January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of NaviCare® HMO SNP, a Medicare HMO Special Needs Plan

This document gives you the details about your Medicare and MassHealth (Medicaid) health care, including over-the-counter drugs, long term care, and/or home- and community-based services, and prescription drug coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Enrollee Services at 1-877-700-6996. (TTY users should call TRS 711). Hours are 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31). This call is free.

This plan, NaviCare HMO SNP, is offered by Fallon Community Health Plan, Inc. (Fallon Health) (When this *Evidence of Coverage* says "we," "us," or "our," it means Fallon Community Health Plan, Inc. (Fallon Health). When it says "plan" or "our plan," it means NaviCare HMO SNP.)

Benefits may change on January 1, 2026.

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

Fallon Health is an HMO plan with a Medicare contract and a contract with the Massachusetts Medicaid program. Enrollment in Fallon Health depends on contract renewal. NaviCare is a voluntary program in association with MassHealth/EOHHS and CMS.

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

- Your plan premium and cost sharing (Note: NaviCare members have no costs for covered services);
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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2025 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in NaviCare HMO SNP, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and MassHealth (Medicaid):

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

You have chosen to get your Medicare and MassHealth (Medicaid) health care and your prescription drug coverage through our plan, NaviCare HMO SNP. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

NaviCare HMO SNP is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. NaviCare HMO SNP is designed for people who have Medicare and who are also entitled to assistance from MassHealth Standard (Medicaid).

Because you get assistance from MassHealth (Medicaid) with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. MassHealth (Medicaid) may also provide other benefits to you by covering health care services, over-the-counter and prescription drugs, long term care, and/or home- and community-based services that are not usually covered under Medicare. You will also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. NaviCare HMO SNP 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.

NaviCare HMO SNP is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Massachusetts' Medicaid program to coordinate your MassHealth (Medicaid) benefits. We are pleased to be providing your Medicare and MassHealth (Medicaid) health care coverage, including your prescription drug coverage, long term care, and/or home- and community-based services.

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

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

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

The words *coverage* and *covered services* refer to the medical care, long term care, and/or home- and community-based services, and the prescription drugs available to you as a member of NaviCare HMO SNP.

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how NaviCare HMO SNP 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 NaviCare HMO SNP between January 1, 2025 and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of NaviCare HMO SNP after December 31, 2025. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2025.

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

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain MassHealth (Medicaid) benefits. (MassHealth (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and MassHealth (Medicaid), and be age 65 or older. People who meet all other requirements but have MassHealth Standard (Medicaid) only are, eligible for NaviCare SCO. To be eligible for our plan you must also:

- not be subject to a six-month deductible period under 130 CMR 520.028: Eligibility for a Deductible;
- not be a resident of an intermediate care facility for the developmentally disabled;
- not be an inpatient in a chronic or rehabilitation hospital; and
- not be enrolled in or have access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 2-months, 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 MassHealth (Medicaid)?

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

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

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

Section 2.3 Here is the plan service area for NaviCare HMO SNP

NaviCare HMO SNP 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.

The NaviCare HMO SNP service area includes these counties in Massachusetts:

- Barnstable
- Berkshire
- Bristol
- Essex
- Franklin
- Hampden
- Hampshire
- Middlesex
- Norfolk
- Plymouth
- Suffolk
- Worcester

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

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Enrollee Services to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

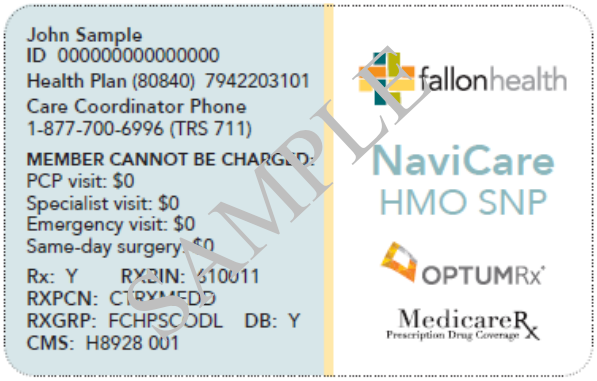
Section 2.4 U.S. Citizen or Lawful Presence

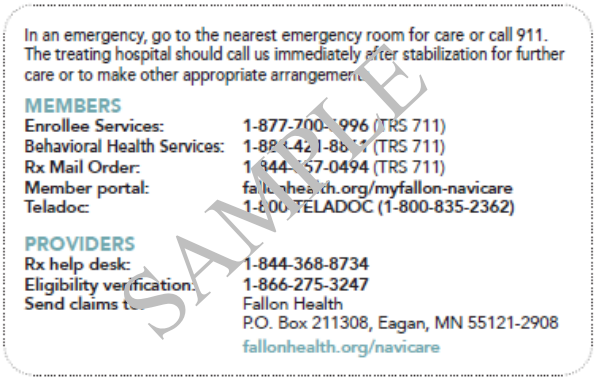
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify NaviCare HMO SNP if you are not eligible to remain a member on this basis. NaviCare HMO SNP must disenroll you if you do not meet this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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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





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

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

Section 3.2 Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists our current network providers, durable medical equipment suppliers, and pharmacies, including MassHealth (Medicaid) participating providers. **Network providers** are the doctors and other health care professionals, medical groups, 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. NOTE: NaviCare members have no costs for covered services.

You must use network providers to get your medical care and services. Your primary care provider (PCP) determines what specialists and hospitals you will use because they have affiliations with only certain specialists and hospitals in our network. Your PCP does not have access to all of the specialists and hospitals in our network. If you go elsewhere without proper authorization, you will have to pay in full. The only exceptions are emergencies, urgently needed

services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in network), out-of-area dialysis services, and cases in which NaviCare HMO SNP authorizes use of out-of-network providers.

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

If you don't have the *Provider and Pharmacy Directory*, you can get a copy from Enrollee Services. You can also find this information on our website at fallonhealth.org/navicare.

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in NaviCare HMO SNP. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the NaviCare HMO SNP 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 (fallonhealth.org/navicare) or call Enrollee Services.

SECTION 4 Your monthly costs for NaviCare HMO SNP (NaviCare members have no costs for covered services.)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

NOTE: NaviCare members have no costs for covered services.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for NaviCare HMO SNP.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

While NaviCare members do not have a separate premium for the plan, some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for MassHealth Standard (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most NaviCare HMO SNP members, MassHealth (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If MassHealth (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Part B. (You receive a $1.06 reduction of your monthly Part B premium. The premium reduction applies only to amounts you pay toward your Medicare Part B premium.) It may also include a premium for Part A, which affects members who aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

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

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

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs Health Administration (VA). Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2025, this average premium amount is $36.78.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $36.78, which equals $5.15. This rounds to $5.20. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- . After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

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

SECTION 5 More information about your monthly premium (NaviCare members have no plan premium other than Medicare premiums.)

Section 5.1 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1. Note that outside of any Medicare premiums, NaviCare HMO SNP members do not have a separate premium for the plan.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed. Or need to start paying a late enrollment penalty. This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year.

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose "Extra Help," you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

Your membership 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 or domestic partner's employer, workers' compensation, or MassHealth (Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Enrollee Services. You can also update your address and phone number online by going to fallonhealth.org/navicare and clicking on "MyFallon online tools" under "Member resources" to log into our secure member portal.

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

SECTION 7 How other insurance works with our plan

Other insurance

NOTE: As a NaviCare member, you can't be enrolled in another health insurance plan, except Medicare.

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical 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 Enrollee Services. 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.

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

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

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

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

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

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 NaviCare HMO SNP contacts (how to contact us, including how to reach Enrollee Services)

How to contact our plan's Enrollee Services

For assistance with claims, billing, or member card questions, please call or write to NaviCare HMO SNP Enrollee Services. We will be happy to help you.

Method	Enrollee Services – Contact Information
CALL	1-877-700-6996 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) Enrollee Services also has free language interpreter services available for multiple languages.
TTY	TRS 711 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31)
FAX	1-508-368-9013
WRITE	Fallon Health NaviCare Enrollee Services 1 Mercantile Street, Suite 400 Worcester, MA 01608
WEBSITE	fallonhealth.org/navicare

How to contact us when you are asking for a coverage decision or appeal about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-877-700-6996 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) After hours and on holidays, please leave a message and a representative will return your call on the next business day.
TTY	TRS 711 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) After hours and on holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-508-368-9700 for regular coverage decisions. 1-508-368-9133 for “fast” coverage decisions.
WRITE	Fallon Health NaviCare Enrollee Services 1 Mercantile Street, Suite 400 Worcester, MA 01608
WEBSITE	fallonhealth.org/navicare

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-844-657-0494 Calls to this number are free. If you need assistance, someone is available 24 hours a day, 7 days a week.
TTY	TRS 711 Calls to this number are free. If you need assistance, someone is available 24 hours a day, 7 days a week.
FAX	1-844-403-1028
WRITE	OptumRx Prior Authorization Department P.O. Box 2975 Mission, KS 66201
WEBSITE	fallonhealth.org/navicare

Method	Appeals for Medical Care or Part D prescription drugs – Contact Information
CALL	1-877-700-6996 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) After hours and on holidays, please leave a message and a representative will return your call on the next business day.
TTY	TRS 711 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) After hours and on holidays, please leave a message and a representative will return your call on the next business day.
FAX	1-508-755-7393
WRITE	Fallon Health Member Appeals and Grievances 1 Mercantile Street, Suite 400 Worcester, MA 01608
WEBSITE	fallonhealth.org/navicare

How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care or Part D Prescription Drugs – Contact Information
CALL	1-877-700-6996 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) "Fast" complaints can be made and are processed 24 hours a day, seven days a week by leaving a voice message at this number.
TTY	TRS 711 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) "Fast" complaints can be made and are processed 24 hours a day, 7 days a week by leaving a voice message at this number.
FAX	1-508-755-7393
WRITE	Fallon Health Member Appeals and Grievances 1 Mercantile Street, Suite 400 Worcester, MA 01608
MEDICARE WEBSITE	You can submit a complaint about NaviCare HMO SNP directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay the cost for medical care or a drug you have received (NaviCare members have no costs for covered services.)

