services provided by the Commonwealth Care Alliance palliative care program or from a network provider.	$0

General services that our plan covers	What you must pay
Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$0

General services that our plan covers	What you must pay
Personal care attendant services The plan covers personal care attendant services to assist you with activities of daily living and instrumental activities of daily living if you qualify. These include, for example: • bathing • meal preparation and eating • dressing and grooming • medication management • moving from place to place • toileting • transferring • laundry • housekeeping These services also include Personal Assistance Services, such as cueing and monitoring. You can hire a worker yourself or use an agency to hire one for you. A worker can help you with hands-on tasks. The plan may also pay for a worker to help you, even if you do not need hands-on help. Alternative services may be recommended when no hands-on help is needed. Personal assistance services are available through community agencies. Your care team will work with you to decide if that service is right for you and will be in your Individualized Care Plan (ICP). ***Prior authorization is required.***	$0

Physician/provider services, including doctor's office visits
 	
The plan covers the following services.
○ Medically necessary healthcare or surgery services given in places such as:
  ○ physician's office
  ○ certified ambulatory surgical center
  ○ hospital outpatient department
○ Consultation, diagnosis, and treatment by a specialist
○ Basic hearing and balance exams given by your primary care provider or specialist, if your healthcare provider orders it to find out whether you need treatment
○ Second opinion before a medical procedure. Your primary care provider/care team will help you to arrange to receive a second opinion services from out-of-network provider if a network provider is not available.
○ Non-routine dental care. Covered services are limited to the following:
○ Surgery of the jaw or related structures
○ Setting fractures of the jaw or facial bones
○ Pulling teeth before radiation treatments of neoplastic cancer, or
  ○ surgery of the jaw or related structures
  ○ setting fractures of the jaw or facial bones
  ○ pulling teeth before radiation treatments of neoplastic cancer, or
  ○ services that would be covered when provided by a physician
○ Virtual check-ins (for example, by phone or video chat) with your healthcare provider for 5-10 minutes if:
  ○ 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
	$0

Physician/provider services, including doctor's office visits (continued)
○ Evaluation of video and/or images you send to your provider and interpretation and follow-up by your 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 provider has with other providers by phone, the Internet, or electronic health record if you're not a new patient
○ Second opinion by another network provider before surgery
○ Non-routine dental care. Covered services are limited to the following:
○ Services that would be covered when provided by a physician.
○ Certain telehealth ("video visit" or "virtual care") services, 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 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 (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
○ Telehealth services to diagnose, evaluate, or treat symptoms of a stroke
○ Telehealth services for members with a substance use disorder or co-occurring behavioral health disorder
○ Telehealth services for diagnosis, evaluation, and treatment of behavioral health disorders if:	

Physician/provider services, including doctor's office visits (continued) ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances ○ Telehealth services for behavioral health visits provided by Rural Health Clinics and Federally Qualified Health Centers ○ virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ○ 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 doctor and interpretation and follow-up by your doctor 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 doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • second opinion by another network provider before surgery • Non-routine dental care. Covered services are limited to the following: ○ surgery of the jaw or related structures ○ setting fractures of the jaw or facial bones ○ pulling teeth before radiation treatments of neoplastic cancer, **or** ○ services that would be covered when provided by a physician	

General services that our plan covers	What you must pay
Physician/Provider Services - Annual Wellness Visit Reward An annual wellness visit or an annual physical exam qualifies for one $25 reward per year after you've completed the visit. Routine PCP visits, like a follow-up or sick visit, don't qualify for the reward. To earn this reward, you must have an annual wellness visit or an annual exam. Either annual visits type is longer than routine primary care provider visits. During an annual wellness visit or an annual physical exam, you and your healthcare provider will review your overall health in detail. After you've completed your qualifying exam, and the provider bills us (the health plan), we will send you information about choosing your reward. Covered once every calendar year. **See "Dental services" earlier in this section for more information on dental services, prior authorization requirements, and limitations.** ***Prior authorization is required for: services provided in a certified ambulatory surgical center, non-routine dental care, outpatient surgery, and services provided by out-of-network providers.***	
Physician, nurse practitioner, and nurse midwife services The plan covers physician, nurse practitioner, and nurse midwife services. These include, for example: • office visits for primary care and specialists • OB/GYN and prenatal care • diabetes self-management training • medical nutritional therapy • tobacco-cessation services • Prior authorization is not required for services provided by a network provider.	

General services that our plan covers	What you must pay
Podiatry services The plan covers the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes ***Prior authorization is required, for podiatric surgery and podiatry services provided in a nursing home.***	$0
Prescription Digital Therapeutics You pay a **$0** copay for the following prescription digital therapy: 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 One Care Plan to determine if this will work for you. Call the plan's Member Services line for more information.**	$0
Prostate-cancer screening exams The plan covers the following services: • A digital rectal exam • A prostate specific antigen (PSA) test Prior authorization is not required for services provided by a network provider.	$0

General services that our plan covers	What you must pay
Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. The plan covers services including: • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) In addition, the plan covers some supplies related to prosthetic devices. The plan also covers repairing or replacing prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. Refer to "Vision Care" later in this section for details. ***Prior authorization is required.*** For help in determining authorization requirements, please call Member Services.	$0
Pulmonary-rehabilitation services The plan covers pulmonary-rehabilitation programs for members who have moderate-to-very-severe chronic obstructive pulmonary disease (COPD). The member must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD. ***Prior authorization is required.***	$0

General services that our plan covers	What you must pay

Renal (Kidney) disease services and supplies
 	
The plan covers the following services:
• Kidney disease education services to teach kidney care and help members make good decisions about their care.
  ○ you must have stage IV chronic kidney disease, and your healthcare provider must refer you.
  ○ the plan will cover up to six sessions of kidney disease education services.
• 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, including training for you and anyone helping you with your home dialysis treatments
• Home dialysis equipment and supplies
• Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply
 	
Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart.
 	
Prior authorization is not required for services provided by a network provider.
 	
You do not need a prior authorization for out-of-area dialysis services.
	$0

General services that our plan covers	What you must pay
Sexually transmitted infections (STIs) screening and counseling The plan covers screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care provider must order the tests. The plan also covers face-to-face, high-intensity behavioral counseling sessions. The plan covers these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office. Prior authorization is not required for family planning services provided by in-network or MassHealth providers.	$0

Skilled nursing facility (SNF) care
 	
The plan covers services including:
• A semi-private room, or a private room if it is medically necessary
• Meals, including special diets
• Nursing services
• Physical therapy, occupational therapy, and speech therapy
• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors
• Blood, including storage and administration
  ○ The plan will pay for whole blood and packed red cells. The coverage of whole blood and packed red cells begins with the first pint of blood that you need.
  ○ The plan will pay for all other parts of blood, beginning with the first pint used.
• Medical and surgical supplies given by nursing facilities
• Lab tests given by nursing facilities
• X-rays and other radiology services given by nursing facilities
• Appliances, such as wheelchairs, usually given by nursing facilities
• Physician/provider services
 	
You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment.
• A nursing home or continuing-care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)
• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital
 	
Inpatient hospital stay prior to skilled nursing facility admission is not required.
 	
If MassHealth determines you have a monthly Patient Paid Amount (PPA) for your custodial care, you are responsible for the payments.
 	
Prior authorization is required.
	$0

General services that our plan covers	What you must pay
Supervised exercise therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have an order for PAD from the physician responsible for PAD treatment. The plan will pay for: Up to 36 sessions during a 12-week period if all SET requirements are met An additional 36 sessions over time if deemed medically necessary by a healthcare provider The SET program must be: 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) In a hospital outpatient setting or in a physician's office Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques ***Prior authorization is required.***	$0

General services that our plan covers	What you must pay
Transitional Living Services Program The plan covers services provided by a transitional living services provider for members who qualify. These services are provided in a residential setting and may include the following: • personal care attendant services • on-site 24-hour nurse oversight • meals • skills trainers • assistance with Instrumental Activities of Daily Living (e.g., laundry, shopping, cleaning) ***Prior authorization is required.***	$0
Urgently needed care Urgently needed care is care given to treat the following: • a non-emergency (does not include routine primary care services) • a sudden medical illness • an injury • a condition that needs care right away If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider (for example, when you are outside the plan's service area or during the weekend). Prior authorization is not required. You should inform your PCP/care team whenever possible if you have received such care. Urgently needed care is not covered outside of the United States and its territories.	$0

Vision care

The plan will pay for the following routine vision services:

- Comprehensive eye exams
- Vision training
- Eye glasses which includes:
  - Base lenses (single, bifocal, trifocal)
  - Frames or visually required contact lenses up to $125 per calendar year
- One (1) replacement set of frames or contact lenses up to $125 and base lenses once every two (2) calendar years.
- and other visual aids

Members must receive routine vision services from providers in the VSP provider network. For assistance with routine vision services contact VSP for assistance at 855-492-9028 (TTY 711), 8 am to 8 pm, 7 days a week

Prior authorization is not required for covered routine vision services.

Non-routine vision:

The plan also covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.

For people at high risk of glaucoma, the plan covers glaucoma screenings. The plan covers glasses or contact lenses after cataract surgery when the doctor inserts an intraocular lens.

For questions about your non-routine vision benefits, call Member Services.

Prior authorization is not required for certain non-routine vision care services

General services that our plan covers	What you must pay
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health; • education and counseling about the preventive services you need (including screenings and shots); **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit. We also cover "wellness visits" and other preventive services. See section below for more information on wellness check-ups. Prior authorization is not required for services provided by a network provider.	$0
Wellness visit The plan covers wellness checkups. This is to make or update a prevention plan. Prior authorization is not required for services provided by a network provider.	$0

In addition to the general services, our plan also covers community-based behavioral healthcare services. These are sometimes called “behavioral health diversionary services.” These are services that you may be able to use instead of going to the hospital or a facility for some behavioral health needs. Your care team will work with you to decide if these services are right for you and will be in your Individualized Care Plan (ICP).

Community-based behavioral health (diversionary) services that our plan covers

These services include the following:

- Medically monitored inpatient withdrawal management (also known as acute treatment services) (ASAM Level 3.7)
- 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 (CCS)
- Community support program for chronically homeless individuals (CSP-CHI)
- Community support program (CSP)
- Emergency services program (ESP)
- Enhanced residential rehabilitation services for dually diagnosed individuals
- Intensive outpatient program (IOP)
    - Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.
- Partial hospitalization program (PHP)
    - "Partial hospitalization" is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.
- Program of assertive community treatment (PACT)
- Psychiatric day treatment
- Recovery coaching
- Recovery support navigators
- Residential rehabilitation services (RRS)
    - Cooccurring enhanced RRS (COE RRS) for members with dual diagnosis
- Structured outpatient addiction program (SOAP)
- Transitional support services (TSS) for substance use disorders* (refer to the Note below)

You have the option of getting these services through an in-person visit or by telehealth (virtual care). Prior authorization is not required.

* **Note:** These services may not be available at the beginning of the plan year through your One Care plan. If you have questions, please contact your One Care plan.

Our plan also covers community-based services to promote wellness, recovery, self-management of chronic conditions, and independent living. These services may also help you stay out of the hospital or nursing facility. Your care team will work with you to decide if these services are right for you and will be in your Individualized Care Plan (ICP).

Community-based services that our plan covers
Care transitions assistance The plan pays covers services to help with transitions between care settings for members who qualify. These services may include the following: • coordination of information between your providers • follow-up after your inpatient or facility stay • education about your health condition • referrals Prior authorization is not required for services provided by a network provider.
Chore services These services include activities that assist members in maintaining their homes and/or to correct or prevent environmental defects that may be hazardous to a member's health and safety. ***Prior authorization is required.***

Community-based services that our plan covers
Community health workers The plan covers services provided by community health workers, which may include the following: • health education in your home or community • getting you the services you need • counseling, support and screenings Services from a community health worker means that you'll be getting help from someone who will advocate for you and who understands your culture, needs and preferences. Community health workers from CCA One Care assist 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 eligibility. Prior authorization is not required for services provided by CCA One Care community health workers.
Companion services Companion services allow healthy individuals to remain at home by providing assistance. The plan covers services related to socialization, assistance with preparation of light snacks, help with shopping and errands, and escorts to medical appointments, nutrition sites, and walks. ***Prior authorization is required.***

Community-based services that our plan covers
Day services The plan covers structured day activities at a program to help you learn skills that you need to live as independently as possible in the community. Skills are designed to meet your needs, and may include the following: • daily living skills • communication training • prevocational skills • socialization skills ***Prior authorization is required.***
Home care services The plan covers home care services provided in your home or community if you qualify. These services may include the following: • a worker to help you with household talks • a worker to help you with your everyday tasks and personal care. Assistance can be hands-on, prompting, or supervising these tasks. • training or activities to improve your community living skills and help you advocate for yourself ***Prior Authorization is required.***
Home delivered meals These services include preparing, packaging, and delivering meals to member homes. ***Prior Authorization is required.***

Community-based services that our plan covers
Home modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, welfare and safety or make you more independent in your home. Modifications may include the following: • ramps • grab-bars • widening of doorways • special systems for medical equipment For more information, please call Member Services. ***Prior Authorization is required.***
Medication management The plan covers medication management services from a support worker if you qualify. The support worker will help you take your prescription and over-the-counter medications. The service may include the following: • reminding you to take your medication • checking the medication package • watching you take your medication • writing down when you take your medication • opening medications and reading the labels for you ***Prior Authorization is required.***

Community-based services that our plan covers

Nonmedical transportation

The plan covers transportation to community services and activities that help you stay independent and active in your community.

