2019 SCO EOC

January 1 – December 31, 2019

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Boston Medical Center HealthNet Plan Senior Care Options (SCO).

This booklet gives you the details about your MassHealth (Medicaid) health care, long term care, and/or home and community based services and prescription drug coverage from January 1 – December 31, 2019. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Boston Medical Center HealthNet Plan Senior Care Options (SCO), is offered by *Boston Medical Center Health Plan, Inc.* (When this *Evidence of Coverage* says "we," "us," or "our," it means *Boston Medical Center Health Plan, Inc.* d/b/a Boston Medical Center HealthNet Plan. When it says "plan" or "our plan," it means Boston Medical Center HealthNet Plan Senior Care Options (SCO).

Boston Medical Center HealthNet Plan Senior Care Options (SCO) is a HMO plan with a contract with the Commonwealth of Massachusetts/Executive Office of Health and Human Services (EOHHS) MassHealth program. Enrollment in Boston Medical Center HealthNet Plan Senior Care Options (SCO) depends on contract renewal. Boston Medical Center HealthNet Plan Senior Care Options is a voluntary MassHealth (Medicaid) program in association with the Executive Office of Health and Human Services.

This document is available for free in Spanish and Portuguese.

Please contact our Member Services number at 1-855-833-8125 for additional information. (TTY users should call 711.) Hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. (from October 1 to March 31, representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.)

This document may be available in other formats such as Braille, large print or other alternate formats. For additional information call customer service at 1-855-833-8125 (TTY/TDD: 711). Benefits may change on January 1, 2020.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

2019 *Evidence of Coverage*

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

- Explains how to ask for coverage decisions and file appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

CHAPTER 1

Getting started as a member

Chapter 1. *Getting started as a member*

SECTION 1 Introduction

Section 1.1 You are enrolled in Boston Medical Center HealthNet Plan Senior Care Options (SCO), which is a Senior Care Options Plan (SCO)

You are covered by MassHealth (Medicaid). **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. In Massachusetts, the Medicaid program is called MassHealth.

You have chosen to get your MassHealth (Medicaid) health care and your prescription drug coverage through our plan, Boston Medical Center HealthNet Plan Senior Care Options (SCO).

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

Because you get assistance from MassHealth (Medicaid), you have no out-of-pocket expenses for your health care services. MassHealth (Medicaid) also provides other benefits to you by covering health care services *including* prescription drugs, long term care and home and community based services. Boston Medical Center HealthNet Plan Senior Care Options (SCO) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Boston Medical Center HealthNet Plan Senior Care Options (SCO) is run by a non-profit organization. We have a contract with the Massachusetts (MassHealth) Medicaid program to coordinate your MassHealth (Medicaid) benefits. We are pleased to be providing your MassHealth (Medicaid) health care coverage, including your prescription drug coverage, long term care and home and community based services.

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

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

The word "coverage" and "covered services" refers to the medical care, long term care (LTC), home and community based services and the prescription drugs available to you as a member of Boston Medical Center HealthNet Plan Senior Care Options (SCO).

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in Boston Medical Center HealthNet Plan Senior Care Options (SCO) between January 1, 2019, and December 31, 2019.

MassHealth (Medicaid) must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- –You are eligible for MassHealth (Medicaid) Standard with a SCO-eligible aid category; and
- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a Plan that we offer, or you were a member of a different plan that was terminated; and
- You live in our geographic service area (Section 2.3 below describes our service area); and
- You do not reside in an intermediate care facility for the mentally retarded (IFC/MR); and
- You select a network primary care provider (PCP) and agree to assist your primary care provider in developing an individualized plan or care; and
- You are not subject to a 6-month deductible period under MassHealth regulatlions; and
- You agree to receive all services from Boston Medical Center HealthNet Plan Senior Care Options (SCO), except in the case of emergency or when traveling temporarily out of the service area; and
- You do not reside in a chronic disease or rehabilitation hospital; and
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be age 65 or over and eligible for Full Medicaid.

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

Section 2.2 What is Medicaid?

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

Section 2.3 Here is the plan service area for Boston Medical Center HealthNet Plan Senior Care Options (SCO)

Boston Medical Center HealthNet Plan Senior Care Options (SCO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area consists of these counties in Massachusetts: Barnstable, Bristol, Hampden, Plymouth, and Suffolk.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). It is also important that you call MassHealth (Medicaid) if you move or change your mailing address. You can find phone numbers and contact information in Chapter 2, *Important phone numbers and resources.*

Section 2.4 U.S. Citizen or Lawful Presence

A member of a MassHealth (Medicaid) health plan must be a U.S. citizen or lawfully present in the United States. EOHHS will notify Boston Medical Center HealthNet Plan Senior Care Options (SCO) if you are not eligible to remain a member on this basis. Boston Medical Center HealthNet Plan Senior Care Options (SCO) must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

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

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

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

Here's why this is so important: If you get covered services using your MassHealth (Medicaid) card instead of using your Boston Medical Center HealthNet Plan Senior Care Options (SCO) membership card while you are a plan member, you may have to pay the full cost yourself.

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

Section 3.2 The *Provider and Pharmacy Directory*: Your guide to all providers in the plan's network

The *Provider and Pharmacy Directory* lists our network providers, network pharmacies and durable medical equipment suppliers. This directory is available on our website *www.SeniorsGetMore.org* or if you wish to have a hard copy by calling our Member Services Department. (Phone numbers are printed on the back cover of this booklet.)

What are "network providers"?

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

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

It is important to know which providers are part of our network (which is comprised of our Network Providers and Network Pharmacies as defined in Chapter 11) because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Boston Medical Center HealthNet Plan Senior Care Options (SCO) authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

It is important that you only see network providers, for your MassHealth (Medicaid) benefits. If you do not use participating providers when accessing your benefits you may be responsible for the entire cost of the services that were provided, as the provider and/or facility are not contracted with our plan.

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

What are "network pharmacies"?

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

Why do you need to know about network pharmacies?

You can use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at *www.SeniorsGetMore.org*. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

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

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which prescription drugs are covered by *Boston Medical Center HealthNet Plan Senior Care Options (SCO)*. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare and Medicaid. Medicare and Medicaid have approved the *Boston Medical Center HealthNet Plan Senior Care Options (SCO)* Drug List.

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

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website *www.SeniorsGetMore.org* or call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 Please keep your plan centralized enrollee record up to date

Section 4.1 How to help make sure that we have accurate information about you

Your centralized enrollee record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, or workers' compensation)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

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

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

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

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

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

SECTION 5 We protect the privacy of your personal health information

Section 5.1 We make sure that your health information is protected

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

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

SECTION 6 How other insurance works with our plan

Section 6.1 Which plan pays first when you have other insurance?

When you have other insurance coverage, we work with your other insurance companies to coordinate your Plan benefits. This process is called "Coordination of Benefits."

We are the payor of last resort. This means when you have other insurance (like health insurance from an employer), they always pay first (called "primary insurance") and our plan will always pay second (called "secondary insurance"). This is the case unless the law states something different. In other situations, such as for services that are not covered by the plan, you may be able to get these services covered by your other insurance. If you have additional health insurance, call us at 617-748-6188 to tell us about your other insurance and to find out how payment will be handled.