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 6 (*Asking us to pay a bill you have received for covered medical services or drugs*).

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

Method	Payment Requests for Pharmacy Claims (what you get at the pharmacy) – Contact Information
WRITE	OptumRx Claims Department P.O. Box 650287 Dallas, TX 75265-0287
WEBSITE	optumrx.com

Method	Payment Requests for Medical Claims (what you get at your provider's office) – Contact Information
CALL	1-877-700-6996 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31)
TTY	TRS 711 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31)
WRITE	Fallon Health Member Reimbursement, Claims Department P.O. Box 211308 Eagan, MN 55121-2908
WEBSITE	fallonhealth.org/navicare

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

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in Massachusetts. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about NaviCare HMO SNP: • **Tell Medicare about your complaint:** You can submit a complaint about NaviCare HMO SNP directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page)
- Select **MASSACHUSETTS** from the list. This will take you to a page with phone numbers and resources specific to Massachusetts.

Method	SHINE Program (Massachusetts' SHIP) – Contact Information
CALL	1-800-243-4636
TTY	MassRelay 711 or 1-800-439-0183 (voice) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. TTY/ASCII: 1-800-439-2370
WRITE	SHINE Program Executive Office of Elder Affairs One Ashburton Place, 3rd floor Boston, MA 02108
WEBSITE	www.mass.gov/health-insurance-counseling

SECTION 4 Quality Improvement Organization

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

Acentra Health has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It is not connected with our plan.
You should contact Acentra Health in any of these situations:

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

Method	Acentra Health (Massachusetts' Quality Improvement Organization) – Contact Information
CALL	1-888-319-8452 Weekdays: 9 a.m.–5 p.m. Weekends and holidays: 10 a.m.–4 p.m.
TTY	711
WRITE	Acentra Health 5201 West Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	www.acentraqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 MassHealth (Medicaid)

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

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

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

If you have questions about the assistance you get from MassHealth (Medicaid), contact MassHealth (Medicaid). You can get information about MassHealth (Medicaid) from Area Agencies on Aging. For more information on how to contact Area Agencies on Aging see Section 10 of this chapter. In addition, because you are enrolled in both Medicare and MassHealth (Medicaid), you can also reach out to Medicare (see Section 2 of this chapter for contact information) with any questions.

Method	MassHealth (Massachusetts' Medicaid program) – Contact Information
CALL	MassHealth Customer Service Center 1-800-841-2900 Monday–Friday, 8 a.m.–5 p.m.
TTY	711
WRITE	Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780
WEBSITE	www.mass.gov/masshealth

MassOptions is a free resource that connects elders, individuals with disabilities and their caregivers with information on plan choices that can best meet their needs.

Method	MassOptions – Contact Information
CALL	MassOptions 1-800-243-4636 Monday–Friday, 9 a.m.–5 p.m.
TTY	TRS 711
WEBSITE	www.massoptions.org

The *My Ombudsman* program helps people enrolled in MassHealth (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan. *My Ombudsman* is an independent organization that helps individuals, including their families and caregivers, address concerns or questions that may impact their experience with a MassHealth health plan or their ability to access their health plan benefits and services. *My Ombudsman* works with the member, MassHealth (Medicaid), and each MassHealth (Medicaid) health plan to help resolve concerns to ensure that members receive their benefits and exercise their rights within their health plan.

Method	My Ombudsman – Contact Information
CALL	1-855-781-9898 Monday–Friday, 9 a.m.–4 p.m.
TTY	TRS 711
WRITE	My Ombudsman 25 Kingston St., 4th floor Boston, MA 02111
WEBSITE	www.myombudsman.org

The *LTC Ombudsman Program* helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

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

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

The Medicare.gov website (https://www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Because you are eligible for MassHealth Standard (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this "Extra Help."

If you have questions about "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Massachusetts' MassHealth (Medicaid) Office (See Section 6 of this chapter for contact information).

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

- Please contact Enrollee Services if you need assistance with obtaining best available evidence and for providing this evidence.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Enrollee Services if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance for critical HIV-related medications for residents of the Commonwealth of Massachusetts who are otherwise unable to obtain these life-saving drugs.

Note: To be eligible for the ADAP operating in Massachusetts, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-228-2714.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 9 You can get assistance from Area Agencies on Aging.

Area Agencies on Aging (AAAs) are organizations that provide assistance and services to seniors. Services vary among agencies, and may include home care, home-delivered meals, transportation, housing information and assistance, case management, and adult day health care. AAAs provide information and referrals related to caregiving, aging-related medical conditions, legal services, support groups, and other services available to seniors.

AgeSpan
Main Office: 280 Merrimack St., Suite 400, Lawrence, MA 01843

- Call: 1-800-892-0890. TTY: 1-800-924-4222.
- www.agespan.org

Aging Services of North Central Massachusetts
680 Mechanic St., Suite 120, Leominster, MA 01453
- Call: 1-800-734-7312. TTY: 711.
- www.agingservicesma.org

Boston Senior Home Care
Lincoln Plaza, 89 South St., Suite 501, Boston, MA 02111
- Call: 1-617-451-6400. TTY: 1-617-451-6404.
- www.bostonseniorhomecare.info

Bristol Elder Services, Inc.
1 Father DeValles Blvd., Unit 8, Fall River, MA 02723
- Call: 1-508-675-2101. TTY: 711.
- www.bristolelder.org

Central Boston Elder Services, Inc.
2315 Washington St., Boston, MA 02119
- Call: 1-617-277-7416. TTY: 1-844-495-7400.
- www.centralboston.org

Coastline Elderly Services, Inc.
863 Belleville Ave., New Bedford, MA 02745
- Call: 1-866-274-1643. TDD: 1-508-994-4265.
- www.coastlinenb.org

Elder Services of Berkshire County, Inc.
Main Office: 877 South St., Suite 4E, Pittsfield, MA 01201
- Call: 1-800-544-5242. TTY: 1-413-344-4372.
- www.esbci.org

Elder Services of Cape Cod and the Islands, Inc.
Main Office: 68 Route 134, South Dennis, MA 02660
- Call: 1-800-244-4630. TTY: 1-508-394-3712.
- www.escci.org

Elder Services of Worcester Area, Inc.
67 Millbrook St., Suite 100, Worcester, MA 01606
- Call: 1-800-243-5111. TTY: 711.
- www.eswa.org

Ethos
555 Amory St., Jamaica Plain, MA 02130
- Call: 1-617-522-6700. TDD: 1-617-524-2687.
- www.ethocare.org

Greater Lynn Senior Services, Inc.
8 Silsbee St., Lynn, MA 01901
- Call: 1-800-594-5164. TTY: 1-844-580-1926.
- www.glss.net

Greater Springfield Senior Services, Inc.
66 Industry Ave., Suite 9, Springfield, MA 01104
- Call: 1-800-649-3641. TTY: 1-413-733-1335.
- www.gsssi.org

Health and Social Services Consortium, Inc. (HESSCO)
545 South St., Suite 300, Walpole, MA 02081
- Call: 1-781-784-4944. TTY: 711.
- www.hessco.org

Highland Valley Elder Services, Inc.
320 Riverside Drive, Suite B, Florence, MA 01062
- Call: 1-413-586-2000 TTY: 711.
- www.highlandvalley.org

LifePath, Inc.
101 Munson St., Suite 201, Greenfield, MA 01301
- Call: 1-800-732-4636. TDD: 1-413-772-6566.
- www.lifepathma.org

Minuteman Senior Services
One Burlington Woods Drive, Suite 101, Burlington, MA 01803
- Call: 1-888-222-6171. TYY: 1-800-439-2370.
- www.minutemansenior.org

Mystic Valley Elder Services, Inc.
300 Commercial St., #19, Malden, MA 02148
- Call: 1-781-324-7705. TTY: 1-781-321-8880.
- www.mves.org

Old Colony Elder Services
144 Main St., Brockton, MA 02301
- Call: 1-508-584-1561. TTY: 1-508-587-0280.
- www.ocesma.org

SeniorCare Inc.
Main Office: 49 Blackburn Center, Gloucester, MA 01930
- Call: 1-866-927-1050. TTY: 1-978-282-1836.
- www.seniorcareinc.org

Somerville/Cambridge Elder Services, Inc.
61 Medford St., Somerville, MA 02143

- Call: 1-617-628-2601. TDD: 1-617-628-1705.
- www.eldercare.org

South Shore Elder Services, Inc.
350 Granite St., Suite 2303, Braintree, MA 02184

- Call: 1-781-848-3910. TDD: 1-781-356-1992.
- www.sselder.org

Springwell (formerly BayPath Elder Services)
33 Boston Post Road West, Suite 500, Marlborough, MA 01752

- Call: 1-508-573-7200. TTY: 1-617-923-1562.
- www.springwell.com

Springwell
307 Waverley Oaks Rd., Suite 205, Waltham, MA 02452

- Call: 1-617-926-4100. TTY: 1-617-923-1562.
- www.springwell.com

Tri-Valley, Inc.
10 Mill St., Dudley, MA 01571

- Call: 1-800-286-6640. TDD: 1-508-949-6654.
- www.trivalleyinc.org

WestMass ElderCare, Inc.
4 Valley Mill Rd, Holyoke, MA 01040

- Call: 1-800-462-2301. TTY: 1-800-875-0287.
- www.wmeldercare.org

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

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

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

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

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other 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 equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare and MassHealth Standard (Medicaid) health plan, NaviCare HMO SNP must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare. See the benefits chart in the next chapter, Chapter 4 *(Benefits Chart, what is covered).*

NaviCare HMO SNP will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of 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. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare or MassHealth (Medicaid) requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Authorization must be obtained from the plan prior to seeking care from an out-of-network provider. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

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

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

Your PCP is a provider who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). **There are only a few types of covered services you may get on your own without contacting your PCP first for a referral.** These services are listed in Section 2.2, below.