Eight (8) one-way trips per month are provided for non-medical purposes, such as grocery shopping, food banks and the gym within 50 miles from the pick-up location. Certain locations are prohibited such as casinos. Trips not used within the month are not rolled over for future use. Trips must be booked 72 hours in advance, 7am to 8pm EST Monday through Friday and 8am to 12pm EST Saturday and Sunday. 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, and you either do not show up or late cancel, the scheduled ride will count against your eight one-way non-medical trips per month. This benefit is covered by the 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 One Care.

If you need more than eight (8) one-way trips per month, you can speak to your Care Partner about getting approval for additional trips to covered CCA locations including grocery stores and food banks to align with your Individualized Care Plan.

For more information, please contact your care team.

Prior Authorization is required for rides farther than 50 miles from the pick up location, and for more than eight (8) one-way trips per month.

Community-based services that our plan covers
Peer support/counseling/navigation The plan covers training, instruction, and mentoring services if you qualify. These services will help you to advocate for yourself and participate in your community. You may get these services from a peer or in small groups. The plan also covers services provided by behavioral health certified peer specialist (CPS). A CPS is a person who has been trained to effectively share his or her experiences in a way that is helpful and hopeful to others, especially people using and providing behavioral health services. A CPS must complete an intensive 9-day training program, pass an examination, and participate in continuing education. Prior authorization is not required for services provided by a contracted behavioral health certified peer specialist (CPS). ***Prior Authorization is required.***
Respite care The plan covers respite-care services if your primary caregiver needs relief or is going to be unavailable for a short-term basis. These services can be provided in an emergency or be planned in advance. If planned in advance, services might be in your home, or during a short-term placement in adult foster care, adult day health, nursing facility, assisted living, rest home, or hospital. Prior authorization is not required for services provided by a network provider.

E. Benefits covered outside of CCA One Care

The following services are not covered by CCA One Care but are available through Medicare, MassHealth, or a State Agency.

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what CCA One Care pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by CCA One Care's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F.

Note: If you need hospice or non-hospice care, you should call your Care Partner to help arrange the services. Non-hospice care is care that is not related to your terminal prognosis.

E2. State Agency Services

Psychosocial Rehabilitation and Targeted Case Management

If you are getting Psychosocial Rehabilitation from the Department of Mental Health or Targeted Case Management from the Department of Mental Health or Department of Developmental Services, your services will continue to be provided directly from the state agency. However, CCA One Care will assist in coordinating with these providers as a part of your overall Individualized Care Plan (ICP).

Rest Home Room and Board

If you live in a rest home and join One Care, the Department of Transitional Assistance will continue to be responsible for your room and board payments.

F. Benefits not covered by CCA One Care, Medicare, or MassHealth

This section tells you what kinds of benefits are excluded by the plan. “Excluded” means that the plan does not pay for these benefits. Medicare and MassHealth will not pay for them, either.

The list below describes some services and items that are not covered by the plan under any conditions, and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan.**

- Services that are not medically necessary according to the standards of Medicare and MassHealth.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3, Page 48 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Fees charged by your immediate relatives or members of your household, except as allowed for personal care assistance or adult foster care.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is malformed. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, and other low-vision aids.
- Reversal of sterilization procedures and nonprescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and MassHealth. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

CCA One Care also covers the following drugs, but they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections you get during an office visit with a doctor or other provider, and drugs you get at a dialysis clinic. To learn more about which Medicare Part B drugs are covered, refer to the Benefits Chart in Chapter 4, Section D.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section:

1. A doctor or other provider must write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you to that provider for care.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug generally must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
    - If it is not on the Drug List, we may be able to cover it by giving you an exception.
    - Refer to Chapter 9, Section F2 to learn about asking for an exception.`
5. Your drug must be used for a medically accepted indication. This means that the use of the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. In accordance with Medicaid law and regulation, and per MassHealth, services are medically necessary if:

- They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**
- There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions only if they are filled at the plan's network pharmacies. A network pharmacy is a drugstore that has agreed to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, you can:

- Look in the *Provider and Pharmacy Directory*
- Visit our website at www.ccama.org
- Contact Member Services at 866-610-2273 (TTY 711)

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, or the pharmacy asks you to pay for the drug, contact Member Services right away. We will do what we can to help.

A3. What to do if you change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, you can contact Member Services at 866-610-2273 (TTY 711).

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy so that the plan continues to pay for your prescriptions.

To find a new network pharmacy, you can look in the **Provider and Pharmacy Directory**, visit our website at www.ccama.org, or contact Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility, such as a nursing facility.
    - Usually, long-term-care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

A6. Using mail-order services to fill a prescription

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order up to a 90-day supply. You pay $0.

Filling my prescriptions by mail

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

- Call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.
- Visit our website www.ccama.org and view 'Mail Order Program' information under 'Pharmacy Services.'
- Speak with your care team.

Usually, a mail-order prescription will get to you within 14-21 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.

Mail-order processes

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the mail-order pharmacy gets from you**

   The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. **New prescriptions the mail-order pharmacy gets directly from your provider's office**

   After the pharmacy gets a prescription from a healthcare provider, it will contact you to find out if you want the medication filled immediately or at a later time.

   - This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped.
   - It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. **Refills on mail-order prescriptions**

   For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

   - The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
   - If you choose not to use our auto refill program, 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.

   To opt out of our program that automatically prepares mail-order refills, please contact the mail-order pharmacy, Costco Pharmacy, by calling 1-800-607-6861. You can also disenroll on their website pharmacy.costco.com by managing your 'Refill Prescription' status.

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 the pharmacy to confirm your contact information.

A7. Getting a long-term supply of your prescriptions

You can get a long-term 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.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

You can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above to learn about mail-order services.

A8. Using a pharmacy that is not in the plan's network

You should always use a pharmacy in CCA One Care's network if you can. If you think you are not able to use a pharmacy in our network, call Member Services first.

We usually pay for drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If you are traveling within the United States and its territories, but outside of the plan's service area, and become ill, lose or run out of your prescription drugs, we will cover prescription drugs that are filled at an out-of-network pharmacy. Prior to filling your prescription at an out-of-network pharmacy, call Member Services to find out if there is a network pharmacy in the area where you are traveling at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week. 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 of the drug you have purchased. To learn how and where to send your request for payment, please refer to Chapter 7. We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and its territories, even for a medical emergency.
- If you are unable to get a covered drug in a timely manner within our service area because there is no network pharmacy (within a reasonable driving distance) that provides 24-hour service.

- If you are trying to fill a covered prescription drug that is not regularly stocked at network retail or our mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- If you cannot use a network pharmacy during a declared disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy.

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

In these cases, please check first with Member Services to find out if there is a network pharmacy nearby.

A9. Paying you back if you pay for a prescription

If you use an out-of-network pharmacy for some other reason, the pharmacy may ask you to pay for the full cost of your prescription. If this happens, call Member Services first.

If you pay the full cost when you get your prescription, you can ask us to pay you back.

To learn more about this, refer to Chapter 7, Section A.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of healthcare providers and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will usually cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D, and some prescription and over-the-counter drugs and products covered under your MassHealth benefits.

The Drug List includes brand name drugs and generic drugs

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 such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Generally, generics work just as well as brand name drugs and usually cost less. There are generic drug substitutes

available for many brand name drugs. Generic drugs are approved by the Food and Drug Administration (FDA).

We will usually cover drugs on the plan's Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List that we sent to you in the mail;
- Visit the plan's website at www.ccama.org. The Drug List on the website is always the most current one; **or**
- Call Member Services and ask for a copy of the list.
- Use our "Real Time Benefit Tool" at www.ccama.org or call your Care Partner or Member Services. With this tool you can search for drugs on the Drug List to get an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

B3. Drugs that are not on the Drug List

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

CCA One Care will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug in your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9, Section E3.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and MassHealth drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by CCA One Care for free, but they are not considered to be part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.

3. The use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your healthcare provider might prescribe a certain drug to treat your condition, even though the drug was not approved to treat that condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

By law, the types of drugs listed below are also not covered by Medicare or MassHealth.

- drugs used to promote fertility
- drugs used for cosmetic purposes or to promote hair growth
- drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- drugs used for treatment of anorexia, weight loss, or weight gain
- outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List tiers

Every drug on the plan's Drug List is in one of 5 tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs). All 5 tiers consist of both part D drugs and non-Medicare covered drugs, and/or non- Medicare covered OTC drugs:

- Tier 1 drugs are preferred generic drugs.
- Tier 2 drugs are non-preferred generic drugs.
- Tier 3 drugs are preferred brand name drugs.
- Tier 4 drugs are non-preferred brand name drugs.
- Tier 5 drugs are MassHealth over-the-counter drugs.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

C. Limits on some prescription drugs

There are special rules that limit how and when the plan covers certain prescription drugs. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should

not apply to your situation, you should ask us to make an exception. After review we may agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9, Section F2.

1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. If there is a generic version of a brand name drug, our network pharmacies will give you the generic version.

- We usually will not pay for the brand name drug when there is a generic version.
- However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your healthcare provider must get approval from CCA One Care before you fill your prescription. This is called prior authorization (PA) or approval. If you don't get PA, CCA One Care may not cover the drug.

3. Trying a different drug first (step therapy)

In general, the plan wants you to try lower-cost drugs (that often are just as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

If Drug A does not work for you, then the plan will cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services at 866-610-2273 (TTY 711) or check our website at www.ccama.org.

D. Reasons your prescriptions might not be covered

We try to make your drug coverage work well for you. But sometimes a drug might not be covered in the way that you would like it to be. For example:

- The drug you want to take is not covered by the plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are extra rules or limits on coverage for that drug. As explained in Section C, Limits on some prescription drugs, some of the drugs covered by the plan have rules that limit their use. In some cases, you may want us to ignore the rule for you.

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

D1. Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

CCA One Care determines which drugs are Part D drugs. We may decide that some older drugs or drugs without proven clinical outcomes do not qualify as Part D drugs. If you are taking a drug that CCA One Care does not consider to be a Part D drug, you have the right to get a one-time, 72-hour supply of the drug. If the pharmacy is not able to bill CCA One Care for this one-time supply, MassHealth will pay for it. This is required by Massachusetts law.

Also, you may be able to get a longer temporary supply of a Part D drug, or of a non-Part D drug that MassHealth would cover. To find out how long CCA One Care will provide a temporary supply of a drug, call Member Services at 866-610-2273 (TTY 711).

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:

- is no longer on the plan's Drug List; **or**
- was never on the plan's Drug List; **or**
- is now limited in some way.

2. You must be in one of these situations:

For Medicare Part D drugs:

- 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 up to 31 days.
    - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 31 days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You are new to the plan.
    - We will cover a temporary supply of your Medicare Part D drug **during the first 90 days of your membership in the plan**.
    - This temporary supply will be for up to 31 days.
    - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 31 days of medication. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
    - We will cover one 31-day supply of your Medicare Part D drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- For those who have a level-of-care transition:
    - For current enrollees with level-of-care changes, we will provide an emergency supply of at least 31-days (unless the prescription is written for fewer days) for all non-formulary medications including those that may have step therapy or prior authorization 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 MassHealth drugs:

- You are new to the plan.
    - We will cover a supply of your MassHealth drug for 90 days or until your comprehensive assessment and Individualized Care Plan (ICP) are complete, or less if your prescription is written for fewer days.
    - To ask for a temporary supply of a drug, call Member Services at 866-610-2273 (TTY 711).

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- You can change to another drug.

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- You can ask for an exception.

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for an exception.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9, Section F2.

If you need help asking for an exception, you can contact Member Services or your Care Partner.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but CCA One Care may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require PA for a drug. (PA is permission from CCA One Care before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check CCA One Care's up to date Drug List online at www.ccama.org **or**
- Call Member Services to check the current Drug List at 866-610-2273 (TTY 711).

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug becomes available**. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but there will be no cost to you for the new drug.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.

- You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know.
  - If you are notified that a drug you are taking is taken off the market, follow one of the below steps.
    - Speak with your CCA Care Partner **or**
    - Immediately contact your prescriber to seek an alternative prescription.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.
- We add a generic drug **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 31-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9.

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

F. Prescription drug coverage in special cases

F1. If you are 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 skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will continue to cover your drugs as long as the drugs meet all of our rules for coverage.

F2. If you are in a long-term care facility

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

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get 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 getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4, Sections D & F.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you are taking another drug that does the same thing;
- May not be safe for your age or gender;
- Could harm you if you take them at the same time;
- Have ingredients that you are or may be allergic to; **or**
- Have unsafe amounts of opioid pain medications.

If we find a possible problem in your use of prescription drugs, we will work with your provider to fix the problem.

G2. Programs to help members manage their prescriptions

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your healthcare provider about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other healthcare providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact Member Services.

G3. Drug management program to help members safely use their opioid medications

CCA One Care has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program.

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 or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain healthcare provider**
- **Limiting the amount** of those medications we will cover for you
- **Prescribing durable medical equipment (DME)** to provide medication management via a pill dispenser

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which healthcare providers or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send

your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9, Section E4.)