You must follow all of your primary insurance rules when getting services. Services or items not covered by your primary insurance may be covered by us. It is important to use providers that are in both your primary insurance network and our network for claims to be processed correctly.

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

CHAPTER 2

Important phone numbers and resources

Chapter 2. *Important phone numbers and resources*

SECTION 1 Boston Medical Center HealthNet Plan Senior Care Options (SCO) contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Member Services Representatives are available Monday – Friday 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0884
WRITE	Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Services Department 529 Main Street Suite 500 Charlestown, MA 02129
WEBSITE	*www.SeniorsGetMore.org*

How to contact us when you are asking for a coverage decision about your medical care

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

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0884
WRITE	Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Services Department 529 Main Street Suite 500 Charlestown, MA 02129
WEBSITE	*www.SeniorsGetMore.org*

How to contact us when you are filing an appeal about your medical care

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

Method	Appeals for Medical Care – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0805
WRITE	Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Appeals Department 529 Main Street Suite 500 Charlestown, MA 02129
WEBSITE	*www.SeniorsGetMore.org*

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

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

Method	Complaints about Medical Care – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0805
WRITE	Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Grievances Department 529 Main Street Suite 500 Charlestown, MA 02129
MEDICARE WEBSITE	You can submit a complaint about Boston Medical Center HealthNet Plan Senior Care Options (SCO) directly to Medicare. To submit an online complaint to Medicare go to *https://www.medicare.gov/MedicareComplaintForm/home.aspx*.

How to contact us when you are asking for a coverage decision about your prescription drugs

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

Method	Coverage Decisions for Prescription Drugs – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-877-503-7231
WRITE	Envisions Rx 2181 East Aurora Road Suite 201 Twinsburg, OH 44087
WEBSITE	*www.SeniorsGetMore.org*

How to contact us when you are filing an appeal about your prescription drugs

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

Method	Appeals for Prescription Drugs – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0805
WRITE	Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Appeals Department 529 Main Street Suite 500 Charlestown, MA 02129
WEBSITE	*www.SeniorsGetMore.org*

How to contact us when you are making a complaint about your prescription drugs

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

Method	Complaints about prescription drugs – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0805
WRITE	Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Grievances Department 529 Main Street Suite 500 Charlestown, MA 02129

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

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

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

Method	Payment Request – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0884 for medical requests 1-877-503-7231 for drug requests
WRITE	**For Medical Care Payment Requests:** Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Services Department 529 Main Street, Suite 500 Charlestown, MA 02129 **For Drug Payment Requests:** Envisions Rx 2181 East Aurora Road Suite 201 Twinsburg, OH 44087
WEBSITE	*www.SeniorsGetMore.org*

SECTION 2 MassHealth (Medicaid)
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

When you join our plan you are enrolled in MassHealth (Medicaid).

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

If you have questions about the assistance you get from MassHealth (Medicaid), contact MassHealth (Medicaid). If you have questions about services or agencies that can work with people with disabilities, elders and caregivers to help determine what services you might need and can support you with a statewide network of local partners and agencies, you can contact MassOptions.

Method	MassHealth (Medicaid program) – Contact Information
CALL	1-800-841-2900 Available 8 a.m. – 5 p.m. Monday through Friday
TTY	1-800-497-4648 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth Customer Service Center Health Processing Center PO Box 4405, Taunton, MA 02780 Or you may go to one of the MassHealth Enrollment Centers in your area.
WEBSITE	*www.mass.gov/masshealth*

Method	MassOptions – Contact Information
CALL	1-844-422-6277 Available 9 a.m. – 5 p.m. Monday through Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Please e-mail any questions or concerns to the website address below or visit the website and go to the "How to Contact Us" section – you can chat on-line or send an e-mail.
WEBSITE	www.mass*options.org*

The Massachusetts My Ombudsman Program helps people get information beyond what is available above, such as information regarding plan choice, nursing homes and resolving problems between nursing homes and residents or their families.

Method	Massachusetts My Ombudsman Program – Contact Information
CALL	1-855-781-9898 , Monday through Friday from 9:00 a.m. to 4:00 p.m. Walk-in hours: Monday 1 p.m. – 4 p.m. and Thursday 9 a.m. – 12 p.m. Appointments can be made for times other than these.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	My Ombudsman 11 Dartmouth Street Suite301 Malden, MA 02148
WEBSITE	www.*myombudsman.org*

SECTION 3 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits or premiums. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

SECTION 4 You can get assistance from Area Agencies on Aging

Counties	Area Agency on Aging	Contact Information
Suffolk	Boston Senior Home Care	Lincoln Plaza 89 South Street, Suite 501 Boston, MA 02111 (617) 451-6400
Suffolk	Central Boston Elder Services	2315 Washington Street Boston, MA 02119 (617) 277-7416
Suffolk	Somerville-Cambridge Elder Services	61 Medford Street Somerville, MA 02143 (617) 628-2601
Suffolk	Southwest Boston Senior	555 Amory Street Jamaica Plain, MA 02130

	Services d/b/a Ethos	(617) 522-6700
Suffolk	Mystic Valley Elder Services	300 Commercial Street, #19 Malden, MA 02148 (781) 324-7705
Hampden	WestMass Elder Care	4 Valley Mill Road Holyoke, MA 01040 (413) 538-9020
Hampden	Greater Springfield Senior Services	66 Industry Avenue Springfield, MA 01104 (413) 781-8800
Hampden	Highland Valley Elder Services	320 Riverside Drive Florence, MA 01062 (413) 586-2000
Plymouth	South Shore Elder Services	1515 Washington Street Braintree, MA 02184 (781) 848-3910
Plymouth	Old Colony Elder Services	144 Main Street Brockton, MA 02301 (508) 584-1561
Plymouth	Coastline Elder Services	1646 Purchase Street New Bedford, MA 02740 (508) 999-6400
Barnstable	Elder Services of Cape Cod	68 Route 134 South Dennis, MA 02660 (508) 394-4630 (800) 244-4630 (Cape only) (800) 442-4492 (Mass only)
Bristol	Bristol Elder Services	1 Father DeValles Blvd Unit 8 Fall River, MA 02723 (508) 675-2101
	Coastline Elder Services	1646 Purchase Street New Bedford, MA 02740 (508) 999-6400
	Old Colony Elder Services	144 Main Street Brockton, MA 02301 (508) 584-1561

CHAPTER 3

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

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

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

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

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

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

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

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

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

Boston Medical Center HealthNet Plan Senior Care Options (SCO) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter. Please note that services, including emergency and urgent services, are NOT covered outside the United States and its territories.

- If you need medical care that MassHealth (Medicaid) requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. *You, your PCP, or a plan provider must request prior authorization from the plan for covered services before you receive care/services from an out-of-network provider.* In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
- The plan covers kidney dialysis services that you get at a certified dialysis facility when you are temporarily outside the plan's service area.

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

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care

What is a "PCP" and what does the PCP do for you?