Your PCP determines what specialists and hospitals you will use because they have affiliations with only certain specialists and hospitals in our network. Your PCP does not have access to all of the specialists and hospitals in our network.

Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as member of our plan. This includes:

- Your x-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Outpatient hospital services
- Hospital admissions
- Follow-up care

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us**.**

Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 7 tells you how we will protect the privacy of your medical records and personal health information.

Once you are enrolled in NaviCare HMO SNP, your Primary Care Team, together with you and anyone else you choose to have involved (such as a family member), will construct an Individualized Plan of Care (IPC), also known as your care plan, designed just for you.

Your PCP is responsible for:

- Contributing to your IPC at time of program enrollment and ongoing
- Providing overall clinical direction
- Providing primary medical services, including acute and preventive care
- Referring you to specialty providers as medically appropriate
- Documenting and complying with advanced directives about your wishes for future treatment and health care decisions

Your PCP works with your NaviCare Primary Care Team

Your Primary Care Team (PCT), which may include but is not limited to your primary care provider (PCP), Navigator, nurse case manager, geriatric support services coordinator, or behavioral health case manager, will work with you to develop your IPC and to ensure you receive the care you need. A nurse with access to your care plan is available 24/7.

Your primary care provider is responsible for coordinating all your medical care and for ordering additional medical specialists, if necessary.

Your IPC includes all of the supportive services and benefits that your PCT has authorized for you to receive as a member of NaviCare HMO SNP.

To ensure that you are receiving the most appropriate care at all times, your PCT reviews, approves, and authorizes changes to your IPC, whether adding, changing, or discontinuing services. Your PCT reassesses your needs at least every 6 months, and more frequently if necessary.

How do you choose your PCP?

You may search for a PCP by looking in the *Provider and Pharmacy Directory,* visiting fallonhealth.org/navicare, or by calling Enrollee Services for assistance. If there is a particular specialist or hospital that you want to use, check first to be sure that your PCP makes referrals to that specialist or uses that hospital. Once you have chosen a PCP, you must notify Enrollee Services of your choice either by phone (number is printed on the back cover of this document) or by going online to fallonhealth.org/navicare (click on "MyFallon online tools" under "Member resources"). If you don't select a PCP, we will choose one for 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. In addition, if you change your PCP, the change in your PCP may result in being limited to specific specialists or hospitals to which that PCP refers, see Section 2.3 below for more information.

To change your PCP, follow the same steps as choosing a PCP, above. If you call, be sure to tell Enrollee Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and certain durable medical equipment). Enrollee Services will check to be sure the PCP you want to switch to is accepting new patients. Enrollee Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. We will also send you a letter confirming the change.

Section 2.2 What kinds of medical care and other services can you get without a referral 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 (or vaccines), COVID-19 vaccinations, and pneumonia vaccinations as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are plan-covered services, which are services requiring immediate medical attention that are not emergencies, provided when you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Enrollee Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- Acupuncture services with a plan provider through the 20th visit. For acupuncture services to be covered beyond 20 visits, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.
- Chiropractic services with a plan provider
- Preventive dental care provided by a plan network dentist. For diagnostic services, endodontics, adjunctive general services, restorative services, prosthodontic services (fixed and removable), periodontics, implants and related services, and oral and maxillofacial surgery (with the exception of the removal or exposure of impacted teeth) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. Authorization requests must be sent directly by your treating network dental provider to the plan's dental benefit administrator, DentaQuest, for review.
- Inpatient services in a psychiatric hospital
- Outpatient behavioral health care. For Transcranial Magnetic Stimulation Therapy (TMS), Electro-Convulsive Therapy (ECT), and Intensive Outpatient Therapy (IOP) to

be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.

- Opioid treatment services
- Outpatient substance use disorder services
- Outpatient hospital observation
- Outpatient physical therapy with a plan provider through the 60th visit. For physical therapy to be covered beyond 60 visits, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.
- Outpatient occupational therapy with a plan provider through the 60th visit. For occupational therapy to be covered beyond 60 visits, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.
- Outpatient speech language therapy with a plan provider through the 35th visit. For speech language therapy to be covered beyond the first 35 visits, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.
- Medicare-covered preventive services as long as you get them from a plan provider
- Fallon Health's Additional Tobacco and Smoking Cessation Program
- Nursing hotline
- Routine eye exams as long as you get them from a plan provider

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

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care that we explained earlier in this section). **If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.**

If a specialist feels you need additional specialty services, the specialist will ask for authorization directly from Fallon Health.

For some types of referrals, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization").

Prior authorization may be needed for certain services (please see Chapter 4 for information about which services require prior authorization). Authorization can be obtained from the plan.

You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, 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.

If you do not have an advanced determination, authorization can also be obtained from a network provider who refers an enrollee to a specialist outside the plan's network for a service; provided that service is not explicitly always excluded from plan coverage as discussed in Chapter 4.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals because they have affiliations with only certain specialists and hospitals in our network. Your PCP does not have access to all of the specialists and hospitals in our network. This means that the PCP you select may determine the specialists you can see. You may generally change your PCP at any time if you want to see a plan specialist that your current PCP can't refer you to. Please refer to the "Changing your PCP" section above, where we tell you how to change your PCP. If there are specific hospitals you want to use, you must find out whether the doctors you will be seeing use these hospitals.

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.

- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. For out-of-network services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 8.

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

You may get services from out-of-network providers when providers of specialized services are not available in network. For services to be covered from an out-of-network provider, your in-network provider (usually your PCP) must request prior authorization (approval in advance) from NaviCare HMO SNP. The prior authorization request will be reviewed by Fallon Health's Utilization Management Program staff that are trained to understand the specialist's area of expertise and will attempt to ascertain if that service is available within NaviCare HMO SNP's network of specialists. If the service is not available within your plan's network, your request will be approved. There may be certain limitations to the approval, such as just one initial consultation visit or a specified type or amount of services. If the specialist's services are available within your plan's network, the request for services outside the network may be denied as "services available in network." As with any denial, you will have the ability to appeal the determination.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition), routine care/visits, and/or elective procedures are not covered.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the world, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Enrollee Services (phone numbers are printed on the back cover of this document) to notify us of your emergency.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. Although Medicare does not provide coverage for emergency medical care outside the United States and its territories, our plan covers these services worldwide.

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 doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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 3.3 below).

Section 3.2 What to do if you have a behavioral health emergency

In a behavioral health emergency, you should go to the nearest emergency room. You will be evaluated by a crisis team that will assist in finding you an appropriate facility for care. No prior authorization is required for this type of emergency within the U.S. and its territories. To learn more, see the Medical Benefits Chart in Chapter 4, Section 2.1.

You can also contact a Community Behavioral Health Center (CBHC) at 1-877-382-1609. Listen to the message, and enter your zip code. Your call will be automatically transferred to the CBHC closest to you. CBHCs also include the following services:

1. Adult Mobile Crisis Intervention (AMCI) – provides mobile responses for adult community-based behavioral health crisis assessment, intervention, stabilization and follow-up for up to three days. AMCI services are available 24 hours a day, 7 days a week. Services are provided by trained professionals who can travel to your location or work with you at a CBHC. Instead of going to the ER, AMCI services allow anyone going through a crisis to either walk into a CBHC or call for a team to come to their location and access immediate behavioral health care. Services may also be provided via telehealth when requested by the member or directed by the 24/7 Massachusetts Behavioral Health Help Line (1-833-773-2445) and clinically appropriate.
2. Community crisis stabilization (CCS) – offers a less restrictive alternative to inpatient hospitalization for people in need of short-term, overnight crisis care. Services include treatment; crisis intervention and stabilization; and future crisis prevention planning. These services are available 24 hours a day, 7 days a week.

You can find a CBHC near you at https://www.mass.gov/doc/list-of-cbhcs/download.

Section 3.3 Getting care when you have an urgent need for services

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

To access urgently needed services you should go to the nearest urgent care center that is open. If you are seeking urgent care in our service area, you should look in the *Provider and Pharmacy Directory* for a listing of the urgent care centers in your plan's network.

Although Medicare does not provide coverage for urgent care services outside the United States and its territories, our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition), routine care/visits, and/or elective procedures are not covered.

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.

Section 3.4 Getting care during a disaster

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

Please visit the following website: fallonhealth.org/navicare for information on how to obtain needed care during a disaster.

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

SECTION 4 What if you are billed directly for the full cost of your services? (NaviCare members have no costs for 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?

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

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. These costs will not count toward your out-of-pocket maximum.

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. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

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

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

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

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

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical 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. This benefit is provided only for Part A inpatient services (non-medical health care services).

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

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

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

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

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

  You are covered for an unlimited number of days.

SECTION 7 Rules for ownership of durable medical equipment

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

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 you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of NaviCare HMO SNP, however, you will acquire ownership of rented DME items after 10 consecutive months while a member of our

plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will not transfer ownership of the DME item to you. Call Enrollee Services for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will own the item only after 10 consecutive months as a member of our plan.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage NaviCare HMO SNP will cover:

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

If you leave NaviCare HMO SNP or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what is covered)

SECTION 1 Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of NaviCare HMO SNP. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 You pay nothing for your covered services

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

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

Section 2.1 Your medical as a member of the plan

The Medical Benefits Chart on the following pages lists the services NaviCare HMO SNP. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and MassHealth (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and MassHealth (Medicaid).
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.
- Some of the services listed in the Medical 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 Medical Benefits Chart in italics.

- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- You are covered by both Medicare and MassHealth (Medicaid). Medicare covers health care and prescription drugs. MassHealth (Medicaid) covers your cost sharing for Medicare services, including coinsurance and deductibles. MassHealth (Medicaid) also covers services Medicare does not cover, like long-term care, over-the-counter drugs, and home- and community-based services. NOTE: As a NaviCare member, you can't be enrolled in another health insurance plan, except Medicare.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.
- Because you get assistance from MassHealth (Medicaid), you pay nothing for your covered services as long as you follow the plan's rules for getting your care. (See Chapter 3 for more information about the plan's rules for getting your care.) Under our agreement with MassHealth (Medicaid), our plan also provides additional benefits to you as approved in your Individualized Care Plan. Our plan covers health care services, including but not limited to long-term care, home- and community-based services, dental care, and some prescription drugs that are not usually covered under Medicare. The plan will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to. All these benefits are listed in the Benefits Chart below.
- If you are within our plan's 2-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will continue to cover MassHealth (Medicaid) benefits that are included under MassHealth Standard (Medicaid), but we will not pay the Medicare premiums or costs for which the state would otherwise be liable had you not lost your MassHealth Standard (Medicaid) eligibility.