The Drug Management Program may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your outpatient prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- drugs and items covered under MassHealth, **and**
- drugs and items covered by the plan as additional benefits.

Because you are eligible for MassHealth, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

To learn more about prescription drugs that CCA One Care covers, you can look in these places:

- The plan’s **List of Covered Drugs**.
  - We call this the “Drug List.” It tells you:
    - Which drugs the plan pays for;
    - Which of the 5 tiers each drug is in;
    - Whether there are any limits on the drugs.
  - If you need a copy of the Drug List, call Member Services at 866-610-2273 (TTY 711). You can also find the Drug List on our website at www.ccama.org. The Drug List on the website is always the most current.
- Chapter 5 of this *Member Handbook*.
  - Chapter 5, Section A tells how to get your outpatient prescription drugs through the plan.

- It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.

- The plan's **Provider and Pharmacy Directory**.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
  - The **Provider and Pharmacy Directory** has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A.

- When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call your Care Partner or Member Services for more information.

Table of Contents

A. The Part D Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. With CCA One Care, you do not have to pay anything for your prescriptions, as long as you follow the rules in Chapter 5. Your out-of-pocket costs will be zero.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits.* We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what Part D prescription drugs you got for the previous month. It shows the total Part D drug costs, what the plan paid, and what you and others paid for your drugs.
- **"Year-to-date" information.** This is your total drug costs and the total payments made this year.
- **Drug price information.** This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay for them.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you have paid for. You should always follow the rules in Chapter 5 for getting drugs. If you follow the rules, you will pay nothing for drugs covered by CCA One Care. If you ever pay the full cost of your drug, you should keep the receipt and you can ask us to pay you back for the drug.

   Here are some times when you should give us copies of your receipts:

   - When you buy 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 pay a copay for drugs that you get under a drug-maker's patient-assistance program.
   - When you buy covered drugs at an out-of-network pharmacy.
   - When you pay the full price for a covered drug.

   To learn how to ask us to pay you back for the drug, refer to Chapter 7, Section A.

3. **Check the EOBs we send you.**

   When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, please call Member Services. Be sure to keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With CCA One Care, you pay nothing for covered drugs as long as you follow the plan's rules.

C1. The plan's tiers

Tiers are groups of drugs on our Drug List. Every drug in the plan's Drug List is in one of 5 tiers. You have no copays for prescription and OTC drugs on CCA One Care's Drug List. To find the tiers for your drugs, you can look in the Drug List.

All five tiers consist of both part D drugs and non-Medicare covered drugs, and/or non- Medicare covered OTC drugs:

- Tier 1 drugs are preferred generic drugs. Your copay is $0 for Tier 1 drugs.

- Tier 2 drugs are non-preferred generic drugs. Your copay is $0 for Tier 2 drugs.
- Tier 3 drugs are preferred brand name drugs. Your copay is $0 for Tier 3 drugs.
- Tier 4 drugs are non-preferred brand name drugs. Your copay is $0 for Tier 4 drugs.
- Tier 5 drugs are MassHealth over-the-counter drugs. Your copay is $0 for Tier 5 drugs.

C2. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5, Section A8 to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5, Section A in this handbook and the plan's *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5, Section A or the *Provider and Pharmacy Directory*.

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).* Our plan covers adult Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered Drugs* (*Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.

2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your healthcare provider.

D1. What you need to know before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.
- We can tell you how to keep your costs down by using network pharmacies and providers Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with CCA One Care to ensure that you do not have any costs for a Part D vaccine.
- If you are not able to use a network provider and pharmacy, you may have to pay the entire cost for both the vaccine itself and for getting the shot. If you are in this situation, we recommend that you call Member Services first. You can also ask the provider to call CCA One Care before you get your vaccine. If you pay the full cost of the vaccine at a provider's office, we can tell you how to ask us to pay you back. When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. To learn how to ask us to pay you back, see Chapter 7.

Chapter 7: Asking us to pay for services

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Asking us to pay

With One Care, there are some rules for getting services. One of the rules is that the service must be covered by CCA One Care. Another rule is that you must get the service from one of the providers that CCA One Care works with. Refer to Chapter 3 to read all the rules.

If you follow all the rules, then the plan will pay for your services automatically and you do not have to ask us to pay. In those cases, you should not pay anything to your providers or get any bills.

If you are not sure if the plan will pay for a service you want to get or a provider you want to use, ask your Care Partner or call Member Services. **Do this before you get the service.** Your Care Partner or Member Services will tell you if CCA One Care will pay, or if you need to ask CCA One Care for a coverage decision. Read Chapter 9 to learn more about coverage decisions.

Here are some different situations and information about payment for your services.

1. **If you get emergency or urgently needed healthcare from an out-of-network provider**

   You should ask the provider to bill the plan. Call Member Services or your Care Partner if you need help.

   - If you pay the full amount when you get the care, ask us to make sure you get paid back. Send us the bill and proof of any payment you made.
   - If you get a bill from the provider asking for payment that you think you do not owe, send us the bill, and if you paid all or part of the bill, proof of any payment you made.
     - If the provider should be paid, we will pay the provider directly.
     - If you have already paid for the service, we will make sure you get paid back.

2. **If a provider in CCA One Care's network sends you a bill**

   Network providers must always bill the plan. Show your CCA One Care Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

   - Because CCA One Care pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.

- If you ever get a bill from a network provider, do not pay the bill. Send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will help you get paid back for your covered services.

3. If you use an out-of-network pharmacy to get a prescription filled

If you use a pharmacy that is not in CCA One Care's network, you may have to pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Please refer to Chapter 5, Section A to learn more about out-of-network pharmacies.

4. If you pay the full cost for a prescription because you do not have your CCA One Care Member ID Card with you

If you do not have your Member ID Card with you, ask the pharmacy to call the plan or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back.

5. If you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
    - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (refer to Chapter 9, Section E2).
    - If you and your healthcare provider think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9, Section E2).
- Send us a copy of your receipt when you ask us to pay you back. 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.

To learn how to make an appeal, refer to Chapter 9, Section 6.5.

B. Sending a request for payment

Send us your bill and proof of any payment you have made. Proof of payment must be a receipt from the provider. It is a good idea to make a copy of your bill and receipts for your records. You can ask your Care Partner for help.

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. The following information is required to process your request:

- First and Last Name
- Member ID or your date of birth
- The name of the service/supply provider and their National Provider ID (NPI)
- Date(s) of service
- CPT code(s)
- Diagnosis code(s)
- 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
  - Items/services to be reimbursed
- 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, or gift cards. CCA will not reimburse for coupons.

- It would be helpful for you to indicate the service type:
  - Medical/Behavioral Health
  - Dental
  - Equipment/Supplies
  - Delivered Meals
  - Transportation

- You can get a copy of the form on 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

You must submit your claim to us within 365 days of the date you got the service, item, or drug.

Prescription (Part D) Reimbursement

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

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

- You can get a copy of the form on 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 One Care Manual Claims
PO Box 1039
Appleton, WI 54912-1039
Fax: 1-855-668-8550

You must submit your claim to us within 365 days of the date you got the service, item, or drug.

Vision Reimbursement

Routine vision care reimbursement is different from medical services reimbursement. The plan works in partnership with its vision benefit manager, VSP, to provide routine vision reimbursements. In some situations, we may need to get more information from your doctor in order to pay you back.

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

- You don't have to use the 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:
  - Member date of birth
  - First and last name
  - Gender
  - Member address
  - Member last four digits of their Social Security Number

- Date of service
- Lens type
- Provider information (name, address, city and state)
- Itemized receipt including services paid for by code, date of service and method of payment
    - 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. We cannot honor reimbursement requests for items purchased with gift certificates, or gift cards. We will not reimburse for coupons.
- Proof of payment

- You can get a copy of the form on our website (www.ccama.org) or call Member Services and ask for the form.

Go online to submit your request at www.vsp.com or mail your request for payment together with any bills or paid receipts to VSP at this address:

VSP

PO Box 385018

Birmingham, AL 35238-5018

You must submit your claim to us within 365 days of the date you got the service, item, or drug.

Hearing Benefit Reimbursement

Routine hearing care reimbursement is different from medical services reimbursement. The plan works in partnership with its vision benefit manager, NationsHearing, to provide routine hearing reimbursements. In some situations, we may need to get more information from your doctor in order to pay you back.

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 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
- Member ID or your date of birth
- The name of the service/supply provider and their NPI
- Date(s) of service
- CPT code(s)
- Diagnosis code(s)
- 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
  - Items/services to be reimbursed
- 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, or gift cards. CCA will not reimburse for coupons.

- You can get a copy of the form on our website (www.ccama.org) or call Member Services and ask for the form.

Go online to submit your request by email at OONClaims@nationsbenefits.com your request for payment together with your purchase agreement, proof of payment, and audiogram.

You must submit your claim to us within 365 days of the date you got the service, item, or drug.

C. Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your service or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the service or prescription.

- We will let you know if we need more information from you.
- If we decide that the service or drug is covered and you followed all the rules for getting it, we will pay for it. If you have already paid for the service or drug, we will mail you a check for what you paid. If you have not paid for the service or drug yet, we will pay the provider directly.

Chapter 3 the rules for getting your services covered. Chapter 5 explains the rules for getting your prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9, Section 4.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount we pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, refer to Chapter 9, Section E5.

- If you want to make an appeal about getting paid back for a healthcare service, refer to page 202 in Chapter 9, Section E5.
- If you want to make an appeal about getting paid back for a drug, refer to page 211 in Chapter 9, Section F5.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

Table of Contents

A. Your right to get services and information in a way that meets your needs

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about the plan's benefits, your health and treatment options, and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. You can get this document and other printed materials in Spanish or speak with someone about this information in other languages, for free. We can also give you information for free in other formats as requested. Call 866-610-2273 to request information in other languages and formats. The call is free. For purposes of future mailings, we will keep your request for alternative formats and/or special languages on file. You can change your communication preferences with us at any time by calling Member Services. You can reach the accessibility and accommodations officer, who is the ADA Compliance officer, to request a reasonable accommodation at:
    - Commonwealth Care Alliance, Inc.
    - ADA Officer
    - 30 Winter Street
    - Boston, MA 02108
    - Phone: 617-960-0474, ext. 3932 (TTY 711)
    - Email: civilrightscoordinator@commonwealthcare.org

If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, you can call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- My Ombudsman at 1-855-781-9898, Monday through Friday from 9:00 A.M. to 4:00 P.M.
    - Use 7-1-1 to call 1-855-781-9898. This number is for people who are deaf, hard of hearing, or speech disabled.

  - Use Videophone (VP) 339-224-6831. This number is for people who are deaf or hard of hearing.

- MassHealth Customer Service Center at 1-800-841-2900, Monday through Friday, from 8:00 A.M. to 5:00 P.M. (TTY: 1-800-497-4648).
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.
- Debemos asegurarnos de que todos los servicios se le prestan de forma culturalmente competente y accesible. Además, debemos informarle de las prestaciones del plan, de sus opciones de salud y tratamiento y de sus derechos de forma que pueda entenderlos. Debemos informarle sobre sus derechos cada año que esté en nuestro plan.

  - Para obtener información de una manera que pueda entender, llame al Servicio de Atención al Afiliado. Nuestro plan dispone de servicios gratuitos de interpretación para responder a las preguntas en diferentes idiomas.

  - Nuestro plan también puede proporcionarle materiales en otros idiomas además del inglés y en formatos como letra grande, braille o audio. Puede obtener este documento y otros materiales impresos en español o hablar con alguien sobre esta información en otros idiomas, de forma gratuita. También podemos darle información gratuita en otros formatos si lo solicita. Llame al 866-610-2273 para solicitar información en otros idiomas y formatos. La llamada es gratuita. A efectos de futuros envíos, mantendremos archivada su solicitud de formatos alternativos y/o idiomas especiales. Puede cambiar sus preferencias de comunicación con nosotros en cualquier momento llamando al Servicio de Atención al Socio.

    - Commonwealth Care Alliance, Inc.
    - ADA Officer
    - 30 Winter Street
    - Boston, MA 02108
    - Teléfono: 617-960-0474, ext. 3932 (TTY 711)
    - Correo electrónico: civilrightscoordinator@commonwealthcare.org

- Si tiene problemas para obtener información de nuestro plan debido a problemas lingüísticos o a una discapacidad y quiere presentar una queja, puede llamar:

  - Medicare en el 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.

  - My Ombudsman al 1-855-781-9898, de lunes a viernes de 9:00 a 16:00 horas.

    - Utilice el 7-1-1 para llamar al 1-855-781-9898. Este número es para personas sordas, con problemas de audición o con problemas de habla.
    - Utilice el videoteléfono (VP) 339-224-6831. Este número es para personas sordas o con problemas de audición.
  - Centro de Servicio al Cliente de MassHealth al 1-800-841-2900, de lunes a viernes, de 8:00 am a 5:00 pm (TTY: 1-800-497-4648).
  - Oficina de Derechos Civiles al 1-800-368-1019 TTY 1-800-537-7697

B. Our responsibility to treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members for any of the following reasons:

- Age
- Appeals
- Behavior
- Claims experience
- Ethnicity
- Evidence of insurability
- Gender identity
- Genetic information
- Geographic location within the service area
- Heath status
- Medical history
- Mental ability
- Mental or physical disability
- National origin
- Race
- Receipt of healthcare
- Religion
- Sex
- Sexual orientation
- Use of services

You can also refer to Chapter 11, Section B, “Notice about nondiscrimination,” for more information.