- A PCP is your "primary care provider." A PCP is the primary doctor who manages your general health care, meets state requirements, and is trained to give you basic medical care. Generally, you see your PCP first for most of your routine health care needs.
- A PCP is a primary care provider who will act as your family doctor or primary health care resource. Physicians or nurse practitioners may act as a PCP. PCP's provide routine medical care and assist in coordinating covered services, such as seeing a specialist or having a procedure in a hospital or outpatient setting.
- A PCP is a family practice physician, a general practitioner, geriatrician, nurse practitioner, or internal medicine physician practicing as primary care.
- A PCP is your partner in meeting your health care needs.
- Your PCP knows your complete medical history and evaluates changes in your health. Your PCP provides the care he/she is qualified to provide and will refer you to network specialists and other providers when your health condition requires the services of other providers.
- In some cases your PCP will obtain prior authorization for services that require prior authorization, in other cases the specialist or other provider will obtain prior authorization for services he/she will provide.
- Selecting your network PCP does not limit your use of network providers and facilities.

How do you choose your PCP?

Every member of our plan is required to select a network PCP. The PCP that you select has to be a state licensed clinician (e.g., Family Practitioner, Internal Medicine, or Gerontologist). During our enrollment process, if necessary our sales representatives can closely work with you to select your PCP. You may also contact Member Services (phone numbers are printed on the back cover of this booklet) to receive assistance in selecting your PCP. If you do not select a PCP, one will be assigned to you. However, you are not required to keep this assigned PCP. You may contact Member Services to receive assistance in changing the PCP we assigned to you.

Changing your PCP

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

If you wish to change your PCP please contact Member Services to select your new Primary Care Provider or fill out a PCP selection form at your provider's office and request they fax it to us. This form is also available on our

website at www.SeniorsGetMore.org.

(Note: Your new PCP will become effective on the day you call or the day we receive the PCP selection form.)

At times a PCP might choose to leave Boston Medical Center HealthNet Plan's Senior Care Options (SCO) network. If this occurs, and you currently receive services from them, you will have to switch to another PCP who is participating with Boston Medical Center HealthNet Plan's Senior Care Options (SCO) network. We will send you a letter to let you know and help you switch to another PCP so that you can keep getting your covered services. Member Services can help you find and select another PCP that is contracted with Boston Medical Center HealthNet Plan's Senior Care Options (SCO) network. If this change suddenly impacts your current health, exceptions can be made for you to continue your treatment plan until you are able to transition to the care of your new PCP.

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

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

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

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

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

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions
- A referral (an order from your Primary Care Provider (PCP) to see an in-network specialist for covered services) is not required.
- Prior Authorization from the Plan may be required for out-of-network specialists.
- Some types of services will require getting prior approval from our plan (this is called getting "prior authorization"). Prior Authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your PCP, other network provider, or you can request the authorization from our plan. The request will be reviewed and a decision (Organization Determination) will be sent to you and the provider. Please refer to the Benefits Chart in Chapter 4, Section 2.1 of this booklet for the specific services that require "prior authorization."

- Selecting your network PCP does not limit your use of network providers and facilities.

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

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

- Even though our network of providers may change during the year, MassHealth (Medicaid) requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

For assistance please contact Member Services (phone numbers for Member Services can be found on the back cover of this booklet).

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

You must receive your care from a network provider (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. However, you are entitled to receive services from out-of-network providers in cases of emergency/urgent care. If the services you need are not available in-network, you would need a Prior Authorization from the Plan. You are also able to receive dialysis treatment if you are traveling outside the plan's service area and are unable to receive treatment from network providers.

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

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. (The phone number for Member Services can be found on the back of your card and also on the back of this booklet).

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan does not cover emergency medical care, urgently needed services or any other care if you receive the care outside of the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

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

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

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

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

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

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

Please contact your PCP's office for additional assistance in locating a network urgent care facility or contact us for a listing of urgent care facilities that are in-network.

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

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

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

Section 3.3 Getting care during a disaster

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

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

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

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

Section 4.1 You can ask us to pay for covered services

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

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

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

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

Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

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

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

When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

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

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

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

Once you join a qualified clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

The plan pays most of the cost of the covered services you receive as part of the study. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

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

When you are part of a clinical research study, **our plan will not pay for any of the following**:

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

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

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

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

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

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

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

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

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

Inpatient Hospitalization coverage with Boston Medical Center HealthNet Plan Senior Care Options (SCO) has no coverage limitations for this covered service. For more information, please refer to the benefits chart in Chapter 4.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after the plan makes a certain number of payments?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that are rented.

As a member of Boston Medical Center HealthNet Plan Senior Care Options (SCO), you usually will not acquire ownership of rented DME. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

CHAPTER 4

Benefits Chart (what is covered)

Chapter 4. *Benefits Chart (what is covered)*

SECTION 1 Understanding covered services

This chapter focuses on what services are covered. It includes a Benefits Chart that lists your covered services as a member of Boston Medical Center HealthNet Plan Senior Care Options (SCO). Later in this chapter, you can find information about medical services that are not covered.

Section 1.1 You pay nothing for your covered services

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

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

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

The Benefits Chart on the following pages lists the services covered by Boston Medical Center HealthNet Plan Senior Care Options (SCO). The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

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

Other important things to know about our coverage:

- We cover everything that MassHealth (Medicaid) Standard covers, including long-term care, over-the-counter drugs, and home and community-based services.