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

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed by a plan provider with the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for special supplemental benefits for the chronically ill. The diagnosis must be on file and recorded with Fallon Health prior to receiving Special Supplemental Benefits for the Chronically Ill. Not all members qualify.
    - Chronic alcohol and other drug dependence
    - Autoimmune disorders
    - Cancer
    - Cardiovascular disorders
    - Chronic heart failure
    - Chronic and disabling mental health conditions
    - Chronic lung disorders
    - Dementia
    - Diabetes
    - End-stage liver disease
    - End-stage renal disease
    - Severe hematologic disorders
    - HIV/AIDs
    - Neurologic disorders
    - Stroke

Eligibility related to Special Supplemental Benefits for the Chronically Ill (SSBCI) is determined at the discretion of the Plan. Benefits are available to members who are identified via the receipt of provider documentation (e.g., a provider submitted claim) that includes a qualifying chronic condition, have a high risk of hospitalization or other adverse health outcomes, and whose care is being coordinated by a NaviCare navigator or network provider. Upon validation that eligibility criteria have been met, Fallon Health will notify you of your enrollment in these benefits. These benefits are not retrospective.

- Please go to the *Special Supplemental Benefits for the Chronically Ill* row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.

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

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture *For acupuncture beyond the 20th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Medicare only covers acupuncture for chronic low back pain (see below in chart). MassHealth (Medicaid)-covered services include services to treat outpatient substance use disorder. For more information, see Outpatient substance use disorder in this chart. NaviCare HMO SNP covers the following supplemental acupuncture services: up to 20 visits without prior authorization for any diagnosis including electrical stimulation, infrared and ultrasound services.	You pay $0 for MassHealth (Medicaid)-covered acupuncture and the supplemental acupuncture.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); and • not associated with surgery. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	You pay a $0 copayment for Medicare-covered acupuncture services to treat chronic low back pain

Services that are covered for you	**What you must pay** when you get these services
Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Adult Day Health *For adult day health to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* A day program for those who are eligible where an organized program of nursing services and supervision, assistance with activities of daily living (such as eating, toileting, exercising, and taking medications), maintenance-therapy services, therapeutic, recreation, nutrition at a site outside the home, dementia-specific interaction, and transportation to a site outside the home are provided following MassHealth Adult Day Health Program regulations.	You pay $0 for MassHealth (Medicaid)-covered adult day health services.
Adult Foster Care *For adult foster care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Services include assistance with activities of daily living (such as bathing, dressing, eating, shopping, laundry, snacks,	You pay $0 for MassHealth (Medicaid)-covered adult foster care services.

Services that are covered for you	**What you must pay** when you get these services
and meal preparation), other personal care as needed, managing medication, medical transportation, and supervision from a MassHealth (Medicaid)-approved adult foster care or group adult foster care provider following MassHealth Adult Foster Care regulations. Medical oversight, teaching and training for the care provider, and care management is provided by the Adult Foster Care provider following MassHealth Adult Foster Care regulations.	
Ambulance services *For non-emergency ambulance services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* NaviCare HMO SNP covers ambulance (air and land), taxi and chairvan transport under the MassHealth (Medicaid) benefit. Coverage is worldwide. Covered ambulance services, whether for an emergency or non-emergency situation, 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. If the covered ambulance services are not for an emergency situation, it should be 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.	You pay $0 for Medicare- or MassHealth (Medicaid)-covered ambulance services.
Annual physical exam The covered supplemental annual physical exam includes a detailed medical/family history and a thorough head to toe assessment with hands-on examination of all the body systems to assess overall general health and detect abnormalities or signs that could indicate a disease process that should be addressed.	You pay $0 for the covered supplemental annual physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Services that are covered for you	**What you must pay** when you get these services
Note: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	
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.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
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 referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	There is no coinsurance copayment, or deductible for Medicare- and MassHealth (Medicaid)-covered cardiac or intensive cardiac rehabilitation services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). MassHealth (Medicaid) covers additional blood tests when medically necessary.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. You pay $0 for MassHealth (Medicaid)-covered additional blood tests.
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 MassHealth (Medicaid) covers additional Pap tests and pelvic exams when medically necessary.	There is no coinsurance, copayment, or deductible for Medicare- and MassHealth (Medicaid)-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation • MassHealth (Medicaid) covers chiropractic manipulative treatment and radiology services.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered office visit for chiropractic services.
Chore services *For chore services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture.	You pay $0 for MassHealth (Medicaid)-covered chore services.
Colorectal cancer screening The following screening tests are covered:	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal

Services that are covered for you	**What you must pay** when you get these services
• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	cancer screening exam, including barium enemas. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. There is no copayment, deductible, or coinsurance for a covered diagnostic exam.
Community-based services (In-home care) *For community-based services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Before you receive community-based services, you must first discuss these services with your Primary Care Team.	You pay $0 for MassHealth (Medicaid)-covered community-based services.

Services that are covered for you	**What you must pay** when you get these services
These services will be provided following MassHealth regulations and guidelines. Services include but are not limited to: • Companion services • Complex Care Training and Oversight • Consumer Directed Care • Environmental Accessibility Adaptations (Home Modification) • Evidence Based Educational Programs • Goal Engagement Programs • Grocery shopping and delivery • Habilitation Therapy • Homemaker services • Home delivered meals • Home Delivered Prepackaged Medications • Home Safety Independence Evaluations • Laundry service • Medication Dispensing System • Orientation & Mobility Services • Personal care services • Personal Emergency Response System (PERS) • Peer Support • Respite care • Supportive Home Care Aide • Transitional Assistance • Translation/Interpreting Services • Wander Response System	
Continuous nursing services *For continuous nursing services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Continuous, specialized skilled nursing services or skilled nursing for more than two continuous hours per day provided in the home in accordance with MassHealth Continuous Nursing Services regulations.	You pay $0 for MassHealth (Medicaid)-covered continuous nursing services.
Day habilitation *For day habilitation services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	You pay $0 for MassHealth (Medicaid)-covered day habilitation services.

Services that are covered for you	**What you must pay** when you get these services
A structured, goal-oriented, active treatment program of medically oriented, therapeutic and habilitation services for developmentally disabled individuals who need active treatment, following MassHealth Program regulations.	
Dementia day care *For dementia day care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Specialized services to address the needs of members with Alzheimer's Disease, other dementias or related disorders. The services assist in the maximization of the member's functional capacity and in the reduction of disruptive behavior.	You pay $0 for MassHealth (Medicaid)-covered dementia day care services.
Dental services *For diagnostic services, endodontics, adjunctive general services, restorative services, prosthodontic services (fixed and removable), periodontics, implants and related services, and oral and maxillofacial surgery (with the exception of the removal or exposure of impacted teeth) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. Authorization requests must be sent directly by your treating network dental provider to the plan's dental benefit administrator, DentaQuest, for review.* **Limitations to covered services are listed below.** In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, NaviCare HMO SNP covers these dental services under the MassHealth (Medicaid) benefit: • Preventive/diagnostic:	You pay $0 for Medicare- and MassHealth (Medicaid)-covered and supplemental dental services. Services must be performed by a DentaQuest provider. Limitations may apply. For more information, contact Enrollee Services.

Services that are covered for you	**What you must pay** when you get these services
○ Comprehensive oral evaluations (New patient or full periodontal visit) ○ Periodic oral evaluations (Routine or problem-focused visit) ○ Regular dental cleanings • Restorative: ○ Amalgam and resin-based composite fillings • Oral and maxillofacial surgery: ○ Extractions (removal of teeth) ○ Biopsy and soft tissue surgery ○ Alveoplasty ○ Bone grafting • Adjunctive general services: ○ Sedation and anesthesia ○ Cleaning and inspection of removable dentures – partial and complete • Emergency medical care, such as to relieve pain or stop bleeding as a result of injury to the sound natural teeth or tissue, provided in the office of a physician or dentist as soon as possible after the injury. This does not include restorative or other dental care. Go to the nearest provider, you do not need a referral from your PCP. • Topical fluoride treatment (for individuals who have medical or dental conditions that significantly interrupt the flow of saliva) • Other services, including oral screenings for members undergoing radiation treatment or chemotherapy; palliative treatment of dental pain or infection; occlusal guards; and facility calls. Additional NaviCare-covered supplemental services include: • Diagnostic services ○ Cleanings (Prophylaxis) ○ Bitewing X-rays • Endodontic therapy: ○ Root canal therapy, anterior, premolar, molar root canals, pulpal regeneration, and apicoectomy • Restorative: ○ Crowns, cores, inlays, onlays, and posts, reinforcing pins and crown repair	

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

• Prosthodontic services (fixed):
  o Pontic – porcelain or resin, and crowns, inlays, onlays, crowns and retainer, recement or rebond fixed partial denture
• Prosthodontic services (removable):
  o Complete, immediate, overdenture, and partial dentures (upper and lower)
  o Relines and adjustments of complete dentures
  o Repair, replace teeth, rebase, soft liner, tissue conditioning, metal substructure
• Periodontics:
  o Gingivectomy/gingivoplasty
  o Scaling and root planning
  o Periodontal maintenance
• Implant services:
  o Implant placement, abutment, implant supported crown, retainer, removable or fixed denture
These services below are covered without prior authorization:
• Comprehensive and periodic oral evaluations and X-rays
• Regular dental cleanings and fluoride
• Restorative fillings
• Complete dentures and relines (after 6 months of initial placement)
• Partial dentures and relines (after 6 months of initial placement)
• Non-surgical periodontal services (cleanings and maintenance)
• Non-surgical extractions
• Emergency care
The following frequency limitations apply. *This list is not a guarantee of coverage*.
• Preventive oral exams, cleanings and fluoride are covered 2 times per calendar year.
• Comprehensive oral evaluation, or new patient exam, is covered once every 36 months.
• Periodic Oral Evaluation are covered 2 per calendar year.	