You have the right to have your questions and concerns answered completely and courteously.

You have the right to be treated with respect and with consideration for your dignity.

Under the rules of the plan, you have the right to be free from any kind of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation. (In other words, you should be free from being physically controlled or kept alone as a way to force you to do something, to punish you, or to make things easier for others.)

You have the right to make recommendations regarding your rights and responsibilities. This includes making recommendations to the CCA One Care Member Rights and Responsibilities policy.

We cannot deny services to you or punish you for exercising your rights.

- For more information, or if you think that you might have a complaint about discrimination or that you got unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY: 1-800-537-7697). You can also visit www.hhs.gov/ocr for more information.
- You can also call your local Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

If you have a disability and need help getting care or reaching a provider, call 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, please refer to Section D.

C. Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan, these are your rights:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3, Section D.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn which healthcare providers are accepting new patients.
- You have the right to use a women's health specialist without getting a referral. We do not require you to get referrals to go to network providers.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

- You have the right to get emergency services or urgent care without first getting authorization (prior approval (PA)) in an emergency.
- You have the right to get your prescriptions filled without long delays at any of our network pharmacies.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3, Section D.

Chapter 9 tells you what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells you what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. Our responsibility to protect your privacy and personal health information (PHI)

You have the right to have privacy during treatment and to expect confidentiality of all records and communications.

We protect your personal health information (PHI) as required by federal and state laws.

- Your PHI includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have the rights related to your information and to control how your PHI is used. We will give you a written notice that tells about these rights. The notice is called the “Notice of Privacy Practice.” The notice also explains how we protect the privacy of your PHI.

D1. How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

Except for the cases noted below, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies that are checking on our quality of care.
- We must give Medicare and MassHealth your PHI. If Medicare releases your PHI for research or other uses, it will be done according to federal laws. If MassHealth

releases your PHI for research or other uses, it will be done according to federal and state laws.

D2. You have a right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct 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 if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, 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, 2023

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

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

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

Commonwealth Care Alliance, Inc.
Attention: Privacy and Security Officer
30 Winter Street

Boston, MA 02108
Toll Free: 866-457-4953 (TTY 711)

SECTION 1: Companies to Which This Notice Applies

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

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

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

Our Health Plans

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

Our Healthcare Providers

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

SECTION 2: Information We Collect

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

through our services, we may collect Medical Information and other information from you, as further described below.

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

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

SECTION 3: How We Use and Disclose Your Medical Information

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

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

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

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

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

Example: Your healthcare provider may send Our Health Plan a claim for healthcare services furnished to you. The Health Plan may use that information to pay your healthcare provider's

claim and it may disclose the Medical Information to Medicare or Medicaid when the Health Plan seeks payment for the services.

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

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

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

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

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

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

authority to act on behalf of the individual, such as a child's parent or guardian, a person with a healthcare power of attorney, or a disabled individual's court-appointed guardian.

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

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

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

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

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

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

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

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

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

SECTION 4: Other Uses and Disclosures Require Your Prior Authorization

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

If you sign a written authorization, you may later revoke (or cancel) your authorization. If you would like to revoke your authorization, you must do so in writing (send this to us using the

Contact Information at the beginning of this Notice). If you revoke your authorization, we will stop using or disclosing your Medical Information based on the authorization except to the extent we have acted in reliance on the authorization. The following are uses or disclosures of your Medical Information for which we would need your written authorization:

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

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

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

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

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

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

Right to an Accounting of Disclosures: You have the right to receive a list of certain disclosures we make of your Medical Information ("**disclosure accounting**"). The list will not

include disclosures for treatment, payment, and healthcare operations, disclosures made more than six years ago, or certain other disclosures. We will provide one accounting each year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months. You must make a request for disclosure accounting in writing.

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

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

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

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

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

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

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

SECTION 7: State-Specific Requirements

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

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

E. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of CCA One Care, you have the right to get timely information and updates about your plan from us. If you do not speak English, we must give you the information in a language you understand free of charge. You can get this document and other printed materials in Spanish or speak with someone about this information in other languages, for free. Call 866-610-2273 (TTY 711). We can also give you information free of charge in large print, braille, audio, American Sign Language video clips, and other ways.

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

- Our plan, including:
  - what financial information is available;
  - how the plan has been rated by plan members;
  - how many appeals our members have made; **and**
  - how to leave the plan.
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers;
  - what the qualifications are of our network providers and pharmacies; **and**
  - how we pay the providers in our network.
  - a list of providers and pharmacies in the plan's network, in the **Provider and Pharmacy Directory.** For more detailed information about our providers or pharmacies, call Member Services or visit our website at www.ccama.org.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
  - services and drugs covered by the plan;
  - limits to your coverage and drugs; **and**

    rRules you must follow to get covered services and drugs.
- Why a drug or service is not covered and what you can do about it (refer to Chapter 9), including:
  - asking us to put in writing why the drug or service is not covered;

- asking us to change a decision we made; **and**
- asking us to pay for a bill you got.

F. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay them less than they charged us. To learn what to do if a provider tries to charge you for covered services, refer to Chapter 7, Section A.

G. Your right to leave our plan

You have the right to leave the plan. No one can make you stay in our plan if you do not want to. You can contact the MassHealth Customer Service Center at 1-800-841-2900 or TTY: 1-800-497-4648 (for people who are deaf, hard of hearing, or speech disabled) and ask to leave the plan. You can also call 1-800-Medicare to enroll in a Medicare Advantage or prescription drug plan and leave our plan. Please refer to Chapter 10 for more information on leaving our plan.

If you choose to leave our plan, your services will stay in place until the end of that month. For example, if you leave our plan on September 5, you will be covered by our plan until the end of September.

- If you leave our plan, you will still be in the Medicare and MassHealth programs.
- You have the right to get most of your healthcare services through Original Medicare or a Medicare Advantage plan.
- You also have a right to get your MassHealth benefits directly from the MassHealth Medicaid program.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.

H. Your right to make decisions about your healthcare

H1. Your right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other healthcare providers. You also have the right to have access to doctors and other providers who can meet your needs. This includes providers who can meet your healthcare needs, communicate with you, and provide you with services in locations that you can physically access. Your providers must explain your condition and your treatment choices in a way that you can understand. You may also choose to have family member or caregiver involved in your services and treatment discussions. You have the right to:

- **Know your choices.** You have the right to have your medical needs explained to you, and to be told about all the kinds of treatment available to you, regardless of cost or benefit coverage.
- **Know the risks.** You have the right to be told about any risks involved in your services or treatments. You must be told in advance if any of your services or treatments are part of a research experiment. You have the right to refuse experimental treatments.

- **Get a second opinion.** You have the right to use another healthcare provider before you decide on a treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your healthcare provider advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **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, as specified in other Federal regulations on the use of restraints and seclusion.
- **Ask us to cover a service or drug that was denied or that is usually not covered.** This is called a coverage decision. Chapter 9 tells you how to ask the plan for a coverage decision.
- **Change your providers.** You have the right to change your providers.

H2. Your right to say what you want to happen if you are unable to make healthcare decisions for yourself

Sometimes people are unable to make healthcare decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make healthcare decisions for you**; **and**
- **Give your healthcare providers written instructions** about how you want them to handle your healthcare if you become unable to make decisions for yourself.
    - The legal document that you can use to give your directions is called an advance directive. 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.

You do not have to use an advance directive, but you can if you want to. 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.honoringchoicesmass.com). Or, you can get a form from your healthcare provider, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or MassHealth (Medicaid), such as the State Health Insurance Assistance Program (SHIP) called SHINE (Serving the Health Insurance Needs of Everyone), may also have advance directive forms.
- **Fill it out and sign it.** The form is a legal document. You should consider having a lawyer help you fill it out.
- **Give copies to people who need to know about it.** You should give a copy of the form to your healthcare providers. You should also give a copy to the person you name as the one who will make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it 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 to fill out an advance directive.

H3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a healthcare provider or hospital did not follow the instructions in it, you may file a complaint with the 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.

I. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 tells you what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you are being treated unfairly—and it is **not** about discrimination for the reasons listed in Section B of this chapter—or you would like more information about your rights, you can get help by calling:

- Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.
- The State Health Insurance Assistance Program called SHINE (Serving the Health Insurance Needs of Everyone). For details about this organization and how to contact it, refer to Chapter 2, Section E.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.
- MassHealth at 1-800-841-2900, Monday through Friday, from 8:00 A.M. to 5:00 P.M. (TTY: 1-800-497-4648).
- My Ombudsman at 1-855-781-9898 (Toll Free), Monday through Friday from 9:00 A.M. to 4:00 P.M.
    - Use 7-1-1 to call 1-855-781-9898. This number is for people who are deaf, hard of hearing, or speech disabled.
    - Use Videophone (VP) 339-224-6831. This number is for people who are deaf or hard of hearing.
    - Email My Ombudsman at info@myombudsman.org.

My Ombudsman is an independent program that can help you address concerns or conflicts with your enrollment in One Care or your access to One Care benefits and services.

I2. Your 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 suggestions with us by calling Member Services 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

J. Your responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, refer to Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get healthcare. Please call Member Services if you have other coverage.
- **Tell your doctor and other healthcare providers** that you are enrolled in our plan. Show your Member ID Card every time you get services or drugs.
- **Help your doctors** and other healthcare providers give you the best care.
  - Choose a primary care provider.
  - Call your primary care provider or Care Partner when you need healthcare or within forty-eight hours of receiving any emergency or out-of-network treatment.
  - Give them the information they need about you and your health that is complete and accurate. Learn as much as you can about your health problems. Follow mutually agreed upon treatment goals and follow plans and instructions for care that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Make sure you ask any questions that you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
  - Understand the role of your primary care provider, your Care Partner, and your care team in providing your care and arranging other healthcare services that you may need.
  - Follow the Individualized Care Plan (ICP) you and your care team agree to.

  - Understand your benefits and what is covered and know what is not covered.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, other providers' offices, and in your home when your providers are visiting you.

- **Pay what you owe.** As a plan member, you are responsible for these payments:

  - If you get any services or drugs that are not covered by our plan, you must pay the full cost.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.

  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get CCA One Care. Chapter 1, Section D tells you about our service area.

  - We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area.

  - You can also call MassHealth Customer Service Center to transfer to another One Care plan in your new area.

  - Also, be sure to let Medicare and MassHealth know your new address when you move. Refer to Chapter 2, Sections F and G, for phone numbers for Medicare and MassHealth.

  - **If you move but stay in our service area, we still need to know.** We need to keep your record up to date and know how to contact you.

- **Tell us if your personal information changes.** It is important to tell us right away if you have a change in personal information such as telephone, marriage, additions to the family, eligibility, or other health insurance coverage.

- Call Member Services at 866-610-2273 (TTY 711) for help if you have questions or concerns.

J1. Estate recovery

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 www.mass.gov/estaterecovery.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or a complaint about your plan or your care.
- You need a service or drug that your plan said it will not pay for.
- You disagree with a decision that your plan made about your care, including reducing services.
- You think your plan should provide or arrange a service faster.
- You think that you were asked to leave the hospital too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find information about what to do for your problem or concern.

If you are facing a problem with your services

You should get the medical services, behavioral health services, drugs, and long-term services and supports (LTSS) that are necessary for your care as a part of your Individualized Care Plan (ICP). **If you are having a problem with your care, you can call My Ombudsman at 1-855-781-9898 (or by using MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831).** This chapter explains the options you have for different problems and complaints, but you can also call My Ombudsman to help you with your problem. For additional resources to address your concerns and ways to contact them, refer to Chapter 2, Section I for more information about My Ombudsman.

Table of Contents

A. What to do if you have a problem

This chapter tells you what to do if you have a problem with CCA One Care or with your services. Medicare and MassHealth approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed. This is a summary of your rights.

A1. About the legal terms

There are legal terms for some of the rules and deadlines in this chapter. Some of these terms may be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Understanding and knowing the meaning of the proper legal terms can help you communicate more clearly, so we provide those too.

B. Where to call for help

B1. Where to get more information and help

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

You can get help from My Ombudsman

My Ombudsman is an independent program that can help you if you have questions, concerns, or problems related to One Care. You can contact My Ombudsman to get information or help to resolve any issue or problem with your One Care plan. My Ombudsman’s services are free. Information about My Ombudsman may also be found in Chapter 2, Section I. My Ombudsman’s staff:

- Can answer your questions or refer you to the right place to find what you need.
- Can help you address a problem or concern with One Care or your One Care plan, CCA One Care. My Ombudsman’s staff will listen, investigate the issue, and discuss options with you to help solve the problem.

- Help with appeals. An appeal is a formal way of asking your One Care plan, MassHealth, or Medicare to review a decision about your services. My Ombudsman's staff can talk with you about how to make an appeal and what to expect during the appeal process.

You can call, email, write, or visit My Ombudsman at its office.

- Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831.
- Email info@myombudsman.org
- Write to or visit My Ombudsman's office at 25 Kingston Street, 4th floor, Boston, MA 02111.
    - Please refer to the My Ombudsman website or contact them directly for updated information about location, appointments, and walk-in hours.
- Visit My Ombudsman online at www.myombudsman.org

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). In Massachusetts, this program is called SHINE (Serving the Health Insurance Needs of Everyone). SHINE counselors can answer your questions and help you understand what to do to take care of your problem. SHINE is not connected with us or with any insurance company or health plan. SHINE has trained counselors in Massachusetts, and services are free. The SHINE phone number is 1-800-243-4636 and their website is https://shinema.org/. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370 (Massachusetts only).

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY (for people who have difficulty speaking or hearing): 1-877-486-2048. The call is free.
- Visit the Medicare website at www.medicare.gov.

Getting help from MassHealth

You can call MassHealth Customer Service directly for help with problems. Call 1-800-841-2900. TTY (for people who are deaf, hard of hearing, or speech disabled): 711.

C. Which sections to read in this chapter to help with your problem

C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter to read for your problem or complaint.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care, behavioral healthcare, long-term services and supports, or prescription drugs are covered and paid for by our plan.)	
Yes. My problem is about benefits or coverage. Refer to **Section D: "Coverage decisions and appeals"** on page 184.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section J: "How to make a complaint"** on page 230.

D. Coverage decisions and Appeals

D1. Overview

When you ask for information on coverage decisions and making Appeals, it means that you're dealing with problems related to your benefits and coverage. This also includes problems with payment.

What is a coverage decision?

A coverage decision is a decision we make about what services, items, and drugs we will cover for you. For example, your plan network provider makes a (favorable) coverage decision for you whenever you receive medical care from them or if your network provider refers you to a medical specialist.

If you or your provider are not sure if a service, item, or drug is covered by our plan, either of you can ask for a coverage decision before the provider gives the service, item, or drug. In other words, if you want to know if we will cover a service, item, or drug before you receive it, you can ask us to make a coverage decision for you.

What is an appeal?

An appeal is a formal way of asking us to review our coverage decision. For example, we might decide that a service, item, or drug that you want is not covered or is not medically necessary for you. If you disagree with our decision, you can appeal this decision. If you want, your provider can file an Appeal for you.

D2. Getting help

Who can I call for help with asking for coverage decisions or making an Appeal?

There are a few different ways that you can ask for help.

- Call **Member Services** at 866-610-2273.
- Speak to your Care Partner.
- Call, email, write, or visit **My Ombudsman**.
    - Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831.
    - Email info@myombudsman.org.
    - Visit My Ombudsman online at www.myombudsman.org.
    - Write to or visit the My Ombudsman office at 25 Kingston Street, 4th floor, Boston, MA 02111.

      Please refer to the My Ombudsman website or contact them directly for updated information about location, appointments, and walk-in hours.
- Call the **State Health Insurance Assistance Program (SHIP)** for free help. In Massachusetts, the SHIP is called SHINE. SHINE is an independent organization. It is not connected with this plan. The SHINE phone number is 1-800-243-4636. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370 (Massachusetts only).
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf, and act as your representative.
- Talk to a **friend or family member** and ask them to act for you. 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 beside your provider to be your representative, call Member Services and ask for the “Appointment of

Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.ccama.org.

- The form gives the person permission to act for you. You must give us a copy of the signed form. Your designated representative will have the same rights as you do in asking for a coverage decision or making an Appeal. You do not need to provide this form for your doctor or other healthcare provider to act as your representative.

- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Our plan will not pay for you to have a lawyer. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
  - However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an Appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and Appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- Section E on page 189 gives you information if you have problems about services, items, and some drugs (**not** Part D drugs). For example, use this section if:
  - You are not getting a service, item, or drug you want and you believe our plan covers this care.
  - We did not approve services, items, or drugs that your healthcare provider wants to give you, and you believe this care should be covered and is medically necessary.
    - **NOTE:** Use Section E only if these are drugs **not** covered by Part D. Drugs in the **List of Covered Drugs***,* also known as the Drug List, with a DP are **not** covered by Part D. Refer to Section F on page 204 for Part D drug Appeals.
  - You got and paid for services, items, or drugs you thought were covered, and you want to ask us to pay you back.

        - **NOTE:** For more information about the rules to follow for our plan to pay for your healthcare, refer to Chapter 3, Section B.

    - We notified you that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.

        - **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 a separate section of this chapter because special rules apply to these types of services. Refer to Sections G and H on pages 216 and 223.

    - Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, 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, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- Section F on page 204 gives you information about Part D drugs. For example, use this section if:

    - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.

    - You want to ask us to waive limits on the amount of the drug you can get.

    - You want to ask us to cover a drug that requires prior authorization (PA) or approval.

    - We did not approve your request or exception, and you or your doctor or other prescriber thinks that we should have.

    - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)

- Section G on page 215 gives you information on how to ask us to cover a longer inpatient hospital stay. Use this section if you are in the hospital and think that the healthcare provider asked you to leave the hospital too soon.

- Section H on page 223 gives you information if you think your home healthcare, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at 866-610-2273 (TTY 711).

If you need other help or information, please call My Ombudsman at 1-855-781-9898 (or use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831) or email info@myombudsman.org.

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical care, behavioral healthcare, and long-term-services and supports (LTSS). You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the Drug List with a DP are **not** covered by Part D. Use Section F for Part D drug Appeals.

This section tells what you can do if:

1. You think we cover a medical, behavioral health, or LTSS service you need but are not getting.

What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 184 for information on asking for a coverage decision.

2. We did not approve care that your doctor or provider wants to give you, and you think we should have. Or, we reduced or stopped your coverage for a certain service, and you disagree with our decision.

What you can do: You can appeal our decision. Refer to Section E3 on page 186 for information on making an appeal.

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, special rules apply. Read Sections G or H on pages 208 and 220 to find out more.

3. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

What you can do: You can ask us to pay you back. Refer to Section E5 on page 195 for information on asking us for payment.

E2. Asking for a coverage decision

To ask for a coverage decision, call, write, or fax us, or ask your representative or provider to ask us for a decision. You may also speak with your Care Partner or another member of your care team.

- You can call us at: 866-610-2273 (TTY 711)
- You can fax us at: 857-453-4517
- You can write to us at: Commonwealth Care Alliance, Inc.
  Member Services Department
  30 Winter Street
  Boston, MA 02108

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you ask unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we will take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and if that happens, we will send you a letter telling you that we will take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

> **The legal term** for "fast coverage decision" is **"expedited determination."**

To ask for a fast coverage decision:

- Start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week. Or fax us at 857-453-4517. For details on how to contact us, go to Chapter 2, Section A.

- You can also have your provider or your representative call us.

What are the rules for asking for a fast coverage decision?

You can get a fast coverage decision only if you meet the following two requirements:

1. You are asking about care you have not yet received. (You cannot ask for a fast coverage decision if your request is about care you already got.)
2. The usual 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.

    - If your provider says that you need a fast coverage decision, we will automatically give you one.
    - If you ask for a fast coverage decision without your provider's support, we will decide if you get a fast coverage decision.
        - If we decide not to give you a fast coverage decision, we will use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead. We will also send you a letter.
        - This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give you one.
        - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J on page 230.

How will I find out the plan's answer about my coverage decision?

The plan will send you a letter telling you whether or not we approved coverage.

What if the coverage decision is No?

If the answer is **No**, the letter we send you will tell you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an Appeal. Making an Appeal means asking us to review our decision to deny coverage.
- If you decide to appeal the coverage decision, it means you are going on to Level 1 of the appeals process (read the next section for more information).

E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An Appeal is a formal way of asking us to review a coverage decision, or any Adverse Action that we took. If you or your healthcare provider disagree with our decision, you can appeal. In all cases, you must start your Appeal at Level 1 with our plan.

If you need help during the appeals process, you can call My Ombudsman at 1-855-781-9898 (or use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831). My Ombudsman is not connected with us or with any insurance company or health plan.

What is an Adverse Action?

An Adverse Action is an action, or lack of action, by our plan that you can appeal. This includes:

- We denied or approved a limited service or item your provider requested;
- We reduced, suspended, or ended coverage that we had already approved;
- We did not pay for a service or item that you think is covered by our plan;
- We did not resolve your authorization request within the required time frames;
- You could not get a covered service or item from a provider in our network within a reasonable amount of time; **or**
- We did not act within the time frames for reviewing a coverage decision and giving you a decision.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review our coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision.

You can ask us for a "standard Appeal" or a "fast Appeal." When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

At a glance: How to make a Level 1 Appeal

You, your provider, or your representative may put your request in writing and mail or fax it to us. You may also ask for an Appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your Appeal is processing.
- Keep reading this section to learn about what deadline applies to your Appeal.

How do I make a Level 1 Appeal?

- To start your Appeal, you, your provider, or your representative must contact us. You can call us at 866-610-2273. For additional details on how to reach us for Appeals, refer to Chapter 2, Section A.
- If you are asking for a standard Appeal or a fast Appeal, you can make your Appeal in writing or call us.
  - You can submit a request to the following address:

    Commonwealth Care Alliance, Inc.
    Appeals & Grievances Department
    30 Winter Street
    Boston, MA 02108

  - Or, you can call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

The legal term for "fast Appeal" is **"expedited reconsideration."**

Can someone else make the Level 1 Appeal for me?

Yes. Your provider can request the Appeal on your behalf. If you want someone besides your provider to make the Appeal for you, you must first complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at www.ccama.org.

If the Appeal comes from someone besides you or your provider, we must get the completed Appointment of Representative form before we can review your request.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

How much time do I have to make a Level 1 Appeal?

You must ask for an Appeal **within 60 calendar days** from the date on the letter we sent you to tell you our coverage decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your Appeal. Examples of a good reason include: you had a serious illness, or we gave you the wrong information about the deadline for requesting an Appeal. You should explain the reason your Appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your Appeal is processing. Read "Will my benefits continue during a Level 1 Appeal" on page 197 for more information.

Can I get a copy of my case file?

Yes. You can ask to look at the medical records and other documents used to make our decision at any time. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision. Ask us for this information by calling Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

Can my provider give you more information to support my Level 1 Appeal?

Yes. Both you and your provider may give us more information to support your Appeal.

How will we make the Level 1 Appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then we check to find out if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your provider for it.

When and how will I hear about a standard Level 1 Appeal decision?

We must give you our answer within 30 calendar days after we get your Appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). This rule applies if you sent your Appeal before getting services or items. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide we need to take extra days to make a decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your Appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 230.
- If we do not give you an answer to your Appeal within 30 calendar days (or within 7 calendar days after we get your Appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), your case will automatically go to Level 2 of the appeals process if the service or item is usually covered by Medicare or both Medicare and MassHealth. You will be notified if this happens. If your problem is about coverage of a MassHealth service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 197.

We will send you a letter giving you our answer about your Appeal.

If our answer is Yes to part or all of what you asked for, we must approve or give that coverage. We must approve or give coverage for a Medicare Part B prescription drug within 7 calendar days after we get your Appeal.

If our answer is No to part or all of what you asked for, we will send you a letter. If the service or item is traditionally paid for by Medicare or both Medicare and MassHealth, the letter we send will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If the service or item is traditionally paid for by MassHealth, the letter will also tell you that you can ask for a Level 2 Appeal from the MassHealth Board of Hearings. For more information about the Level 2 Appeal process, refer to Section E4 on page 197.

When and how will I hear about a fast Level 1 Appeal decision?

If you get a fast Appeal, we will give you our answer within 72 hours after we get your Appeal. We will give you our answer sooner than 72 hours if your health requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 230.

- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), your case will automatically go to Level 2 of the appeals process if the service or item is usually covered by Medicare or both Medicare and MassHealth. You will be notified if this happens. If your problem is about coverage of a MassHealth service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 197.

We will send you a letter giving you our answer about your Appeal.

If our answer is Yes to part or all of what you asked for, we must approve or give that coverage.

If our answer is No to part or all of what you asked for, we will send you a letter. If the service or item is traditionally paid for by Medicare or Medicare and MassHealth, the letter we send will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If the service or item is traditionally paid for by MassHealth, the letter will also tell you that you can ask for a Level 2 Appeal from the MassHealth Board of Hearings. For more information about the Level 2 Appeal process, refer to Section E4 on page 197.

Will my benefits continue during a Level 1 Appeal?

If you are appealing to get a new service from our plan, then you would not get that service unless your Appeal is finished and our decision is that the service is covered.

If you are appealing because we decided to change or stop a service that was previously approved, you have the right to keep getting that service from our plan during your Appeal. Before we change or stop a service, we will send you a notice. If you disagree with the action described in the notice, you can file a Level 1 Appeal and ask that we continue your benefits for the service. You must **make the request on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice of action; **or**

- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service while your Appeal is processing. If your benefits are continued and the final result of the Appeal upholds our action, we may recover the cost of the services provided to you while the Appeal was pending.

- If you want to continue your benefits while your Appeal is pending:
  - You can call Member Services at 866-610-2273 (TTY 711); **or**
  - You can get additional help by calling My Ombudsman at 1-855-781-9898 (or use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831) or email info@myombudsman.org.

E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if your Appeal is for a service or item covered by Medicare, both Medicare and MassHealth, or just by MassHealth. This letter will tell you how to make a Level 2 Appeal and will describe the Level 2 appeals process.

What is a Level 2 Appeal?