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

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

Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0 copay
Acupuncture Medically necessary acupuncture services are covered for the relief of pain, anesthesia, or substance abuse detoxification.	$0 copay
Adult Day Health and Transportation (minimum 2 days/week) Center-based services that may include nursing services and health oversight, assistance with activities of daily living, nutritional and dietary services, counseling services, activities, and transportation at a MassHealth (Medicaid) approved site.	$0 copay
Adult Foster Care (AFC)/Group Adult Foster Care (GAFC) **AFC** is for members who need daily help with personal care, but want to live in a family setting rather than in a nurisng home or other facility. The caregiver provides meals, companionship, personal care assistance, and 24-hour supervision. AFC member slive with trained paid caregivers who provide daily care. Caregivers may be individuals, couples, or larger families. **GAFC** includes personal care services for eligible members with disabilities who live in GAFC-approved housing. Housing may be an assisted living residence or specially designated public or subsidized housing.	$0 copay
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. *Prior authorization is required for non-emergency transportation services as described in the paragraph above.* **Ambulance services (including emergency ambulance) are not covered outside the United States and its territories.**	$0 copay
Annual wellness visit You can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	$0 copay
Breast cancer screening (mammograms) Covered services include: • One screening mammogram every 12 months • Clinical breast exams once every 24 months	$0 copay
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. *Prior authorization may be required.*	$0 copay
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	$0 copay
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months)	$0 copay
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation without a limit • Routine office visits or chiropractic manipulation treatments, other than to correct subluxation of the spine, are limited to 20 visits per calendar year ***Prior Authorization is required for any Chiropractic Services that exceed the 20 visit limit, for services other than to correct a subluxation of the spine which are not subject to the 20 visit limit.***	$0 copay
Chore Services Assistance with light chores and heavy chores to help members remain at home or promote safety and health.	$0 copay
Colorectal cancer screening The following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	$0 copay
Companion Services Includes socialization, help with shopping and errands, escort to doctor's appointments, nutrition sites, walks, recreational activities, and assistance with preparation and serving of light snacks.	$0 copay
Day Habilitation Services Structured, goal-oriented treatment program of medically oriented, therapeutic and habilitation services for developmentally disabled members.	$0 copay
Dementia Day Care Structured, secure environment for members with cognitive disabilities approved by Elder Affairs.	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are covered. Including but not limited to the following services: • Emergency care visits • Extractions (Removing Teeth) • Some oral surgery such as biopsies and soft-tissue surgery • Restorative (Fillings) • Endodontic (Root Canal) • Periodontic (Deep Scaling) • Crowns • Dentures (Full, Partial, or Repair) • Surgical Procedures related to full or partial dentures • Diagnostic (X-rays and Exams) • Preventive (Cleanings) • Other as medically necessary ***Prior authorization may be required for some non-routine Dental Services.***. In addition, you also receive extra dental services. Our plan covers up to $1000 toward dental implants per plan year.	$0 copay Replacement dentures are limited to coverage once every five years unless authorized differently by your Primary Care Provider or Primary Care Team
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	$0 copay
Diabetes Prevention Program (DPP) DPP services will be covered for eligible members. DPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	$0 copay
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain condition	$0 copay
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 11 of this booklet.) Covered items include, but are not limited to: • wheelchairs, • crutches, • powered mattress systems, • diabetic supplies, • hospital beds ordered by a provider for use in the home, • IV infusion pumps, • speech generating devices, • oxygen equipment, • nebulizers, • walkers • nutritional supplements • personal Emergency Response System (PERS) • environmental aids • assistive/adaptive technology • tub and toilet grab bars • Wander Response Systems Coverage includes, but is not limited to, the purchase or rental of medical equipment, replacement parts, and repair for such items. *Prior authorization is required for certain durable medical equipment and supplies.*	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ***Emergency Care is not covered outside of the United States and its territories.***	$0 copay If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered *OR* you must have your inpatient care at the out-of-network hospital authorized by the plan.
Environmental Adaptation Services Home adaptations, modifications or adaptive equipment to help member remain independent or improve independence.	$0 copay
Geriatric Support Services Coordination In-home assessment and home-based services coordination provided by a plan contracted ASAP case manager.	$0 copay
Grocery Shopping/Delivery Services Includes obtaining grocery orders, shopping, delivery and assistance as needed; may include nutritional information and education.	$0 copay
Health/Wellness Education Coverage includes: • Written health education materials • Nutritional training • Nutritional benefits • Other wellness services • Fitness Benefit	$0 copay The plan will reimburse you up to 25%, not to exceed $150 per Plan Year, for membership in a Health Club or participation in health classes such as water aerobics, Yoga, Pilates, fall prevention, etc.

Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. The plan also covers the following benefits: • Routine hearing exams • Hearing aids, including evaluations for fitting hearing aids, repairs, and replacements • Audiology exams and evaluations • Diagnostic services *Prior authorization is required for hearing aids or instrument replacement before they are 5 years old.* *No prior authorization is required for the hearing exams.*	$0 copay
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months •	$0 copay
Home-Delivered Meals Includes well balanced meals (meeting Elder Affairs' definition of Nutrition Standards and client's nutritional needs) delivered to members unable to prepare nutritional meals or attend congregate meal site. This would include, members who have either been discharged from the hospital with certain conditions or recently diagnosed with certain conditions (such as diabetes or congestive heart failure) for a short period of time (no more than 2 weeks) to help transition to a healthier lifestyle.	$0 copay
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Other medical services when home is determined by the plan to be the best place for those services to be provided *Prior authorization is required for certain home health agency care services.* *Prior authorization is not required for the initial evaluation.*	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Home Health Aide Services Includes simple dressing changes, assistance with medications, activities to support skilled therapies and routine care of prosthetic and orthotic devices under the supervision of a licensed RN or other professional. You do not need to be homebound for services to be covered under this benefit. *Prior authorization is required for Home Health Aide Services.*	$0 copay
Homemaker Includes assistance with shopping, menu planning, meal preparation, laundry and light housekeeping.	$0 copay
Hospice care You may receive care from any certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care *Prior authorization is required for hospice care.* *The plan will continue to cover plan-covered services that are not related to your terminal prognosis while you are in hospice care. You should contact us to arrange the services.* The plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	$0 copay
Immunizations Covered immunizations include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B	$0 copay
Institutional Long Term Nursing Home Care (Custodial Care) Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. *Prior authorization is required for Institutional Long Term Nursing Home Care.*	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Medical Nutrition Therapy Coverage provided when services are not covered by Medicare or when medically necessary such as when the member is unable to meet daily nutritional requirements using traditional foods alone due to injury or illness. *Prior authorization is required for Medical Nutrition Therapy.*	$0 copay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a plan-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept our plan rate. If Boston Medical Center HealthNet Plan Senior Care Options (SCO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components of blood are covered beginning with the first pint used. • Physician services • Inpatient care from a religious non-medical health care institution **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.	
Inpatient mental health care • Covered services include mental health care services that require a hospital stay. *Prior authorization is required for inpatient mental health care.*	$0 copay
Laundry Services Cleaning services provided by a laundry company.	$0 copay
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. *Prior authorization is required for medical nutrition therapy.*	$0 copay
Medical Supplies Includes coverage for supplies such as incontinence supplies and nutritional supplements. *Prior authorization is required for certain Medical Supplies.*	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Nutritional Assessment Comprehensive assessment conducted by a qualified nutritionist with nutritional plan based on assessment.	$0 copay
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	$0 copay
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests • High-End Radiology (CT, MRI, Nuclear Cardiac Imaging, PET Scan, etc.) • Genetic testing *Prior authorization is required for High-End Radiology. Prior authorization is also required for some outpatient diagnostic tests (i.e., some genetic tests may require prior authorization) and therapeutic services (i.e., Intensity Modulated Radiation Therapy (IMRT) and supplies).*	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. *Prior authorization may be required for certain outpatient hospital services.*	$0 copay
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional as allowed under applicable state laws. *Prior authorization is required for outpatient mental health care after the first 15 visits. You must use a Beacon Health Strategies (Beacon) provider. Please contact Member Services to coordinate care at 1-855-833-8125 (TTY/TDD: 711).*	$0 copay
Outpatient Rehabilitation Services The following services are covered: • **Physical therapy services** – evaluation, treatment, and restoration to normal or best possible functioning o neuromuscular, musculoskeletal, cardiovascular, and respiratory systems. • **Occupational therapy services** – evaluation and treatment of an enrollee in his or her own environment for impaired physical functions. • **Speech and Hearing therapy services** – evaluation and treatment of speech, language, voice, hearing, fluency, and swallowing disorders. *Prior authorization is required for Outpatient Rehabilitation Services. Prior authorization is waived for the initial evaluation for each therapy.*	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance abuse services Coverage is provided for the following: Individual and Group Therapy outpatient treatment visits *You must use a Beacon Health Strategies (Beacon) provider. Please contact Member Services to coordinate care at 1-855-833-8125 (TTY/TDD: 711)*	$0 copay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." *Prior authorization may be required for certain Outpatient surgery services.*	$0 copay
Over-the-Counter (OTC) Items You will receive a debit card to use towards approved covered items. This card comes prefunded. Additional funds are automatically loaded for each calendar quarter that you are enrolled in our plan for use with contracted providers.	Your card will have $85 loaded per calendar quarter. Any unused funds per quarter will NOT rollover to the next quarter.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. *You must use a Beacon Health Strategies (Beacon) provider. Please contact Member Services to coordinate care at 1-855-833-8125 (TTY/TDD: 711).* *Prior authorization is required for partial hospitalization services.*	$0 copay
Personal Care Attendant A consumer-directed program that allows members to hire PCAs to help with Activities of Daily Living (ADLs) such as mobility/transfers, medications, bathing or grooming, dressing or undressing, range of motion exercises, eating, toileting and with Instrumental Activities of Daily Living (IADLs) such as shopping, laundry, meal preparation, housekeeping.	$0 copay
Personal Care Services Includes bathing, dressing, grooming, foot care, assistance with dentures, shaving, assistance with bedpan, eating, ambulating and transfers.	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Personal Emergency Response Systems (PERS) A medical communications system allowing members with a medical emergency at home to activate electronic device to transmit signal to a monitoring station.	$0 copay
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP *or* specialist, if your doctor orders it to see if you need medical treatment • Second and third opinions • Non-routine dental care - covered services include but are not limited to, surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician *Some services provided by your PCP or other practitioner may require Prior Authorization.*	$0 copay
Prescription drugs Chapter 5, *Using the plan's coverage for your prescription drugs,* explains the prescription drug benefit, including rules you must follow to have prescriptions covered.	$0 copay
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs *Prior authorization may be required for some podiatric services.*	$0 copay
Prostate cancer screening exams Covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: • colostomy bags and supplies directly related to colostomy care, • pacemakers, • braces, • prosthetic shoes, • artificial limbs, and • breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. *Prior authorization is required for Prosthetic devices and related supplies.*	$0 copay
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. *Prior authorization is required for pulmonary rehabilitation services.*	$0 copay
Respite Care Includes one or more home care services to temporarily relieve the primary caregiver of a member, in emergencies or planned circumstances, of the daily stresses and demands of caring for a member in efforts to strengthen or support the informal support system. May include short term placement in Adult Foster Care, nursing facilities, rest homes, or hospitals. In addition, you may provide your caregiver with a minimum of 1 day up to a maximum of 3 days off per year and during that time you will be allotted respite care – inpatient or outpatient as needed. *Prior authorization is required for Respite Care Services.*	$0 copay
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the criteria for such visits. *Prior authorization is required for screening lung cancer with low dose computed tomography (LDCT).*	$0 copay
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover STI screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply)	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 11 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") The plan covers up to 100 days in a Skilled Nursing Facility in a benefit year. There is additional coverage for Long Term Care coverage beyond the 100 days described under the "Institutional Long-Term Nursing Home Care (Custodial Care) benefit in this chapter. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts the plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides SNF care) • A SNF where your spouse is living at the time you leave the hospital *Prior authorization is required for Skilled Nursing Facility care.*	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. Nicotine replacement medicine including nicotine patches, gum, lozenges, and certain other medicines if prescribed by your doctor. **Prescription required for nicotine replacement medicine.**	$0 copay
Social Day Care Services Individualized programs of social activity for members requiring daytime supervision at sites other than home.	$0 copay
Substance Abuse **(Substance Use Disorder) Treatment Services** Coverage including: • Inpatient Treatment • Outpatient Treatment • Drugs Used to Treat Opioid Dependence • Acupuncture Treatment • Clinical support services • Structured Outpatient addiction program *Prior authorization is not required for Substance Abuse (Substance Use Disorder) Services.*	$0 copay You must use a Beacon Health Strategies (Beacon) provider. Please contact Member Services to coordinate at 1-855-833-8125 (TTY/TDD: 711)