Services that are covered for you	**What you must pay** when you get these services
• Bitewing X-rays are covered 1 time per calendar year. • Vertical bitewings, panoramic, and intraoral tomosynthesis radiographic images have a shared frequency limit of 1 per every 3 calendar years. • Intraoral periapical radiographic images are covered up to 8 per calendar year. • Cone beam CT capture and interpretation, and panoramic radiographic image capture are covered once every 36 months. • Amalgam and resin-based composite restorative services are covered once per tooth per surface every 36 months. • Endodontics are covered 1 per tooth per lifetime. • Gingivectomy/gingivoplasty is covered once per quadrant per 36 months. • Periodontal scaling and root planing are covered once per 24 months. • Complete, immediate, and partial dentures are covered once every 60 months. • Denture adjustments, recement or rebond of fixed partial dentures are covered once every 60 months. • Denture teeth repair or replacement are covered 3 every 60 months. • Denture repair: replacement of all teeth, rebasing, relining, soft liner, and metal substructure is covered once every 12 months. • Crowns and bridges are covered once per tooth/site every 60 months. • Implants and related services are covered for a maximum of 4 implants per calendar year. • Implants are covered once per tooth/site per 60 months. Benefit limitations apply for dental services; other limitations may apply. Services requiring medical necessity review will be determined by a licensed dental consultant.	

Services that are covered for you	**What you must pay** when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies *For more than five test strips per day, non-preferred brand blood glucose monitors and supplies, those with adaptive features and any continuous glucose monitors and supplies (both preferred and non-preferred) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* 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. o Our preferred blood glucose monitors are OneTouch® glucose monitors and test strips (up to five test strips per day) manufactured by LifeScan. Plan members can obtain a One Touch® glucose monitor at network pharmacies, by calling LifeScan at 1-877-356-8480 (TTY: 711), order code number 160FCH002, or by going to the LifeScan	You pay $0 for Medicare- and MassHealth (Medicaid)-covered diabetes self-management training, diabetic services and supplies.

Services that are covered for you	**What you must pay** when you get these services
website, www.onetouch.orderpoints.com and entering brochure code 160FCH002. o Our preferred continuous blood glucose monitors are Freestyle Libre monitors and supplies. Members may obtain Freestyle Libre at network pharmacies. Products other than FreeStyle Libre will only be covered upon documentation of failure of FreeStyle Libre or other reason why it cannot be medically used. o Members with a demonstrated need, including having a severe visual impairment or impaired manual dexterity, may require a blood glucose monitor with adaptive features, such as an integrated voice synthesizer or integrated lancing device. • 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 conditions. • As needed, for persons at risk of diabetes: Fasting plasma glucose tests. **Note:** Syringes and insulin (unless used with an insulin pump) are covered under the outpatient prescription drug benefit.	
Durable medical equipment (DME) and related supplies *For certain durable medical equipment and related supplies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* (For a definition of durable medical equipment, see Chapter 11 as well as Chapter 3, Section 7 of this document.) Medicare-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	You pay $0 for Medicare- and MassHealth (Medicaid)-covered durable medical equipment and related supplies. You pay $0 for Medicare oxygen equipment.

Services that are covered for you	**What you must pay** when you get these services
home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. MassHealth (Medicaid) covers certain additional supplies and equipment. MassHealth (Medicaid)-covered supplies include, but are not limited to: • Assistive/adaptive technology • Environmental aids • Home-Based Wandering Response • Incontinence supplies • Nutritional supplements • PAP therapy • Personal Emergency Response Systems (PERS) • Tub and shower grab bars We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer (except for blood glucose monitors), you may ask them if they can special order it for you. The most recent list of brands, manufacturers, and suppliers is also available on our website at fallonhealth.org/navicare. For information on blood glucose monitor coverage, see the "Diabetes self-management training, diabetic services and supplies" section above. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 8, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*) NaviCare HMO SNP covers a seat lift chair once per lifetime up to $900. You pay all charges over the $900 plan coverage limit.	You pay $0 up to $900 for a seat lift recliner chair once per lifetime. You pay all charges over the $900 plan coverage limit. Note: If you are a patient in an institution, or distinct part of an institution which provides the services described in Social Security Act, Section 1819(a)(1) or Section 1819(e)(1), you are not entitled to coverage for the rental or purchase of durable medical equipment because such an institution may not be considered your home. Facilities that are not considered a home include but are not limited to a skilled nursing facility (SNF), or a distinct part of a SNF.
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.	You pay $0 for each Medicare- and MassHealth (Medicaid)-covered emergency room visit in-network and out-of-network. If you receive

Services that are covered for you	**What you must pay** when you get these services
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. Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition), routine care/visits, and/or elective procedures are not covered.	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.
Geriatric Support Services Coordination In-home assessment and home-based services coordination provided by Aging Service Access Points (ASAPs) staff.	You pay $0 for MassHealth (Medicaid)-covered geriatric support services coordination.

Services that are covered for you	**What you must pay** when you get these services
Group Adult Foster Care *For group adult foster care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Group Adult Foster Care (GAFC) includes personal care services up to 2-hours per day 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 following MassHealth Adult Foster Care regulations.	You pay $0 for MassHealth (Medicaid)-covered group adult foster care services.
Health and wellness education programs **Membership in Health Club/Fitness Classes** • Coverage of up to $400 for a new fitness tracker, new cardiovascular fitness equipment and/or a membership in a qualified health club or fitness facility and/or covered instructional fitness classes. **Nutritional Benefit** • Unlimited group or individual nutritional therapy counseling is available to all members when provided by a registered dietician or other nutrition professional in the network. **Health Education** • A communication that is filled with information to help keep you well. • Health/wellness education classes – Members must receive services from network providers. • Case Management and Disease Case Management programs are available for members with chronic conditions such as diabetes, chronic obstructive pulmonary disease, coronary artery disease and asthma. • An Infusion Drug program is available for members with infusion drug therapies to help ensure that infusion drugs are administered in the most appropriate and convenient setting for the member. For more information on any of these health and wellness education programs, call Enrollee Services at the number on the back cover of this document.	You pay $0 for: • Up to $400 for a new fitness tracker, new cardiovascular fitness equipment and/or a membership in a qualified health club or fitness facility • Nutritional Benefit • Newsletter • Health/wellness education classes • Case Management and Disease Case Management programs • Infusion Drug program

Services that are covered for you	**What you must pay** when you get these services
Hearing services *For audiology services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* 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. NaviCare HMO SNP covers the following hearing services under the MassHealth (Medicaid) benefit. • Routine hearing exams • Diagnostic services • One hearing aid per ear, either one binaural or two monaural, every floating 60 months per MassHealth guidelines • Services related to the care and maintenance of hearing aid(s) • Hearing aid batteries • Hearing aids or instruments	You pay $0 for each Medicare- and MassHealth (Medicaid)-covered hearing services.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care *For home health agency care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home	You pay $0 for Medicare- and MassHealth (Medicaid)-covered home health visits according to MassHealth regulations.

Services that are covered for you	**What you must pay** when you get these services
health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). • Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Some drugs may be covered under Medicare Part D.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered home infusion therapy.
Hospice care 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. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice 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	You pay $0. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not NaviCare HMO SNP.

Services that are covered for you	**What you must pay** when you get these services
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by NaviCare HMO SNP but are not covered by Medicare Part A or B: NaviCare HMO SNP will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. Note: NaviCare members have no costs for covered services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 (*What if you're in Medicare-certified hospice*).	

Services that are covered for you	**What you must pay** when you get these services
Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations *For Hepatitis B vaccines to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. You pay $0 for covered immunizations.
In-home support services Services include but are not limited to assisting members with: ADL/IADL tasks such as providing technical assistance with accessing healthcare information via computer, smartphone and online programs, provider appointment and healthcare screening reminders.	You pay $0 for up to 60 hours of services per calendar year. You pay all costs for services after 60 hours per calendar year.
Inpatient hospital care *For inpatient hospital care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	You pay $0 for Medicare- and MassHealth (Medicaid)-covered inpatient admissions.

Services that are covered for you	**What you must pay** when you get these services
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. Medicare covers up to 90 days in an acute care hospital each benefit period. This includes behavioral health, substance use disorder services, and rehabilitation services. MassHealth (Medicaid) covers your inpatient hospital stay beyond the 90-day limit as medically necessary. See Chapter 11 for an explanation of "benefit period." 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 • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern 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.	If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, you pay of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If NaviCare HMO SNP $0.

Services that are covered for you	**What you must pay** when you get these services
• Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital *For inpatient services in a psychiatric hospital to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include behavioral health care services that require a hospital stay. Medicare covers up to 190 days of inpatient psychiatric hospital care during your lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric health services provided in a psychiatric unit of a general hospital. MassHealth (Medicaid) covers your inpatient stay in a psychiatric hospital beyond the Medicare limit.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered inpatient services in a psychiatric hospital.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay *For the below services in an acute hospital or skilled nursing facility (SNF) to be covered when the admission has been denied or the day limit has been reached, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	You pay $0 for Medicare- and MassHealth (Medicaid)-covered inpatient services (when the hospital or SNF days are not or are no longer covered).