A Level 2 Appeal is the second Appeal, which is done by an independent organization that is not connected to the plan. Medicare's Level 2 Appeal organization is called the Independent Review Entity (IRE). The IRE is an independent organization hired by Medicare. It is not a government agency. Medicare oversees its work. MassHealth's Level 2 Appeal organization is called the MassHealth Board of Hearings.

You have Appeal rights with both Medicare and MassHealth. The services and items that you can get with our plan are covered by Medicare only, MassHealth only, or both Medicare and MassHealth.

- When a service or item is covered only by Medicare, you will **automatically** get a Medicare Level 2 Appeal from the IRE if the answer to your Level 1 Appeal was No.
- When a service or item is covered only by MassHealth, then **you must ask for** a Level 2 Appeal from the MassHealth Board of Hearings if the answer to your Level 1 Appeal was **No** and you want to appeal again.
- When a service or item is covered by **both** Medicare and MassHealth, you will **automatically** get a Medicare Level 2 Appeal from the IRE if the answer to your

Level 1 Appeal was **No**. **You can also ask for** a Level 2 Appeal from the MassHealth Board of Hearings.

To make sure that Level 2 Appeals are fair and do not take too long, there are some rules, procedures, and deadlines that must be followed by us and by you.

What are the rules for asking for a Level 2 Appeal from the MassHealth Board of Hearings?

You must ask for a Level 2 Appeal from the MassHealth Board of Hearings **within 120 calendar days** from the date of our letter telling you about our Level 1 Appeal decision. The letter will tell you how to ask for a Level 2 Appeal from the Board of Hearings:

- The MassHealth Board of Hearings is not connected with CCA One Care.
- You may ask for a copy of your file.

To ask for a Level 2 Appeal from the Board of Hearings, you must complete a Fair Hearing Request Form. You can get the form:

- Online at: www.mass.gov/files/documents/2016/07/rq/fair-hearing.pdf
- By calling MassHealth Customer Service at 1-800-841-2900, TTY 1-800-497-4648 (for people who are deaf, hard of hearing, or speech disabled).

The Board of Hearings must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your Appeal. If the Board of Hearings needs to gather more information that may help you, it can take up to 14 more calendar days.

If you had a “fast Appeal” at Level 1, you will automatically have a fast Appeal at Level 2. The Board of Hearings must give you an answer within 72 hours of when it gets your Appeal. If the Board of Hearings needs to gather more information, it can take up to 14 more calendar days.

What are the rules for getting an Appeal from the Medicare Independent Review Entity?

If we say **No** to part or all of your Appeal at Level 1 and the service or item is traditionally covered by Medicare or both Medicare and MassHealth, you will **automatically** get a Level 2 Appeal from the Independent Review Entity (IRE). The IRE will carefully review the Level 1 decision and decide whether it should be changed.

- We will automatically send any denials (in whole or in part) to the IRE. You will be notified if this happens. You do not need to request the Level 2 Appeal for services and items covered by Medicare.
- The IRE is hired by Medicare and is not connected with this plan.

- You may ask for a copy of your file by calling Member Services at 866-610-2273 (TTY 711).

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your Appeal (or within 7 calendar days of when it gets your Appeal for a Medicare Part B prescription drug). This rule applies if you sent your Appeal before getting medical services or items.

- If the IRE needs to gather more information that may help you, it can take up to 14 more calendar days. If the IRE decides to take extra days to make a decision, they will tell you by letter. The IRE can't take extra time to make a decision if your Appeal is for a Medicare Part B prescription drug.

If you had a "fast Appeal" at Level 1, you will automatically have a fast Appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your Appeal.

- If the IRE needs to gather more information that may help you, it can take up to 14 more calendar days. If the IRE decides to take extra days to make a decision, they will tell you by letter. The IRE can't take extra time to make a decision if your Appeal is for a Medicare Part B prescription drug.

Will my benefits continue during the Level 2 Appeal?

If your problem is about a service **covered by Medicare only**, your benefits for that service will **not** continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service **covered by MassHealth or both Medicare and MassHealth**, your benefits for that service will continue during the Level 2 appeals process if:

- You are appealing because we decided to reduce or stop a service you were already getting, **AND**
- You ask for a Level 2 Appeal from the MassHealth Board of Hearings.

To get a service while you are appealing, you must:

- Ask for the MassHealth Board of Hearings to review your Appeal within 10 days of getting our letter about the Level 1 Appeal decision.
- Tell the MassHealth Board of Hearings that you want our plan to keep giving you the service while you are appealing.

If you continue to receive services during the Board of Hearings Appeal process and the decision isn't in your favor, you may have to pay for the cost of those services.

If you do not ask for the MassHealth Board of Hearings to review your Appeal, you will not get the service during your Appeal.

If you are appealing to get a new service, you will not get that service while you are appealing, even if you ask for an Appeal by the MassHealth Board of Hearings.

How will I find out about the decision?

If your Level 2 Appeal went to the MassHealth Board of Hearings, the Board of Hearings will send you a letter explaining its decision.

- If the Board of Hearings says **Yes** to part or all of what you asked for, we must approve the service or item for you within 72 hours.
- If the Board of Hearings says **No** to part or all of what you asked for, it means they agree with the Level 1 Appeal decision. This is called "upholding the decision." It is also called "turning down your Appeal."

If your Appeal went to the Independent Review Entity (IRE), the IRE will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if I appealed to both the Board of Hearings and the Independent Review Entity and they have different decisions?

If either the Board of Hearings or the Independent Review Entity decide **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your Appeal.

If the decision is No for all or part of what I asked for, can I make another Appeal?

- If your Level 2 Appeal went to the MassHealth Board of Hearings, you can appeal further with the Commonwealth of Massachusetts Superior Court.
- If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.
- If your Level 2 Appeal went to the MassHealth Board of Hearings **and** the IRE, both additional appeal options are available to you.

Refer to Section I on page 221 for more information on additional levels of appeal.

E5. Payment problems

With One Care, there are rules for getting services and items. One of the rules is that the service or item must be covered by our plan. Another rule is that you must get the service or item from one of the providers in our network. Refer to Chapter 3, Section B to read all the rules. If you follow all the rules, then we will pay for your services and items.

If you are not sure if we will pay for a service or item you want to get or a provider you want to use, **ask your Care Partner or Member Services before you get the service**. Your CarePartner or Member Services will tell you if the plan will pay, or if you need to ask us for a coverage decision.

If you choose to get a service or item that may not be covered by our plan, or if you get a service or item from a provider that does not work with our plan, then we will not automatically pay for the service or item. In that case, you may have to pay for the service or item yourself. If that happens and you want to ask us to pay you back, start by reading Chapter 7: “Asking us to pay a bill you have gotten for covered services or drugs.” Chapter 7 describes the situations in which you may need to ask us to pay you back or to pay a bill you got from a provider. It also tells you how to send us the paperwork that asks us for payment.

What if I followed the rules for getting services and items, but I got a bill from a provider?

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for 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.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will decide if the service or item you paid for is a covered service or item, and we will check to find out if you followed all the rules for using your coverage.

- If the service or item you paid for is covered, and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request.
    - Or, if you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying "yes" to your request for a coverage decision.
- If the service or item is not covered, or you did **not** follow all the rules, we will send you a letter telling you that we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an Appeal**. Follow the appeals process described in Section E3 on page 186. When you follow these instructions, please note:

- If you make an Appeal to be paid back, we must give you our answer within 60 calendar days after we get your Appeal.
- If you are asking us to pay you back for a service or item that you already got and paid for yourself, you cannot ask for a fast Appeal.

If we answer **No** to your Appeal and the service or item is covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your Appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your Appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your Appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item

you want meets a certain minimum amount. Refer to Section I on page 221 for more information on additional levels of Appeal.

If we answer **No** to your Appeal and the service or item is covered by MassHealth, you cannot appeal to the MassHealth Board of Hearings for Appeals about payment.

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that MassHealth may cover. **This section applies only to Part D drug Appeals.**

The Drug List, includes some drugs with a DP. These drugs are not Part D drugs. Appeals or coverage decisions about drugs with DP symbol follow the process in **Section E** on page 183.

Can I ask for a coverage decision or make an Appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception, such as:
    - Asking us to cover a Part D drug that is not on the plan's Drug List; **or**
    - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get).
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> **The legal term** for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an Appeal.

Use the chart below to help you decide which section has information for your situation.

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an Appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 199. Also refer to Sections F3 and F4 on pages 200 and 201.	Skip ahead to **Section F4** on page 201.	Skip ahead to **Section F4** on page 201.	Skip ahead to **Section F5** on page 204.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an exception.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make.

1. Covering a Part D drug that is not on our Drug List.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5, Section C).

- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization” (PA).) We must provide the medical necessity criteria to get plan approval for a drug if you, your provider, or MassHealth asks us for it.
  - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - Having quantity limits. For some drugs, we limit the amount of the drug you can have.

> **The legal term** for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

F3. Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this 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 are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar 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 for an exception, you can ask for a review of our decision by making an Appeal. Section F5 on page 211 tells you how to make an Appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 866-610-2273 (TTY 711). Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D on page 158 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes the times when you may need to ask for reimbursement. It also tells you how to send us the paperwork asking us to pay you back for our share of the cost of a drug that you have paid for.

At a glance*:* How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for in 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
- Your doctor or other prescriber can fax or mail the statement to us. Your doctor or other prescriber can also tell us on the phone, and then fax or mail a statement.

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

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

> **The legal term** for "fast coverage decision" is **"expedited coverage determination."**

You can get a fast coverage decision **only if you are asking for a drug you have not yet received.** (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function**.

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 222.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.

- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said no. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.

- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.

- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.

- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.

- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.

- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

- To start your Appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard Appeal, you can make your Appeal by sending a request in writing. **You may also ask for an Appeal by calling us at 866-610-2273 (TTY 711)**.
- If you want a fast Appeal, you may make your Appeal in writing or you may call us.
- Make your Appeal request **within 60 calendar days** from the date on the notice that we sent to you with our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your Appeal. Examples of a good reason include: you had a serious illness; or we gave you the wrong information about the deadline for requesting an Appeal.

At a glance*:* How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an Appeal by calling us at 866-610-2273 (TTY 711).

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have the right to ask us for a copy of the information about your Appeal. To ask for a copy, call Member Services at 866-610-2273 (TTY 711).

The legal term for an Appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

If you wish, you and your doctor or other prescriber may give us additional information to support your Appeal.

If your health requires it, ask for a "fast Appeal"

- If you are appealing a decision our plan 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 F4 on page 208.

> **The legal term** for "fast Appeal" is **"expedited redetermination."**

Our plan will review your Appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to find out 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. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast Appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your Appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request on to Level 2 of the Appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your Appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard Appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your Appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast Appeal."
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request on to Level 2 of the Appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:

- If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your Appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your Appeal request.

- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells you how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your Appeal, you can choose whether to accept this decision or make another Appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

At a glance*:* How to make a Level 2 Appeal

If you want the Independent Review Organization (IRE) to review your case, your Appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you want the IRE to review your case, your Appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an Appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at 866-610-2273 (TTY 711).
- You have a right to give the IRE other information to support your Appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your Appeal. The organization will send you a letter explaining its decision.

The legal term for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast Appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast Appeal."
- If the IRE agrees to give you a fast Appeal, it must answer your Level 2 Appeal within 72 hours after getting your Appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must approve or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard Appeal" at Level 2

- If you have a standard Appeal at Level 2, the Independent Review Entity (IRE) must answer your Level 2 Appeal within 7 calendar days after it gets your Appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must approve or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your Appeal."

If you want to go to Level 3 of the Appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 Appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the Appeal process.

G. Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor, your Care Partner, and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your “discharge date.”
- Your provider or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

G1. Your Medicare rights if you are admitted to the hospital

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights.” If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at 866-610-2273 (TTY 711). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048.

Read this notice carefully and ask questions if you don’t understand. The “Important Message” tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does not mean you agree to the discharge date that may have been told to you by your healthcare provider or hospital staff.

Keep your copy of the signed notice so you will have the information if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 866-610-2273 (TTY 711). You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. The call is free.
- You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an Appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you. In Massachusetts, the Quality Improvement Organization is called KEPRO.

To make an Appeal to change your discharge date call KEPRO at: 1-888-319-8452 (TTY 711).

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. “An Important Message from Medicare about Your Rights” contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your Appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, 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 get after your planned discharge date.

At a glance*:* How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for Massachusetts at 1-888-319-8452 and ask for a fast review.

Call before you leave the hospital and before your planned discharge date.

If you miss the deadline for contacting the Quality Improvement Organization about your Appeal, you can make your Appeal directly to our plan instead. For details, refer to Section G4 on page 212.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 866-610-2273. You can also call the State Health Insurance Assistance Program (SHIP), which is called SHINE in Massachusetts. The SHINE phone number is 1-800-243-4636. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370 (Massachusetts only). Or, you can 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.

What is a Quality Improvement Organization?

It is a group of doctors and other healthcare professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> **The legal term** for "fast review" is **"immediate review."**

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your provider, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your Appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your healthcare provider, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the "Detailed Notice of Discharge." You can get a sample by calling Member Services at 866-610-2273 (TTY 711). 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. Or you can refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your Appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your Appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your Appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar 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 stayed in the hospital after the date that your coverage for the care ended.