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques **SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.**	$0 copay
Transportation (non-emergency to medical appointments) Taxi and chair-car or other transport for covered medical care within the member's community, or nearest community if no other resource is available, when member is unable to transport self due to health reasons. **One-Stop:** The plan will cover up to 1 stop on the way home from your medical appointment if you need to pick up medication or medical supplies/devices as a result of your appointment. This stop is limited to no more than 1 hour and must be arranged in advance of your appointment. You can request a One-Stop at the time you schedule your transportation. **Member must contact Member Services (phone numbers are printed on the back cover of this booklet) to coordinate transportation.**	$0 copay
Transportation – Non-Emergency, Non-Medical Transportation to non-medical services may also be covered when documented and prior authorized in the Individual Care Plan. Member must contact Member Services (phone numbers are printed on the back cover of this booklet) to coordinate transportation.	$0 copay

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **Urgently needed services are not covered outside of the United States or its territories.**	$0 copay
Vision care Covered services include: • Annual eye examinations • Vision training • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Additionally, you also receive supplemental vision services. Our plan pays up to $150 every year for eyewear which is described below. • Contact Lenses	$0 copay

Services that are covered for you	**What you must pay** when you get these services
• Eyeglasses (frames and lenses) • Eyeglass frames • Eyeglass lenses (including upgrades) You may utilize a contracted optometrist, ophthalmologist, or community health center (CHC) that provide hardware as these providers can bill the Plan directly. Please call Member Services (phone numbers are listed on the back cover of this booklet) for assistance in locating a contracted provider. If you prefer, you may use a non-contracted provider (such as Walmart, Sears, etc.). However, these non-contracted providers are unable to bill the Plan directly and may charge you the cost up front. If you choose this option you will need to submit documentation for reimbursement (see Chapter 6, Section 2.1 for information on reimbursement) from the plan. Please call Member Services (phone numbers are listed on the back cover of this booklet) for assistance on the reimbursement process or if you are unable to provide payment at the time you obtain these services.	
Wigs Covered for members with limited diagnoses *Prior authorization is required for wigs.*	$0 copay

SECTION 3 What services are not covered by the plan?

Section 3.1 Services *not* covered by the plan

This section tells you what services are "excluded". Excluded means that the plan doesn't cover these services.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this document, the following services are not covered by the plan:

- Services considered not reasonable and necessary, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by MassHealth or under a MassHealth-approved clinical research study or by our Plan. (See Chapter 3, *Using the Plan's coverage for your medical and other covered services*, Section 3.5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under MassHealth.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses, except as covered under your MassHealth Standard (Medicaid) benefit as Continuous Nursing care.

- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household, except as allowed under your MassHealth Standard (Medicaid) benefit as a Personal Care Attendant.
- 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 procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Reversal of sterilization procedures.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.

The Plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

CHAPTER 5

Using the plan's coverage for your prescription drugs

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

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for prescription drugs

This chapter **explains rules for using your coverage for prescription drugs**.

In addition to your coverage for prescription drugs, Boston Medical Center HealthNet Plan Senior Care Options (SCO) also covers some drugs under the plan's medical benefits.

- The plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay).
- The plan provides benefits for certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.
- Covered prescription drugs can be found on the *Boston Medical center HealthNet Plan Senior Care Options (SCO)* Drug List.

Section 1.2 Basic rules for the plan's prescription drug coverage

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3,*Your drugs need to be on the plan's "Drug List.")*
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

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

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

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

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

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

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

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

What if you need a specialized pharmacy?

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

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

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

Section 2.3 Using the plan's mail-order services

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

Our plan's mail-order service allows you to order **up to a 90-day supply**.

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed,

allow you to stop or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

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

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please contact our Mail-Order pharmacy, EnvisionMail at 1-866-909-5170.