Services that are covered for you	**What you must pay** when you get these services
As described above, the plan covers up to unlimited days per benefit period for inpatient hospital care and up to 100 days per benefit period for skilled nursing facility (SNF) care. You are covered for up to 90 days of care in each benefit period in an inpatient rehabilitation facility or rehabilitation unit of an acute care hospital. If you exceed the 90-day limit in a benefit period, you may use your lifetime reserve days for additional coverage. Once you have reached these coverage limits, the plan will no longer cover your stay in the hospital or SNF. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	

Services that are covered for you	**What you must pay** when you get these services
Institutional Custodial Care *For institutional care services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Services such as nursing, assistance with activities of daily living, therapies, nutrition, and drugs and biologicals provided during stays in a licensed skilled nursing facility, if not covered by Medicare. MassHealth (Medicaid) Patient Paid Amount financial responsibility may apply. Services are covered in accordance with the MassHealth Nursing Facility regulations.	You pay $0 for MassHealth (Medicaid)-covered institutional custodial care services.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year. MassHealth (Medicaid) may cover medical nutrition therapy for members who do not meet the Medicare criteria. Additional NaviCare-covered services include: Three total visits of supplemental one-on-one medical nutrition therapy counseling each year for all members (Medicare-covered and non-Medicare-covered diagnoses). Members must receive services from a registered dietician or other nutrition professional in the network.	There is no coinsurance, copayment, or deductible for members eligible for Medicare- and MassHealth (Medicaid)-covered medical nutrition therapy services.

Services that are covered for you	**What you must pay** when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs *For certain Medicare Part B prescription drugs to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *Certain Part B drugs, including some anti-emetics, anti-inflammatories and chemotherapy may be subject to Part B step therapy. You can find a list of those drugs at the link below.* Part B drugs can be filled for up to a 90-day supply. These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia	You pay $0 for Part B covered prescription drugs. You pay $0 for primary care provider or specialist office visits to administer Part B covered prescription drugs.

Services that are covered for you	**What you must pay** when you get these services
• Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn’t cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they’re administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics	

Services that are covered for you	**What you must pay** when you get these services
• Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://fallonhealth.org/en/find-insurance/navicare/covered-medications.aspx. We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered.	
🍎 **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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable)	You pay $0 for each Medicare-covered opioid use disorder treatment services visit.

Services that are covered for you	**What you must pay** when you get these services
• Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	
Outpatient behavioral health care *For Transcranial Magnetic Stimulation Therapy (TMS), Electro-Convulsive Therapy (ECT), and Intensive Outpatient Therapy (IOP) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: Behavioral health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified behavioral health care professional as allowed under applicable state laws. MassHealth (Medicaid)-covered services include: • Diversionary services, such as: – Observation – Community support services – Crisis assessment, intervention and stabilization – Psychiatric day treatment • Behavioral health emergency services • Medication management services • Day treatment • Residential programs	You pay $0 for each Medicare- and MassHealth (Medicaid)-covered individual or group therapy visit with or without a psychiatrist.
Outpatient diagnostic tests and therapeutic services and supplies *For CT scans, PET scans, MRIs, nuclear studies, proton beam therapy, intensity modulated radiation of the breast, hyperbaric oxygen therapy, genetic testing, lab tests, and sleep studies (polysomnography) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	You pay $0 for Medicare- and MassHealth (Medicaid)-covered outpatient diagnostic tests and therapeutic services and supplies.

Services that are covered for you	**What you must pay** when you get these services
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 begins with the first pint of blood that you need. • Other outpatient diagnostic tests, such as INR testing.	
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered outpatient hospital observation services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services *For outpatient hospital services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Behavioral 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 and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered outpatient hospital services.
Outpatient rehabilitation services *For physical therapy visits beyond the 60th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.*	You pay $0 for each Medicare- and MassHealth (Medicaid)-covered physical, occupational

Services that are covered for you	**What you must pay** when you get these services
For occupational therapy visits beyond the 60th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. *For speech language therapy visits beyond the 35th visit to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). NaviCare HMO SNP covers additional outpatient rehabilitation services under the MassHealth (Medicaid) benefit.	or speech language therapy visit.
Outpatient substance use disorder services Medicare-covered outpatient substance use disorder treatment services are covered when provided in a clinic or hospital outpatient by a psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, and physician assistant department. Covered services include, but are not limited to: • Psychotherapy • Member education regarding diagnosis and treatment MassHealth (Medicaid) covers additional services including: • Acupuncture ○ Coverage includes unlimited treatments with a network acupuncturist. • Methadone maintenance • Structured Outpatient Addiction Program • Clinical Support Services • Adult Residential Rehabilitation Services • Program of Assertive Community Treatment (PACT) • Community support services • Crisis assessment, intervention and stabilization	You pay $0 for Medicare- and MassHealth (Medicaid)-covered individual or group therapy visits. You pay $0 for MassHealth (Medicaid)-covered acupuncture.

Services that are covered for you	**What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *For outpatient surgery to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* NaviCare HMO SNP covers additional outpatient services under the MassHealth (Medicaid) benefit. **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	You pay $0 for each Medicare- and MassHealth (Medicaid)-covered outpatient surgery in an ambulatory surgical center or hospital outpatient facility.
Over-the-Counter items (Save Now card to purchase certain Medicare approved over-the-counter (OTC) items and healthy food) This benefit is covered by the plan under the Medicare and MassHealth (Medicaid) benefits. You receive a NaviCare Save Now card with $275 in credits that are applied at the beginning of each calendar quarter (every three months) to purchase NaviCare-approved OTC items like first aid supplies, toothbrushes, COVID-19 tests and cold/allergy medicine without a prescription. Credits are loaded on the first day of each quarter (in January, April, July and October) and expire on the last day of each quarter (March 31, June 30, September 30 and December 31). • **Members without chronic illness** can only use the Save Now card towards the purchase of NaviCare-approved OTC items. **Members with certain chronic illnesses** can use a portion of the quarterly OTC allowance on the Save Now card for the purchase of NaviCare approved food products at OTC network retailers. Please see the *Special Supplemental Benefits for the Chronically Ill* section below for more information. Chronic diseases are generally conditions that	You pay $0 for MassHealth (Medicaid)-covered over-the-counter items. Using the Save Now card, you pay $0 for: • approved over-the-counter items, up to $275 every quarter. You pay all costs over $275 per quarter. Any unused balances at the end of each calendar quarter will not roll over into the following quarter.

Services that are covered for you	**What you must pay** when you get these services
require ongoing medical attention or limit activities of daily living. The condition is diagnosed by a licensed medical professional, including your primary care provider and similar providers, and be on file and recorded with NaviCare prior to receiving these benefits. Purchases can be made with the Save Now card for members with a qualifying, documented chronic condition, have a high risk of hospitalization or other adverse health outcomes, and whose care is being coordinated by a NaviCare navigator or network provider. Not all members with an eligible condition will qualify. • NaviCare-approved OTC items and/or foods can only be purchased at in-network retailers. For a list of in-network retailers in your area or with questions regarding your Save Now card, visit fallonhealth.org/myfallon-navicare and log into MyFallon. Then, click Save Now under the My Resources menu or contact Enrollee Services. • For more information about OTC drugs covered under the MassHealth (Medicaid) benefit, see the Over-the-Counter and Additional MassHealth Covered Drugs List at fallonhealth.org/navicare. • Prior authorization is not required for covered NaviCare approved OTC and/or food items purchased from a network retailer. • You must treat the card like cash. Any unused or stolen funds are not rolled over or replaced. • Card can only be used for qualified purchases indicated by NaviCare, anywhere Mastercard debit cards are accepted. Card is issued by Bancorp Bank, pursuant to a license from Mastercard International. Please contact Enrollee Services directly for a full list of qualified purchases. Mastercard is a registered trademark of Mastercard International. All other trademarks and service marks belong to their respective owners. No cash or ATM access. Terms and conditions apply, contact Enrollee Services for details. • You should pay for all covered items and services by using your Save Now card, but you may pay out-of-	

Services that are covered for you	**What you must pay** when you get these services
pocket and then request reimbursement for the covered items and services. Save Now reimbursement requests must be received by Fallon Health no later than March 31 of the following year. For more information on situations in which you may need to ask us for reimbursement, see Chapter 2. Important phone numbers and resources. When you swipe your Save Now card, the cost of all eligible items will automatically be deducted up to the remaining balance on your card. You will be responsible for the costs of all items that are not eligible and/or for the costs of eligible items that exceed your remaining balance at the time of purchase. To keep track of your card balance and easily find participating retailers, visit fallonhealth.org/myfallon-navicare and log into MyFallon. Then, click Save Now under the My Resources menu.	
Partial hospitalization services and Intensive outpatient services *For partial hospitalization and intensive outpatient services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community behavioral health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community behavioral health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered partial hospitalization services and intensive outpatient services.

Services that are covered for you	**What you must pay** when you get these services
Personal Care Attendant (PCA) Services *For PCA services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Hands-on assistance with two or more Activities of Daily Living (ADLs) such as bathing, dressing, grooming, eating, ambulating, toileting, and transferring following MassHealth PCA Program Regulations including use of Electronic Visit Verification (EVV) for electronically verifying delivery of PCA services.	You pay $0 for MassHealth (Medicaid)-covered PCA services.
Pharmacy Coverage of certain over-the-counter drugs (drugs for which no prescription is required by federal or state law; sometimes referred to as non-legend drugs), as listed on the *NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List*. MassHealth (Medicaid) and NaviCare HMO SNP require a prescription for both drugs and certain over-the-counter drugs.	You pay $0 for MassHealth (Medicaid)-covered pharmacy services.
Physician/Practitioner services, including doctor's office visits *For some outpatient services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. For more information, see Chapter 3.* *For reconstructive surgery to be covered, your PCP or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: • Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment	You pay $0 for each Medicare- and MassHealth (Medicaid)-covered primary care doctor visit. You pay $0 for each Medicare- and MassHealth (Medicaid)-covered specialist doctor visit. You pay $0 for each MassHealth (Medicaid)-covered diagnostic hearing exam. You pay $0 for Medicare- and MassHealth (Medicaid)-covered dental benefits. You pay $0 for the cost of each Medicare- and

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

• Certain telehealth services, including: primary care; specialist care; outpatient behavioral health services; opioid treatment and outpatient substance use disorder services.
  o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.
  o Covered telehealth services are limited to those that involve both an audio and video component and must be done in real-time over a secure communication method administered by your provider. These services can replace some in-person visits to your provider.
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location
• Telehealth services for members with a substance use disorder or co-occurring behavioral health disorder, regardless of their location
• Telehealth services for diagnosis, evaluation, and treatment of behavioral health disorders if:
  o You have an in-person visit within 6 months prior to your first telehealth visit
  o You have an in-person visit every 12 months while receiving these telehealth services
  o Exceptions can be made to the above for certain circumstances
• Telehealth services for behavioral health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  o You're not a new patient **and**
	MassHealth (Medicaid)-covered visit via telehealth.
	You pay $0 for the cost of each Medicare- and MassHealth (Medicaid)-covered outpatient hospital facility or ambulatory surgical center visit.