In Massachusetts, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: **1-888-319-8452**.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your Appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance*:* How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for Massachusetts at 1-888-319-8452 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first Appeal decision. 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.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

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.

G4. What happens if you miss an Appeal deadline

If you miss an Appeal deadline, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an Appeal to us, asking for a “fast review.” A fast review is an Appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to find out if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a fast review.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- If we say No to your fast review, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on 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 got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast Appeal, we will send your Appeal to the Independent Review Entity. When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for "fast review" or "fast Appeal" is **"expedited Appeal."**

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 220 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews our decision when we said **No** to your fast review. This organization decides whether the decision we made should be changed.

- The IRE does a fast review of your Appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your Appeal of your hospital discharge.
- If the IRE says **Yes** to your Appeal, then we must pay you back for our share of the costs of hospital care that you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your Appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

NOTE: You can also ask for a Level 2 Appeal from the MassHealth Board of Hearings. Section E4 on page 191 tells you how to appeal to the Board of Hearings.

H. What to do if you think your home healthcare, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home healthcare services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the healthcare provider says you need it.

- When we decide to stop covering any of these, we must tell you before your services end. 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.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time for you to stop getting the care.

When your coverage ends, we will stop paying.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an Appeal.

Before you start your Appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 230 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please contact:
  - Member Services at 866-610-2273 (TTY 711)
  - The State Health Insurance Assistance Program (SHIP), which is called SHINE in Massachusetts. The SHINE phone number is 1-800-243-4636. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370 (Massachusetts only), **or**
  - 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.

During a Level 1 Appeal, a Quality Improvement Organization will review your Appeal and decide whether to change the decision we made. In Massachusetts, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-319-8452. Information about appealing to the Quality Improvement Organization is also in the "Notice of Medicare Non-Coverage." This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for Massachusetts at 1-888-319-8452 and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other healthcare professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your Appeal, you can make your Appeal directly to us instead. For details about this other way to make your Appeal, refer to Section H4 on page 218.

The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at 866-610-2273 (TTY 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users—people who have difficulty hearing or speaking—should call 1-877-486-2048.) Or you can refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an Appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your healthcare provider, and review information that our plan has given to them.
- **Within one full day after the reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> **The legal term** for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."**

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 they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your Appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home healthcare, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you may have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the Appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home healthcare, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Massachusetts, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-319-8452. Ask for the Level 2 review **within 60 calendar 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.

At a glance*:* How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for Massachusetts at 1-888-319-8452 and ask for another review.

Make the call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your Appeal.
- The Quality Improvement Organization will make its decision within 14 days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got 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.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to 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 a judge.

H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an Appeal to us, asking for a "fast review." A fast review is an Appeal that uses the fast deadlines instead of the standard deadlines.

At a glance*:* How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a fast review.

We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your home healthcare, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to find out if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a fast review.
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast Appeal, we will send your Appeal to the Independent Review Entity. When we do this, it means that your case is automatically going to Level 2 of the Appeals process.

> **The legal term** for "fast review" or "fast Appeal" is **"expedited Appeal."**

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this

deadline or other deadlines, you can make a complaint. Section J on page 230 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your fast review. This organization decides whether the decision we made should be changed.

At a glance*:* How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your Appeal to the Independent Review Entity.

- The IRE does a fast review of your Appeal. The reviewers will usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your Appeal.
- **If the IRE says Yes** to your Appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your Appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

NOTE: You can also ask for a Level 2 Appeal from the MassHealth Board of Hearings. Section E4 on page 197 tells you how to appeal to the Board of Hearings.

I. Taking your Appeal beyond Level 2

I1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of Appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask the ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can use the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your Appeal.

If you need assistance at any stage of the appeals process, you can contact My Ombudsman at 1-855-781-9898 (interpreters are available for non-English speakers). People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831. You can also email My Ombudsman at info@myombudsman.org.

I2. Next steps for MassHealth services and items

You also have more Appeal rights if you made a Level 1 Appeal and a Level 2 Appeal for MassHealth services and items, and both your Appeals have been turned down. You can ask for a review of your Appeal by a judge.

If you need assistance at any stage of the appeals process, you can contact My Ombudsman at 1-855-781-9898 (interpreters are available for non-English speakers). People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831. You can also email My Ombudsman at info@myombudsman.org.

J. How to make a complaint

J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A healthcare provider or staff was rude or disrespectful to you.
- CCA One Care staff treated you poorly.
- You think you are being pushed out of the plan.

At a glance*:* How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 233.

Complaints about accessibility

- The healthcare services and facilities in a doctor or provider's office are not accessible to you.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about mental health parity

- Mental health services are not available in the same way that physical health services are available. For more information, please refer to Section J4 on page 226.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital, or provider's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.
- You have requested communications in an alternative format (such as Large Print, Braille, recording, etc.) and we do not honor your request.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your Appeal.
- You believe that, after getting a coverage or Appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

> **The legal term** for a "complaint" is a **"grievance."**
>
> **The legal term** for "making a complaint" is **"filing a grievance."**

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. **If you need help making an internal and/or external complaint, you can call My Ombudsman at 1-855-781-9898 (or use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831).**

J2. Internal complaints

To make an internal complaint, call Member Services at 866-610-2273 (TTY 711). You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part

D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also make your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- **Here's how it works:**
  - Member Services will log the complaint in the member database and track any subsequent dialogue pertinent to the complaint within the same log. We will provide you with a timely acknowledgement of receipt of your complaint.
  - If possible, Member Services will try and resolve the complaint over the phone.
  - You or an authorized representative may participate in the discussion and offer suggestions or ideas toward resolving the problem or issue.
  - If the complaint cannot be resolved over the phone, then a more formal process will take place. Responses to a complaint will be based on what is in the member's best interest according to the plan's policy and procedure.
  - The investigation will be completed as quickly as possible. Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we need more time, we will call you and send you notification in writing.
  - You or your authorized representative will receive a phone call (or letter if requested) from our plan with a response to the complaint.
  - If you are concerned about the quality of care that you receive, including care during a hospital stay, you may file a complaint to the plan, and it will be investigated by the plan's Quality Improvement Department. You may also file a complaint to KEPRO, the Quality Improvement Organization for Massachusetts. To find more information about the Quality Improvement Organization in Massachusetts, look in Chapter 2, Section H of this booklet.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints 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. We will tell you in writing why we need more time.
- 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" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We will respond, whether we agree with the complaint or not.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell MassHealth about your complaint

You may file a complaint with MassHealth. You can do this by calling the MassHealth Customer Service Center at 1-800-841-2900, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-800-497-4648.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

Office for Civil Rights – New England Region

U.S. Department of Health and Human Services
Government Center
J.F. Kennedy Federal Building - Room 1875
Boston, MA 02203

Customer Response Center: 800-368-1019; TDD: 800-537-7697
Fax: 202-619-3818
Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act. You can contact My Ombudsman for assistance 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.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices.

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (**without** making the complaint to us).
- If you make a complaint to this organization, we will work with them to resolve your complaint.

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. To learn more about the Quality Improvement Organization, refer to Chapter 2.

In Massachusetts, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is 1-888-319-8452.

J4. Complaints about Mental Health Parity

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

1. Provide the same level of benefits for mental health and substance use problems you may have as for other physical problems you may have;
2. Not have stricter PA requirements and treatment limitations for mental health and substance use services compared to physical health services;
3. Provide you and your provider with the medical necessity criteria we used for PA upon your or your provider’s request; **and**
4. Provide you, within a reasonable timeframe, the reason for any denial of authorization for mental health or substance use disorder services.

If you think that we are not providing parity as explained above, you have the right to file an internal complaint. For more information about internal complaints and how to file them, please refer to Section J2 on page 226.

You may also file a complaint with MassHealth. You can do this by calling the MassHealth Customer Service Center at 1-800-841-2900, Monday through Friday 8:00 a.m. to 5:00 p.m. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-800-497-4648.

Chapter 10: Ending your membership in CCA One Care

Introduction

This chapter tells you when and how you can end your membership in CCA One Care. It also gives you information about options for health coverage if you leave CCA One Care. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook.*

As long as you are still eligible for Medicare and MassHealth, you can leave CCA One Care without losing your Medicare and MassHealth benefits. If you are over age 65 and you decide to leave One Care, you will not be able to enroll in a One Care plan later.

If you think you want to end your membership in our plan, there are a few ways you can get more information about what will happen, and how you can still get Medicare and MassHealth services.

- Call MassHealth Customer Service at 1-800-841-2900, Monday – Friday, 8 A.M. – 5 P.M. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-497-4648.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) may call 1-877-486-2048.
- Contact a SHINE counselor at 1-800-243-4636. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-439-2370.

Table of Contents

A. When you can end your membership in CCA One Care

You can end your membership in CCA One Care plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another One Care plan, or moving to Original Medicare.

Your membership will end on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month (February 1, in this example). If you leave our plan, you can get information about your:

- Medicare options in the table on page 240.
- MassHealth services on page 240.

You can get more information about when you can end your membership by calling:

- MassHealth Customer Service at 1-800-841-2900, Monday – Friday, 8 A.M. – 5 P.M. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-497-4648.
- A SHINE counselor at 1-800-243-4636. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-439-2370.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) may call 1-877-486-2048.

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5, Section G for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, call MassHealth or Medicare and tell them you want to leave CCA One Care.

- Call MassHealth Customer Service at 1-800-841-2900, Monday – Friday, 8 A.M. – 5 P.M. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-497-4648; **OR**
- Send MassHealth an Enrollment Decision Form. You can get the form at www.mass.gov/one-care or by calling 866-610-2273 (TTY 711) if you need us to mail you one; **OR**

- At times when MassHealth Customer Service is closed, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 232.

Your coverage with CCA One Care will end on the last day of the month that we get your request.

C. How to join a different One Care plan

If you want to keep getting your Medicare and MassHealth benefits together from a single plan, you can join a different One Care plan.

To enroll in a different One Care plan:

- Enroll online at: www.mass.gov/one-care
- Call MassHealth Customer Service at 1-800-841-2900, Monday – Friday, 8 A.M. – 5 P.M. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-497-4648.
- Tell them you want to leave CCA One Care and join a different One Care plan. If you are not sure what plan you want to join, they can tell you about the One Care plans in your area; **OR**
- Send MassHealth an Enrollment Decision Form. You can get the form at www.mass.gov/one-care, or by calling 866-610-2273 (TTY 711) if you need us to mail you one.

Your coverage with CCA One Care will end on the last day of the month that we get your request.

D. How to get Medicare and MassHealth services separately

If you do not want to enroll in a different One Care plan after you leave CCA One Care, you will return to getting your Medicare and MassHealth services separately.

D1. Ways to get your MassHealth services

You will get your MassHealth services directly from doctors and other providers by using your MassHealth card. This is called “fee-for-service.” Your MassHealth services include most long-term services and supports and behavioral healthcare.

D2. Ways to get your Medicare services

You will have a choice about how to get your Medicare benefits.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage Plan or a Program of All-inclusive Care for the Elderly (PACE)	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 to enroll in a Medicare health plan or PACE. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users may call 1-800-439-2370. Your coverage with CCA One Care will end on the last day of the month before your new plan’s coverage begins.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	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 to enroll in Original Medicare with a separate Medicare prescription drug plan. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. Your coverage with CCA One Care will end on the last day of the month before your Original Medicare coverage begins.

3. You can change to:	**Here is what to do:**
Original Medicare without a separate Medicare prescription drug plan **NOTE:** 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 tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the SHINE Program at 1-800-243-4636. TTY users should call 1-800-439-2370.	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 to enroll in Original Medicare and opt out of a separate Medicare prescription drug plan. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. Your coverage with CCA One Care will end on the last day of the month before your Original Medicare coverage begins.

E. Other options

Some people who decide not to join a One Care plan may be able to join a different kind of plan to get their Medicare and MassHealth benefits together.

- If you are age 55 or older, you may be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE) (additional criteria apply). PACE helps older adults stay in the community instead of getting nursing facility care.
- If you are age 65 or older when you leave CCA One Care, you may be able to join a Senior Care Options (SCO) plan.

To find out about PACE or SCO plans and whether you can join one, call MassHealth Customer Service at 1-800-841-2900, Monday – Friday, 8 A.M. – 5 P.M. TTY users (people who are deaf, hard of hearing, or speech disabled). Keep getting your Medicare and MassHealth services and drugs through our plan until your membership ends

If you leave CCA One Care, you must keep getting your prescription drugs and healthcare through our plan until the next month starts.

- Use network providers to receive medical care.
- **Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership in CCA One Care ends**, **our plan will cover your hospital stay until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership ends

These are the cases when MassHealth or Medicare must end your membership in our plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you are no longer eligible for MassHealth and your 2-month deeming period has ended. Our plan is for people who are eligible for both Medicare and MassHealth.
- If you join a MassHealth Home and Community Based Services (HCBS) Waiver program
- If you move out of our service area.
- If you move into an Intermediate Care Facility operated by the Massachusetts Department of Developmental Services.
- If you go to jail or prison for a criminal offense.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.
- If you have or get other comprehensive insurance for prescription drugs or medical care.
- If you let someone else use your Member ID Card to get care.
    - If your membership ends for this reason, Medicare may ask the Inspector General to investigate your case, and MassHealth may ask the Bureau of Special Investigations to investigate your case.