Section 2.4 How can you get a long-term supply of drugs?

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

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

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

Your prescription may be covered in certain situations.

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

- *When you are out of the Plan's service area and there is no network pharmacy available.*

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

How do you ask for reimbursement from the plan?

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

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

Section 3.1 The "Drug List" tells which prescription drugs are covered

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

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

The Drug List includes the drugs covered under MassHealth (Medicaid) (earlier in this chapter, Section 1.1 explains about prescription drugs). The list of the MassHealth (Medicaid) covered drugs is available on our website (*www.SeniorsGetMore.org*) or by calling Member Services (phone numbers are listed on the back of this booklet.)

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

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

The Drug List includes both brand name and generic drugs

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

Over-the-Counter Drugs

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

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

If you have a question as to whether a particular drug is on this list or to ask for a copy of the list, please go to our website (*www.SeniorsGetMore.org*.) or call Member Services (phone numbers are printed on the back cover of this booklet). Drugs included on this list are covered at the pharmacy with a prescription.

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

You have *two* ways to find out:

1. Visit the plan's website *www.SeniorsGetMore.org*. The Drug List on the website is always the most current.
2. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

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

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

Section 4.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available

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

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes the requirement for getting approval in advance helps

guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

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

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

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

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

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

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

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

There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

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

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

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

You may be able to get a temporary supply.

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

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

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

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

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

- **For those members who are new or who were in the plan last year:**

  We will cover a temporary supply of your drug **during the first *90 days* of your membership in the plan if you were new and during the first *90 days* of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of a one month supply <30 or 31 days>. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of <30 or 31 days> of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than *90 days* and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- **For those members who have been in the plan for more than 90 days and have level of care changes where they move from one treatment setting to another and need a supply right away:**

  We will cover one 30-day supply (outpatient) or one 31-day supply (long-term care) of a particular drug, or less if your prescription is written for fewer days.

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

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan

or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

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

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells what to do.

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

Section 6.1 The Drug List can change during the year

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

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

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

Information on changes to drug coverage

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

Do changes to your drug coverage affect you right away?

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

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List.
    - We might not tell you in advance before we make that change—even if you are currently taking the brand name drug
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
    - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
    - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
    - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or add new restrictions to the brand name drug. We must give you at least 30 days' notice or give you a one month supply (30 day refill) of the drug you are taking at a network pharmacy.
    - During this 30-day period, you should be working with your prescriber to switch to a different drug that we cover.
    - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

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

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

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

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

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means neither our plan nor MassHealth (Medicaid) pays for these drugs.

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 8 Section 7.5 in this booklet.)

Here are three general rules about drugs that we will not cover:

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

Also, by law, the categories of drugs listed below are not covered:

- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

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

Section 8.1 Show your membership card

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

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

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

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

SECTION 9 Prescription drug coverage in special situations

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

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

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

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

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

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

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

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

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

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

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

Special note about 'creditable coverage':

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

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as MassHealth (Medicaid's) standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. You may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and

your prescriber have the right to ask us for an appeal. See Chapter 8 for information about how to ask for an appeal.

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

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

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

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

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

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

CHAPTER 6

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

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

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

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment

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

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

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

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

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

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

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

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

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

3. **If you are retroactively enrolled in our plan**

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

   If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork for us to handle the reimbursement. Please contact Member Services for additional information about how to ask

us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

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

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

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

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

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

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

Please see Section 3.1 (*How and where to send us your request for payment*) for instructions on how to submit a paper claim. When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to file an appeal.

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

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

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (*www.SeniorsGetMore.org*) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

For medical services:

Boston Medical Center HealthNet Plan Senior Care Options (SCO)
Attn: Member Services
529 Main Street Suite 500
Charlestown, MA 02129
Fax: 1-617-897-0884

For prescriptions:

Envision/Rx Options, Inc.
2181 East Aurora Road
Suite 201
Twinsburg, Ohio 44087

You must submit your claim to us within 1 year of the date you received the service, item, or drug.

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

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

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

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for the medical care or drug, you can file an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can file an appeal. If you file an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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

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

CHAPTER 7

Your rights and responsibilities

Chapter 7. *Your rights and responsibilities*

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

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Appeals and Grievance Department. You may also file a complaint directly with the Department of Health and Human Service's Office for Civil Rights. Contact information is included in this *Evidence of Coverage* or with this mailing, or you may contact our Member Services department for additional information.

Sección 1.1 Debemos proporcionar información de una manera que funcione para usted (en idiomas distintos al inglés, en Braille, en letra grande o en otros formatos alternativos, etc.)

Para obtener información sobre nosotros de un modo que sea conveniente para usted, llame a Servicios para Miembros (los números de teléfono se encuentran en la contraportada de este folleto).

Nuestro plan tiene personal y servicios de intérpretes gratuitos disponibles para responder las preguntas de los miembros que no hablan inglés. También podemos brindarle información en Braille, en letra grande o en otros formatos alternativos si lo necesita. Si es elegible para Medicare debido a una discapacidad, debemos brindarle información sobre los beneficios del plan que sea accesible y adecuada para usted. Para obtener información sobre nosotros de un modo que sea conveniente para usted, llame a Servicios para Miembros (los números de teléfono se encuentran en la contraportada de este folleto).

Si tiene problemas para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar una queja formal a nuestro Departamento de Quejas y Apelaciones. También puede presentar una queja directamente ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. La información de contacto se incluye en esta *Evidencia de Cobertura* o con este envío, o puede comunicarse con el Departamento de Servicios al Miembro para obtener información adicional.

Sección 1.1 Nós devemos fornecer informações de uma forma que funcione para você (em idiomas diferentes do inglês, em Braille, em caracteres grandes ou outros formatos alternativos, etc.)

Para obter informações da forma mais conveniente para você, ligue para o Serviço de Atendimento ao Membro (os números de telefone estão impressos na contracapa deste livreto).

Nosso plano tem pessoal e serviços de interpretação gratuitos disponíveis para responder às dúvidas de membros com deficiência e não falantes de inglês. Nós também podemos fornecer informações em Braille, em caracteres grandes ou outros formatos alternativos sem nenhum custo caso você precise. Nós precisamos lhe

dar as informações sobre os benefícios do plano em um formato que seja acessível e apropriado para você. Para obter informações da forma mais conveniente para você, ligue para o Serviço de Atendimento ao Membro (os números de telefone estão impressos na contracapa deste livreto) ou entre em contato com o nosso Coordenador de Direitos Civis.

Se você tiver problemas para obter as informações do nosso plano em um formato acessível e apropriado para você, ligue para apresentar uma queixa ao nosso Departamento de Recursos e Reclamações. Você também pode apresentar uma reclamação diretamente ao Escritório de Direitos Civis do Departamento de Saúde e Serviços Humanos. As informações de contato estão incluídas nesta *Prova de Cobertura* ou nesta correspondência, e você também pode entrar em contato com o nosso departamento de Serviço de Atendimento ao Membro para obter informações adicionais.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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

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

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

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

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

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

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members.
- **Information about our network providers including our network pharmacies.**
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the pharmacies in the plan's network, see the *Provider and Pharmacy Directory.*
    - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at *www.SeniorsGetMore.org*.