Services that are covered for you	**What you must pay** when you get these services
○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ○ You're not a new patient **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Reconstructive surgery ○ Surgery for post-mastectomy patients for reconstruction of the breast on which the mastectomy was performed. ○ Surgery and reconstruction of the other breast to produce a symmetrical appearance. ○ Treatment of any physical complications resulting from the mastectomy including lymphedema.	

Services that are covered for you	**What you must pay** when you get these services
Podiatry services *For podiatry services in a nursing home and podiatric surgery to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs The plan also covers podiatric care, including routine foot care, not covered by Medicare under the MassHealth (Medicaid) benefit.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered podiatry visits. You pay $0 for MassHealth (Medicaid)-covered routine podiatry visits.
Post-discharge in-home medication reconciliation Following discharge from a hospital or SNF, a member may receive a review of the pre- and post-discharge medication regimen to reduce negative side effects and interactions that may result in injury or illness. A Nurse Case Manager or other qualified network health care provider will conduct the reconciliation.	You pay $0 for covered post-discharge in-home medication reconciliation.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test and digital rectal exam.

Services that are covered for you	**What you must pay** when you get these services
Prosthetic and orthotic devices and related supplies *For prosthetic devices and related supplies to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* NaviCare HMO SNP covers additional prosthetic devices and medical supplies related to prosthetics, splints, and other devices under the MassHealth (Medicaid) benefit. Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered prosthetic devices and related supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered pulmonary rehabilitation services.
Readmission prevention Following discharge home from a hospital or SNF, a member may receive a telephonic or in home post discharge care transition assessment and intervention(s) conducted by a Nurse Case Manager, including but not limited to member health and medication education, arranging follow-up care, and/or facilitation of in-home services.	You pay $0 for covered readmission prevention.
Remote access technology services (Nursing hotline) Phone and online access to registered nurses and other health care professionals who serve as health coaches and are available 24 hours a day, 7 days a week.	There is no copayment for covered nursing hotline services.

Services that are covered for you	**What you must pay** when you get these services
Remote access technology services (Web/phone-based technologies) Covered services include telephone evaluation and management services provided by physicians, including primary and specialty care physicians, and other qualified health care professionals, including physician assistants, nurse practitioners, and clinical nurse specialists.	There is no copayment for covered web/phone-based technology services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	**What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months. We also cover up to two 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
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 six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	You pay $0 for Medicare- and MassHealth (Medicaid)-covered services to treat kidney disease and conditions.

Services that are covered for you	**What you must pay** when you get these services
• Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section **Medicare Part B prescription drugs**.	
Skilled nursing facility (SNF) care *For skilled nursing facility care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* (For a definition of skilled nursing facility care, see Chapter 11 of this document. Skilled nursing facilities are sometimes called SNFs.) 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 begins with the first pint of blood that you need. • 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 pay $0 for Medicare- and MassHealth (Medicaid)-covered skilled nursing facility admissions.

Services that are covered for you	**What you must pay** when you get these services
you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	

Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.
If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.
MassHealth (Medicaid)-covered services include:
• Face-to-face individual and group tobacco cessation counseling
• Pharmacotherapy treatment
  ○ nicotine patches
  ○ gum
  ○ lozenges
Fallon Health's Additional Supplemental Tobacco and Smoking Cessation – One-on-one telephone-based coaching offered by certified tobacco treatment counselors from our smoking cessation program, Quit to Win.
	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
	You pay $0 for MassHealth (Medicaid)-covered services.
	You pay $0 for Fallon Health's Additional Supplemental Smoking Cessation, Quit to Win.

Services that are covered for you	**What you must pay** when you get these services
Special Supplemental Benefits for the Chronically Ill Enrollees with chronic condition(s) that meet certain criteria may be eligible for supplemental benefits for the chronically ill. Chronic diseases are generally conditions that require ongoing medical attention or limit activities of daily living. The condition is diagnosed by a licensed medical professional, including your primary care physician, nurse practitioner and similar providers. Qualifying members will have access to $100 of the OTC funds per calendar quarter through their Save Now card for healthy food and produce items at network retailers. Chronic conditions include: Autoimmune disorders, cancer, cardiovascular disorders, chronic alcohol and other drug dependence, chronic heart failure, chronic and disabling behavioral health conditions, chronic lung disorders, dementia, diabetes, end-stage liver disease, end-stage renal disease, severe hematologic disorders, HIV/AIDS, neurologic disorders, and stroke. This is not a complete list of eligible chronic conditions. Not all members with an eligible condition will qualify. Other eligibility and coverage criteria also apply.	With the Save Now card, eligible members will pay $0 and receive: • An allowance of up to $100 per calendar quarter from the Save Now OTC funds to purchase Fallon Health-approved food and produce at network retailers. • You pay all costs over $100 per calendar quarter. Any unused balances at the end of each calendar quarter will not roll over into the following quarter.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). 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	There is no copayment for Medicare-covered Supervised Exercise Therapy (SET).

Services that are covered for you	**What you must pay** when you get these services
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.	
Transportation (non-emergent medical) *For ambulance transportation (non-emergent) to be covered, you, your doctor or other plan provider must get prior authorization (approval in advance) from 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. Necessary taxi, and chair car transport for medical reasons, within the Commonwealth of Massachusetts. Additionally, the plan will reimburse friends or family designated by the member for qualified non-emergent medical transportation mileage. Transportation, including friends and family reimbursements, must be coordinated and arranged during Fallon's business hours by calling the plan's transportation vendor. We suggest making these arrangements at least 2 business days in advance.	You pay $0 for MassHealth (Medicaid)-covered non-emergent medical trips.
Transportation (non-emergent non-medical) *For ambulance transportation (non-emergent, non-medical) to be covered, you, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Plan will cover up to a total of 130 one-way trips per year by ambulance when authorized as medically necessary, van/chairvan, rideshare services or taxi to locations such as the grocery store or religious services. Transports are limited to up to a 30-mile radius from the member's pick-up location based upon the plan's transportation vendor system. Additionally, the plan will reimburse friends or family designated by the member for qualified non-emergent non-medical transportation mileage noted above based upon the plan's transportation vendor calculation. Reimbursements will only be made per ride, regardless of the number of	You pay $0 for up to 130 MassHealth (Medicaid)-covered one-way transports per year.

Services that are covered for you	**What you must pay** when you get these services
eligible members in the vehicle traveling to the same or different location. Transportation, including friends and family reimbursements, must be coordinated and arranged during Fallon's business hours by calling the plan's transportation vendor. We suggest making these arrangements at least 2 business days in advance.	
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition), routine care/visits, and/or elective procedures are not covered.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered urgent care visits.
Vision care Covered services include: Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't	You pay $0 for Medicare- and MassHealth (Medicaid)-covered vision care services, including low vision aids.

Services that are covered for you	**What you must pay** when you get these services
cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • 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.) MassHealth (Medicaid)-covered services include: • Routine vision exams • Contact lenses and one set of glasses per year • Fitting adjustment or repair of glasses Additional NaviCare covered-services include: • Two new pairs of eyeglasses, contacts, new lenses, new frames, and/or upgrades up to the $403 plan coverage limit per calendar year. Items must be purchased from an EyeMed network provider. You pay all charges over $403. The following exclusions apply: o Store promotions or coupons o The one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery o Two pairs of glasses in lieu of bifocals o Non-prescription lenses and/or contact lenses o Non-prescription sunglasses	You pay $0 for supplemental eyewear up to $403. There is a $403 plan coverage limit for supplemental eyewear per calendar year. You pay all charges over $403 each year.

Services that are covered for you	**What you must pay** when you get these services
Welcome to Medicare preventive visit The plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.
Wigs For members who suffer hair loss as a result of the treatment for any form of cancer or leukemia, wigs are covered up to the $400 plan coverage limit per calendar year. You pay all charges over $400.	You pay $0 for Medicare- and MassHealth (Medicaid)-covered wigs. You pay $0 for covered wigs up to $400. There is a $400 plan coverage limit for covered wigs per calendar year. You pay all charges over $400 each year.

SECTION 3 What services are not covered by the plan

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

This section tells you what services are excluded.