We can also ask you to leave our plan if you continuously behave in a way that is so disruptive that we cannot provide care for you or other members of our plan. We can only make you leave if we get permission from Medicare and MassHealth first.

G. Rules against asking you to leave our plan for any reason related to your health or your disability

If you feel that we are asking you to leave our plan for a reason related to your health or disability, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

You should also call MassHealth Customer Service at 1-800-841-2900, Monday – Friday, 8 A.M. – 5 P.M. TTY users may call 1-800-497-4648.

You may also call My Ombudsman at 1-855-781-9898 (Toll Free), Monday through Friday from 9:00 A.M. to 4:00 P.M.

- Use 7-1-1 to call 1-855-781-9898. This number is for people who are deaf, hear of hearing, or speech disabled.
- Use Videophone (VP) 339-224-6831. This number is for people who are deaf or hard of hearing.
- You can also email My Ombudsman at info@myombudsman.org.

H. How to get more information about ending your plan membership

If you have questions or would like more information about when your membership may end, you can call Member Services at 866-610-2273 (TTY 711).

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in CCA One Care. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities, even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs and state laws about the Medicaid program. Other federal and state laws may apply, too.

B. Notice about nondiscrimination

Our plan and every company or agency that works with Medicare and MassHealth must obey laws that protect you from discrimination or unfair treatment. We do not discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation.

In addition, we do not discriminate against members or treat you differently because of appeals, behavior, gender identity, mental ability, receipt of healthcare, use of services, medical condition, health status, receipt of health services, marital status, 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 mental 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: 800-368-1019, 800-537-7697 (TDD)

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

You can also refer to Chapter 8, Section B, “Our responsibility to treat you with respect, fairness, and dignity at all times,” for more information.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at 617-963-2917. TTY users should call 617-727-4765. You can also visit: https://www.mass.gov/how-to/file-a-civil-rights-complaint for more information.

If you have a disability and need help accessing healthcare services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about CCA One Care as a second payer

Sometimes someone else has to pay first for the services that you get from us. For example, if you are in a car accident or if you are injured at work, insurance or Workers’ Compensation has to pay first. Then, if needed, we will pay.

CCA One Care has the right and the responsibility to collect payment for covered services when someone else has to pay first.

C1. Subrogation

Subrogation is the process by which CCA One Care gets back some or all of the costs of your healthcare from another insurer. Examples of other insurers include:

- Your motor vehicle or homeowner's insurance
- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' Compensation

If an insurer other than CCA One Care should pay for services related to an illness or injury, CCA One Care has the right to ask that insurer to repay us. Unless otherwise required by law, coverage under this policy by CCA One Care will be secondary when another plan, including without limitation medical payment coverage under an automobile or home insurance policy, provides you with coverage for healthcare services.

C2. Health plan's right of reimbursement

If you get money from a lawsuit or settlement for an illness or injury, CCA One Care has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

As a member of CCA One Care, you agree to:

- Let us know of any events that may affect CCA One Care's rights of Subrogation or Reimbursement.
- Cooperate with CCA One Care when we ask for information and assistance with Coordination of Benefits, Subrogation, or Reimbursement.
- Sign documents to help CCA One Care with its rights to Subrogation and Reimbursement.
- Authorize CCA One Care to investigate, request and release information which is necessary to carry out Coordination of Benefits, Subrogation, and Reimbursement to the extent allowed by law.

If you are not willing to help us, you may have to pay us back for costs we may incur, including reasonable attorneys' fees, in enforcing our rights under this plan.

D. Notice about privacy practices

This Notice describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, please call Member Services at 866-610-2273 (TTY 711), 8 am to 8 pm, 7 days a week.

The Notice of Privacy Practices describes how CCA One Care may use and disclose your medical information; explains your rights with respect to your medical information; and describes how and where you may file a privacy-related complaint. The Notice explains when an authorization is needed or not needed to share your information with others. The Notice is available at all times on the CCA One Care website, and in Chapter 8, Section D2 of this handbook, and upon request.

E. 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 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: Things that people do on a normal day, like eating, using the toilet, getting dressed, bathing, or brushing teeth.

Adverse action: An action, or lack of action, by CCA One Care that you can appeal. This includes:

- CCA One Care denied or approved a limited service your provider requested;
- CCA One Care reduced, suspended or ended coverage that we had already approved;
- CCA One Care did not pay for an item or service that you think is a Covered Service;
- CCA One Care did not resolve your service authorization request within the required time frames;
- You could not get a Covered Service from a provider in CCA One Care's network within a reasonable amount of time; **and**
- CCA One Care did not act within the time frames for reviewing a coverage decision and giving you a decision.

Aid paid pending: Getting your benefits while you are waiting for an appeal decision. This continued coverage is called "aid paid pending."

Ambulatory surgical center: A facility that provides outpatient surgical services to patients who do not need hospital care and who are not expected to need more than 24 hours of care in the facility.

Appeal: A formal way for you to challenge our decision if you think we made a mistake. You can ask us to change or reverse our decision by filing an appeal. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to get. Chapter 9 explains appeals, including telling you how to make an appeal.

Behavioral health services: Treatments for mental health and substance use.

Brand name drug: A prescription drug that is made and sold by the company that first made the drug. Brand-name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Partner: One main person who works with you, CCA One Care, and your care providers to make sure that you get the care you need.

Care Team: A team that may include doctors, nurses, counselors, other health professionals, and others who you choose who help you get the care you need. Your Care Team will also help you make an Individualized Care Plan (ICP).

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 explains how to contact CMS.

Complaint or Grievance: A written or spoken statement saying that you have a concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive assessment: A review of a patient's medical history and current condition. It is used to determine the patient's health and how it might change in the future.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Continuity of Care: The amount of time you can keep using your providers and getting your current services after you become a member of CCA One Care. The Continuity of Care period lasts for 90 days or until your comprehensive assessment and Individualized Care Plan (ICP) are complete.

Coverage decision: A decision about which benefits we cover. This includes decisions about covered drugs and services, or the amount that we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the drugs that our plan covers.

Covered services: The general term we use to mean all of the healthcare, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services that our plan covers.

Cultural Competence training: Training that provides additional instruction for our healthcare providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice, for example if you are no longer eligible for MassHealth).

Durable medical equipment (DME): Certain items that your healthcare provider orders for use in your own home. Examples of these items are 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 and supplies, nebulizers, and walkers.

Emergency: A medical condition that a prudent layperson with an average knowledge of health and medicine, would expect is so serious that if it does not get immediate medical attention it could result in death, serious dysfunction of a body organ or part, or serious impairment to a bodily function, or, with respect to a pregnant woman, place her or her unborn child's physical or behavioral health in serious jeopardy. Medical symptoms of an emergency include severe pain, difficulty breathing, or uncontrolled bleeding.

Emergency care: Covered services needed to treat a medical emergency, given by a provider trained to give emergency services.

Enrollment: The process of becoming a member in our plan.

Exception: Permission to get coverage for a drug that is not normally covered by our plan or to use the drug without certain rules and limitations.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS".

Flexible Benefits: Items or services other than Covered Services. Your health plan may cover Flexible Benefits as specified in your Individualized Care Plan (ICP) and to help address needs.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand-name drug. A generic drug has the same active ingredients as a brand-name drug. It is usually cheaper and works just as well as the brand-name drug.

Grievance: Refer to "Complaint or Grievance."

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Partners to help you manage all your providers and services. They all work together to make sure you get the care you need.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, like help with personal care (for example, bathing, using the toilet, dressing, or doing the exercises that a provider orders). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. Services include nursing; medical social services; physician; counseling, including bereavement, dietary, spiritual, or other types of counseling; physical, occupational, and speech language therapy; homemaker/home health aide; medical supplies, drugs, biological supplies; and short term inpatient care.
- CCA One Care must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your CCA One Care Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand. Because CCA One Care pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Independent Review Entity (IRE): The independent organization hired by Medicare to review External (Level 2) Appeals if we don't decide fully in favor of your Internal Appeal.

Individualized Care Plan (ICP): A plan that describes which health services you will get and how you will get them. (Also known as an individualized Personal Care Plan.)

Inpatient: A term used when you have been officially admitted to the hospital for skilled medical services. If you were not officially admitted, you might still be considered outpatient instead of inpatient, even if you stay in the hospital overnight.

Level 1 Appeal: A request by a member to a plan to review an Adverse Action (also called an Internal Appeal).

Level 2 Appeal: An appeal sent to an independent organization not connected to the plan to review the plan's decision on a Level 1 Appeal (the first stage in an External Appeal for a Medicare service).

List of Covered Drugs **(Drug List):** A list of prescription drugs covered by CCA One Care. We choose the drugs on this list with the help of providers and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Assistance so that you can stay at home instead of going to a nursing home or a hospital.

Long-term Supports (LTS) Coordinator: A person who works with you and your Care Team to make sure you get the services and supports you need for independent living.

MassHealth: The Medicaid program of the Commonwealth of Massachusetts.

MassHealth Board of Hearings (BOH): The Board of Hearings within the Massachusetts Executive Office of Health and Human Services' (EOHHS) Office of Medicaid.

Medicaid (or Medical Assistance): A program run by the federal and state governments that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and drugs not covered by Medicare.
- Medicaid programs change from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.
- Refer to Chapter 2 for information about how to contact Medicaid in Massachusetts. MassHealth is the Medicaid program of the Commonwealth of Massachusetts.

Medically necessary: Services that are reasonable and necessary:

- For the diagnosis and treatment of your illness or injury; **or**
- To improve the functioning of a malformed body member; **or**
- Otherwise medically necessary under Medicare law.

In accordance with Medicaid law and regulation, and per MassHealth, services are medically necessary if:

- They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**
- There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive.

The quality of medically necessary services must meet professionally recognized standards of healthcare, and medically necessary services must also be supported by records including evidence of such medical necessity and quality.

Medicare: The federal health insurance program for certain people: those who are 65 years of age or older, those under age 65 with certain disabilities, and those with end-stage renal disease (generally, this means those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for both Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual.”

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a health plan called a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or MassHealth. CCA One Care includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. (Refer to the Drug List for covered drugs.) Congress specifically excluded certain categories of drugs from coverage as Part D drugs, but MassHealth may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and MassHealth who qualifies to get covered services, has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and MassHealth.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments or riders, which explain your coverage, our responsibilities, and your rights and responsibilities as a member of our plan.

Member Services: A department within our plan whose job it is to answer your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2 for information about how to contact Member Services.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: “Provider” is the general term that we use for doctors, nurses, and others who give you healthcare services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you healthcare services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide healthcare services.
- We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount.
- While you are a member of our plan, you must use network providers to get covered services.
- Network providers are also called “plan providers.”

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: A person or organization in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. Ombudsman services for One Care members are provided by My Ombudsman. You can find more information about My Ombudsman in Chapters 2 and 9 of this handbook.

Organization determination: A decision by a plan, or one of its providers, about whether services are covered, or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Medicare offered by the government. Under Original Medicare, Medicare pays doctors, hospitals, and other healthcare providers. These payment amounts are set by Congress.

- You can use any doctor, hospital, or other healthcare provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to 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 are met.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and has not agreed to work with us to provide covered services to members of our plan. Chapter 3 explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to CCA One Care's Notice of Privacy Practices for more information about how CCA One Care protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Personally identifiable information (PII): Information that can be used to distinguish or trace an individual's identity, either alone or when combined with other information that is linked or can be linked to a specific individual.

Primary care provider (PCP): Your primary care provider is the doctor or other provider that you use first for most health problems.

- They make sure you get the care you need to stay healthy. They will work with your Care Team.
- They also may talk with other doctors and healthcare providers about your care and may refer you to them.
- Refer to Chapter 3 for information about getting care from primary care providers.

Prior authorization (PA): An approval from CCA One Care you must get before you can get a specific service or drug or use an out-of-network provider. CCA One Care may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets PA from our plan.

- Covered services that need our plan's PA are marked in the Benefits Chart in Chapter 4.

Some drugs are covered only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs.*

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other healthcare provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other healthcare experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check on and improve the care given to patients. Refer to Chapter 2 for information about how to contact the QIO for Massachusetts.

Quantity limits: A limit on the amount of a drug you can have. There may be limits on the amount of the drug that we cover for each prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. As a CCA One Care member, you don't need a referral to use specialists that are in our network. You can find more information about referrals in Chapter 3 and about services that require referrals in Chapter 4.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation, including physical therapy, speech and language therapy, and occupational therapy. Refer to Chapter 4 to learn more about rehabilitation services.

Service area: A specific area covered by a health plan (some health plans accept members only if they live in a certain area). For plans that limit which healthcare providers and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get CCA One Care.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitation services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of SNF care include physical therapy or intravenous (IV) injections that a registered nurse or a provider can give.

Specialist: A healthcare provider who provides healthcare for a specific disease or part of the body.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Subrogation: A process of substituting one creditor for another, which applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury. We may use this subrogation right, with or without your consent, to recover from the responsible party or that party's insurer the cost of services provided or expenses incurred by us that are related to your illness or injury.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Women's health specialist: A specialist, including an obstetrician or gynecologist, within CCA One Care's provider network for covered services who provides women's routine and preventive healthcare services.

CCA One Care Member Services

CALL	866-610-2273 Calls to this number are free. **Hours of operation:** 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:** 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