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

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

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

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

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

explanation, you will need to ask us for a coverage decision. Chapter 8 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

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

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicaid. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

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

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

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

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

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).

Section 1.9 How to get more information about your rights

You can get more information about your rights by calling Member Services**.** Phone numbers are printed on the back cover of this booklet.

Section 1.10 Mental Health Parity

Federal and state laws require that all managed care organizations, including Boston Medical Center HealthNet Plan Senior Care Options (SCO), provide behavioral health services to Plan members in the same way they provide physical health services. This is what is referred to as "parity." In general, this means that:

1. Boston Medical Center HealthNet Plan Senior Care Options (SCO) must provide the same level of benefits for any mental health and substance abuse (substance use disorder) problems you may have as for other physical problems you may have;
2. Boston Medical Center HealthNet Plan Senior Care Options (SCO) must have similar prior authorization requirements and treatment limitations for mental health and substance abuse (substance use disorders) services as it does for physical health services;
3. Boston Medical Center HealthNet Plan Senior Care Options (SCO) must provide you or your provider with the medical necessity criteria used by Boston Medical Center HealthNet Plan Senior Care Options (SCO) for prior authorization upon your or your provider's request; and

4. Boston Medical Center HealthNet Plan Senior Care Options (SCO) must also provide you, within a reasonable time frame, the reason for any denial of authorization for mental health or substance abuse (substance use disorders) services.

If you think that Boston Medical Center HealthNet Plan Senior Care Options (SCO) is not providing parity as explained above, you have the right to file a Grievance with Boston Medical Center HealthNet Plan Senior Care Options (SCO). For more information about Grievances and how to file them, please see Chapter 8 in this booklet.

You may also file a grievance with MassHealth. You can do this by calling the MassHealth Customer Service Center at 1-800-841-2900 (TTY/TDD: 1-800-497- 4648) Monday—Friday 8:00 a.m. to 5:00 p.m. For more information, please see 130 CMR 450.117(J).

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - Chapters 5 give the details about your coverage for prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
    - We are required to follow rules set by MassHealth (Medicaid) to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area.
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
    - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 8

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

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

BACKGROUND

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination" or "at-risk determination." It also uses abbreviations as little as possible.

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

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

Section 2.1 Where to get more information and personalized assistance

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

You can get help and information from Medicaid

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

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

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. To figure out which part of this chapter will help with your problem or concern, use this chart:

Is your problem or concern about your benefits or coverage?	
This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.	
Yes My problem is about benefits, coverage, or getting paid back.	**No** My problem is **not** about benefits, coverage, or getting paid back.
Go on to the next section of this chapter, **Section 4**, **"*A guide to the basics of coverage decisions and appeals*."**	Skip ahead to **Section 5**, **"*How to make a complaint about quality of care, waiting times, customer service, or other concerns*."**

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and filing appeals: the big picture

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

Asking for coverage decisions

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

Filing an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you file an appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

Section 4.2 How to get help when you are asking for a coverage decision or filing an appeal

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

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- **Your doctor can make a request for you.**
  - For medical care or prescription drugs, your doctor can request a coverage decision or file an appeal on your behalf.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or file an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. The form is available on our website at *https://www.seniorsgetmore.org/OurPlan/AppointingARepresentative*.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

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

- **Section 5** of this chapter: "*Your medical care: How to ask for a coverage decision or file an appeal*"
- **Section 5.4** of this chapter, **"***Your medical care: How to ask us to pay you back***"**
- **Section 7** of this chapter, **"***How to make a grievance about quality of care, waiting times, customer service, or other concerns***"**

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 5 Your medical care or prescription drugs: How to ask for a coverage decision or file an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or prescription drugs or if you want us to pay you back for your care

This section is about your benefits for medical care and services and prescription drugs. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

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

1. You are not getting certain medical care or prescription drugs you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care or prescription drugs your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services or prescription drugs that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services or prescription drugs that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care or prescription drugs you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.**Which of these situations are you in?**

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can file an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the prescription drugs or medical care coverage you want)

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

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

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care or prescription drugs you want

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

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

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 6 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision."

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a fast complaint about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 6 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care or prescription drugs *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care or prescription drugs you have already received.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
    - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 6 of this chapter.)

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

Deadlines for a fast coverage decision

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
    - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
    - If you believe we should *not* take extra days, you can file a fast complaint about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 6 of this chapter.)
    - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to file an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the prescription drug coverage or medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request.**
    - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
    - If you believe we should *not* take extra days, you can file a fast complaint about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 6 of this chapter.)
    - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to file an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by filing an appeal. Filing an appeal means making another try to get the medical care coverage you want.

Section 5.3 Step-by-step: How to file an Appeal (How to ask for a review of a medical care or prescription drug coverage decision made by our plan)

Legal Terms
A request to the plan about a medical care or prescription drug coverage decision is called a plan **"appeal."**

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

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are filing an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are filing an appeal about your medical care*).
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on our website at *www.SeniorsGetMore.org*.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are filing an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

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

Legal Terms
A "fast appeal" is also called an **"expedited appeal."**

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

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast" appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice with a detailed explanation as to why we said no. It will also tell you how you may file a next level appeal with the MassHealth Board of Hearings.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a grievance about our decision to take extra days. When you file a grievance, we will give you an answer to your grievance within 30 days. (For more information about the process for filing grievances, including fast grievances, see Section 6 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), the original determination by the plan is reversed and services must be provided.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice with a detailed explanation as to why we said no. It will also tell you how you may file a next level appeal with the MassHealth Board of Hearings.

Section 5.4 What if you are asking us to pay you back for a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 6 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 6 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

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

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.2 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Benefits Chart (what is covered)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your request or, if you haven't paid for the services, 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 medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can file an appeal**. If you file an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To file this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you file an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Board of Fair Hearings reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days.

SECTION 6 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

Section 6.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint."

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Complaint	Example
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and filing appeals is explained in sections 4-5 of this chapter. If you are asking for a decision or filing an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or filed an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have filed, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 6.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 6.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Contact Member Services at 1-855-833-8125 TTY/TDD: 711 Hours of operation: Friday, 8:00 a.m. – 8:00 p.m. (From October 1 to March 31, representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.*)*
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Here's how it works:**
  1. Our plan's Member Service staff person will log the complaint in our member database and track conversations that could be related to the complaint within the same log.
  2. If possible, the Member Services staff will try and resolve the complaint over the phone.
  3. You, your designated family member, or an authorized representative may participate in the discussion and offer suggestions or ideas toward resolving the problem or issue.
  4. If the complaint cannot be resolved over the phone, then a more formal process will take place. Solutions to a complaint will be based on what is in the member's best interest according to the plan's policy and procedure.
  5. 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.
  6. You or your authorized representative will receive a phone call (or letter if requested) from our plan with a response to the complaint within 3 calendar days of the decision but not later than 30 days from receipt of the grievance.
  7. If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours
  8. If you, or your authorized representative, agree to a solution within 30 calendar days, the complaint is resolved. Due to their nature, some complaints are not able to be resolved (for example: food at Adult Day Health was served cold). Our plan tracks and logs these complaints and looks to identify any repeated offenses and uses this information to inform the appropriate department (e.g.: the Provider Network Management Department or the Clinical Department) of claims of unsatisfactory services.
  9. 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 Department. To file a complaint to the plan, simply follow the steps described in this section.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

SECTION 7 Independent Review of Plan Decisions by the MassHealth Board of Hearings

If you are dissatisfied with the results of your internal appeal, you have the right to ask MassHealth to review our decision. This is called asking for afair hearing through the MassHealth (Medicaid) Board of Hearings appeal process. To pursue a MassHealth (Medicaid) Board of Hearings Appeal, MassHealth (Medicaid) must receive your request for a fair hearing no later than 120 calendar days from the mailing date of the written denial notice from Boston Medical Center HealthNet Plan Senior Care Options (SCO). We will provide information and instructive materials on the Board of Hearings appeals process in your internal appeal denial letter.

If your appeal was expedited (fast-tracked) during our plan's internal appeal process, the Board of Hearings must get your Fair Hearing request within 20 calendar days of the mailing date of Boston Medical Center HealthNet Plan Senior Care Options final written notice to you in order for your appeal to be expedited at the Board of Hearings. If the Board of Hearings gets your fair hearing request form between 21 and 120 calendar days of the mailing date of the plan's final written notice to you, the Board of Hearings will process your appeal using standard appeal times.

You may also continue receiving services that are the subject of your appeal, as long as the service was previously authorized and you submit your request for an Appeal to the Board of Hearings within ten (10) calendar days of receiving our decision on your appeal. Alternatively, you may choose not to continue to receive services during your appeal. Please note that should you continue to receive services during the Board of Hearings appeal process and the decision comes out against you, you may be liable for the cost of those services. If the Board of Hearings agrees with you, Boston Medical Center HealthNet Plan Senior Care Options (SCO) will cover your costs. The request for a Fair Hearing plus a copy of Boston Medical Center HealthNet Plan Senior Care Option's final denial notice must be sent to:

Division of Medical Assistance
Board of Hearings
100 Hancock Street, 6th Floor
Quincy, MA 02171
617-847-1200 or 1-800-655-0338
FAX: 617-847-1204

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

The Board of Hearings will review your appeal. After the Board of Hearings reviews our decision, if any of the services you requested are still denied, you will have further appeal rights. You will be notified of those appeal rights if this happens.

To get the "Fair Hearing Request Form" or for more information about your appeal rights, you may contact the Board of Hearings at 617-847-1200 or 1-800-655-0338. The form is available online at: *http://www.mass.gov/Eeohhs2/docs/masshealth/appforms/fair_hearing.pdf*

You may also contact Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Services for more information about your appeal rights or to request a copy of the MassHealth (Medicaid) Fair Hearing Request Form (phone numbers are on the back cover).

CHAPTER 9

Ending your membership in the plan

Chapter 9. *Ending your membership in the plan*

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Boston Medical Center HealthNet Plan Senior Care Options (SCO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
    - Section 2 tells you when you can end your membership in the plan. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You can end your membership in *Boston Medical Center HealthNet Plan Senior Care Options (SCO)* at any time.

- **When can you end your membership?** At any time of the year.
- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of health plans:
    - Another MassHealth (SCO) plan
    - A PACE plan
    - Original, or fee-for-service, MassHealth. Contact your State Medicaid Office, or MassOptions, to learn about your Medicaid plan options. Telephone numbers are in Chapter 2, *Important phone numbers and resources,* Section 2.1 of this booklet.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.
- **Where can you get more information about when you can end your membership?** If you have any questions or would like more information on when you can end your membership, you can call Member Services to request a disenrollment form. Phone numbers are printed in the back of this booklet.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our Plan, you simply enroll in another health plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this. Phone numbers are printed o in the back of this booklet; OR
- You can contact MassHealth Senior Care Options (SCO) for more information about enrollment: 1-888-885-0484 TTY/TDD: 1-888-821-5225.

SECTION 3 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Boston Medical Center HealthNet Plan Senior Care Options (SCO), it may take time before your membership ends and your new MassHealth (Medicaid) coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 4 Boston Medical Center HealthNet Plan Senior Care Options (SCO) must end your membership in the plan in certain situations

Section 4.1 When must we end your membership in the plan?

Boston Medical Center HealthNet Plan Senior Care Options (SCO) must end your membership in the plan if any of the following happen:

- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for MassHealth (Medicaid) Standard. If you lose your MassHealth (Medicaid) Standard coverage, Boston Medical Center HealthNet Plan Senior Care Options (SCO) will grant you one additional month of coverage with our plan beyond your loss of MassHealth (Medicaid) coverage. If you **do not** regain your MassHealth (Medicaid) coverage within that time period, your membership with Boston Medical Center HealthNet Plan Senior Care Options (SCO) will end.
- If you move out of our service area
- If you are away from our service area for more than six months
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison)
- If you are not a United States citizen or lawfully present in the United States
- If you lie about or withhold information about other health insurance you have

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)
    - If we end your membership because of this reason, MassHealth (Medicaid) may refer your case for investigation.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Boston Medical Center HealthNet Plan Senior Care Options (SCO) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call MassHealth: 1-888-885-04884 TTY/TDD: 1-888-821-5225. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 8, Section 6 for information about how to make a complaint.

CHAPTER 10

Legal notices

Chapter 10. *Legal notices*

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. One of the principal laws that applies to this document is Title XIX of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal and state laws may apply.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicaid plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you believe that *Boston Medical Center HealthNet Plan Senior Care Options (SCO)* has discriminated on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Boston Medical Center HealthNet Plan

Civil Rights Coordinator
529 Main Street, Suite 500
Charlestown, MA 02129

Phone: 877-957-1300 (TTY/TDD 711)
Fax: 617-897-0805

CHAPTER 11

Definitions of important words

Chapter 11. *Definitions of important words*

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you file if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also file an appeal if you disagree with our decision to stop services that you are receiving. For example, you may appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 8 explains appeals, including the process involved in filing an appeal.

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

Centers for Medicare and Medicaid Services (CMS) – The federal agency that administers Medicare and that administers Medicaid, in cooperation with state agencies.

Centralized Enrollee Record (CER): Centralized and comprehensive documentation, containing information relevant to maintaining and promoting each member's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions.

Complaint — The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 8 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

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

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage **(EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, or riders which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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

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

Grievance – A type of complaint you make about us, providers, or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible. A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

MassHealth Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Member (Member of our Plan, or "Plan Member") – A person with MassHealth (Medicaid) who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by MassHealth (Medicaid).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network: Our network is composed of our network providers and network pharmacies as defined in this section.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicaid and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 8 explains how to ask us for a coverage decision.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicaid health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization –Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Services

Method	Member Services – Contact Information
CALL	1-855-833-8125 Calls to this number are free. Representatives are available Monday – Friday 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available for non-English speakers.
TTY	711: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Member Services Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	1-617-897-0884
WRITE	Boston Medical Center HealthNet Plan Senior Care Options (SCO) Member Services Department 529 Main Street, Suite 500 Charlestown, MA 02129
WEBSITE	*www.SeniorsGetMore.org*
Method	**MassHealth (Medicaid) Customer Service—Contact Information**
CALL	1-800-841-2900 or 617-573-1770
TTY/TDD	1-800-497-4648 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth 55 Summer Street Boston, MA 02110
WEBSITE	*www.mass.gov/masshealth*