The chart below describes some services and items that aren't covered by the plan under any conditions or are covered by the plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 8, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture	**Tui Na and Oriental massage therapy services**	Covered by Medicare for people with chronic low back pain under certain circumstances. See Benefit Chart above. Covered as part of our plan under the MassHealth (Medicaid) benefit.
All services, procedures, treatments, medications and supplies related to Workers' Compensation claims.	**Not covered under any condition**	
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		Covered as part of our plan under the MassHealth (Medicaid) benefit.
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and behavioral performance), except when medically necessary.	**Not covered under any condition**	
Environmental Accessibility Adaptations (Home modifications)		Covered as part of our plan under the MassHealth (Medicaid) benefit
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.		Fees associated with the personal attendant program or adult foster care program are covered as part of our plan under the MassHealth (Medicaid) benefit, following MassHealth Program regulations.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home.		Covered as part of our plan under the MassHealth (Medicaid) benefit in accordance with the Continuous Nursing Services Guidelines and MassHealth criteria.
Functional medicine services/ procedures and supplies (including labs and supplements). Functional medicine includes alternative, holistic, and naturopathic medicine.	**Not covered under any condition**	
Health services for treatment of military service-related disabilities provided by the Military Health Services System (including CHAMPUS or TRICARE) under which the federal government agrees to pay for the services and supplies.	**Not covered under any condition**	
Health services received as a result of war or any act of war that occurs during the member's term of coverage under this Evidence of Coverage.	**Not covered under any condition**	
Home-delivered meals		Covered as part of our plan under the MassHealth (Medicaid) benefit.
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		Covered as part of our plan under the MassHealth (Medicaid) benefit.
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-routine dental care		Covered as part of our plan under the MassHealth (Medicaid) benefit. Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. Also covered as part of our plan under the MassHealth (Medicaid) benefit.
Personal care services not covered by Medicare or MassHealth (Medicaid), including babysitting, recreation, supervision, verbal prompting or cueing, or vocational training.	**Not covered under any condition**	
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Physical examinations or immunizations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes and/or other non-preventive reasons.	**Not covered under any condition**	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered. Additional chiropractic care services are covered as part of our plan under the MassHealth (Medicaid) benefit.
Routine dental care, such as cleanings, fillings or dentures.		Routine dental care is covered as part of our plan under the MassHealth (Medicaid) benefit.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. MassHealth (Medicaid) benefits and additional supplemental plan coverage for routine eye exams, glasses, contact lenses are covered by the plan, subject to limits.
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). May also be covered as part of our plan under the MassHealth (Medicaid) benefit.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		Covered as part of our plan under the MassHealth (Medicaid) benefit.
Self-referral to providers outside of the plan's network		Emergency care, urgent care and out-of-area dialysis.
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**	
Services provided to veterans in Veterans Health Administration (VA) facilities.		When emergency services are received at a VA hospital, we will reimburse veterans for the VA costs.
Services that you get from non-plan providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
temporarily outside the NaviCare HMO SNP service area, and care from non-plan providers that is arranged with prior authorization from NaviCare HMO SNP.		
Transportation to appointments for someone other than the member.	**Not covered under any condition**	

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs and over-the-counter (OTC) drugs

How can you get information about your drug costs?

Because you are eligible for MassHealth Standard (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.**

SECTION 1 Introduction

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

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth (Medicaid) benefits. The *NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List* tells you which drugs are covered (with a prescription) under your MassHealth Standard (Medicaid) drug coverage.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter.) Or you can fill your prescription 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 in this chapter.)
- 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 references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 in this chapter for more information about restrictions on your coverage.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

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

You may go to any of our network pharmacies.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Enrollee Services or use the *Provider and Pharmacy Directory*. You can also find information on our website at fallonhealth.org/navicare.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy, which may be covered when:
  - Our plan has approved your prescription for your home infusion therapy,
  - Your prescription is written by an authorized prescriber, and
  - You get your home infusion services from a plan network pharmacy.

  Please refer to your *Provider and Pharmacy Directory* to find a home infusion pharmacy provider in your area. For more information, please contact Enrollee Services.

- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Enrollee 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. To locate a specialized pharmacy, look in your *Provider and Pharmacy Directory* (fallonhealth.org/navicare) or call Enrollee Services.

Section 2.3 Using the plan's mail-order service

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

Our plan's mail-order service allows you to order **up to a 100-day supply.**

To get order forms and information about filling your prescriptions by mail call Enrollee Services (phone numbers are listed on the back cover of this document).

Usually, a mail-order pharmacy order will be delivered to you in no more than 10-15 days. If the mail-order pharmacy expects a delay of more than 10 days, we will contact you and help you decide whether to wait for the medication, cancel the mail order, or fill the prescription at a local pharmacy. If you need to request a rush order due to mail-order delay, you may contact Enrollee Services (phone numbers are printed on the back cover of this document) to discuss options that may include filling at a local retail pharmacy or expediting the shipment method. Provide the representative with your ID number and prescription number(s). If you want second day or next day delivery of your medications, you may request this from the customer care representative for an additional charge.

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by calling 1-844-657-0494 (TRS 711). If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 1-844-657-0494 (TRS 711).

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 7-10 business days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling 1-844-657-0494 (TRS 711).

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

The plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* (fallonhealth.org/navicare) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Enrollee Services for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Enrollee Services** to see if there is a network pharmacy nearby. 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.

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

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- Any in-network drug management programs, such as prior authorization and quantity limits, apply to out-of-network purchases. Out-of-network pharmacies must be in the United States and its territories.

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. NaviCare members have no costs for covered services. You can ask us to reimburse you (Chapter 6, Section 2 explains how to ask the plan to pay you back.)

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

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

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your MassHealth (Medicaid) benefits. The *NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List* tells you which drugs are covered (with a prescription) under your MassHealth Standard (Medicaid) drug coverage.

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

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 11 for definitions of the types of drugs that may be on the "Drug List.

What is *not* on the "Drug List"?

The drugs covered under your MassHealth Standard (Medicaid) drug coverage are not included on the Drug List. To find out which drugs are covered (with a prescription) under your MassHealth Standard (Medicaid) drug coverage, refer to the *NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List*.

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more information about this, see Section 7.1 in this chapter.)

- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the Drug List. (For more information, please see Chapter 8.)

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

You have four ways to find out:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (fallonhealth.org/navicare). The Drug List on the website is always the most current.
3. Call Enrollee Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
4. Check the most recent *NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List* we provided electronically.

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

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 What kinds of restrictions?

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Enrollee 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.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

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

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

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. **If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.**

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

If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an **exception** and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

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

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

- **If you are a new member,** we will cover a temporary supply of your drug during the first **108 days** of your membership in the plan**.**
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first **108 days** of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 108 days and reside in a long-term care facility and need a supply right away:**

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those members who have been admitted or discharged from a long-term care facility:**

  If needed, we will cover an early refill on your medications.

For questions about a temporary supply, call Enrollee Services.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Enrollee Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

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

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

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

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

See Chapter 11 for definitions of the drug types discussed in this chapter.

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. This section describes the types of changes we may make to the Drug List and when you will get direct notice if changes were made for a drug that you are taking.

Changes we may make to the Drug List that affect you during the current plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be with the same or fewer restrictions.
    - We will make these immediate changes only if we are adding a new generic version of a brand name or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be with the same or fewer restrictions.
    - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We will tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**

  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.

- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 8.

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

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

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

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

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

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

Section 7.1 Types of drugs we do not cover

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

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

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories, unless administered by a qualified provider in an emergency or urgent care setting to stabilize an emergency medical condition.Our plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *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.

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your MassHealth Standard (Medicaid) drug coverage; refer to the NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List on fallonhealth.org/navicare.

- Non-prescription drugs (also called over-the-counter drugs), unless listed on our NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List
- Drugs used for the relief of cough or cold symptoms, unless prescribed and covered under our OTC benefit
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations, unless prescribed and covered under our OTC benefit
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss (unless listed on our NaviCare SCO and NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List), 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 Filling a prescription

Section 8.1 Provide your membership information

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

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

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment 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 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

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

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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

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

Check your *Provider and Pharmacy Directory* (fallonhealth.org/navicare) to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Enrollee Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

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

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

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

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

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 8 for information about how to ask for an appeal.

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

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

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

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. NOTE: NaviCare members have no costs for covered services. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Enrollee Services.

SECTION 11 We send you reports that explain payments made on your behalf for your drugs

Section 11.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the *Part D EOB*)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

NOTE: NaviCare members have no costs for covered services.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim, if applicable

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

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances
    - Note that NaviCare members are not responsible for any costs for covered drugs or services. If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 6, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

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

CHAPTER 6:

Asking us to pay a bill you have received for covered medical services or drugs (Note: NaviCare members have no costs for covered services)

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

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

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called **reimbursing** you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

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

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

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

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- 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 for your services.

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

3. If you are retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 Drug List 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received (NaviCare members have no costs for covered services.)

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one year** of the date you received the service, item, or drug.

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. Your request must be written, and be signed by you, an authorized representative, or a licensed prescriber. You must include the following information with your request:
    - First and Last Name
        - Member ID
        - Date of birth
        - Service type:
            - Medical/Behavioral Health
            - Dental
            - Equipment/Supplies
            - Worldwide Emergency Services
            - Transportation
            - Healthy Savings
            - Fitness/Wellness
            - Delivered Meals

    - Vision
  - The name of the service/supply provider
  - Date(s) of service
  - CPT/Diagnosis code
  - You must include a copy of the receipt and an itemized bill of services or supplies. Receipts must show:
    - Place and date of purchase
    - Total amount paid and payment method
    - Items/services to be reimbursed
    - Service provider and date of service
  - The receipt or bill should include diagnostic and procedure codes. If an itemized bill is not available, you can submit a statement from the provider/supplier on their letterhead. Both your receipt and your itemized bill must be easy to read. Fallon Health will not honor reimbursement requests for items purchased with gift certificates, gift cards, or pre-paid debit cards. Fallon Health will not reimburse for coupons.
- Either download a copy of the form from our website (fallonhealth.org/navicare) or call Enrollee Services and ask for the form.

Prescription reimbursement is different from medical services reimbursement. The plan works in partnership with its pharmacy benefit manager (PBM), OptumRx, to provide Part D prescription reimbursements. **You must submit your claim to OptumRx within three years** of the date you received the drug.

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

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

  - Final form of compound (cream, patches, suppository, suspension, etc.)
  - Time spent preparing drug
  - Compound ingredients
- National Drug Code
- Quantity
- Day supply
- Total volume (grams, ml., each, etc.)
- Proof of payment
- Prescriber first and last name
- Prescriber NPI
- Original cost of drug
- Amount primary insurance paid on the drug
- Member paid amount

- Either download a copy of the form from our website (fallonhealth.org/navicare) or call Enrollee Services and ask for the form.

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

Medical claims **(services you get at your provider's office):**	**Pharmacy claims** **(services you get at the pharmacy):**
Fallon Health P.O. Box 211308 Eagan, MN 55121-2908 Email: reimbursements@fallonhealth.org	OptumRx Claims Department P.O. Box 650287 Dallas, TX 75265-0287

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, we will pay for the service or drug. If you have already paid for the service or drug, we will mail your reimbursement to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you have not paid for the service or drug yet, we will mail the payment directly to the provider.

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

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 8 of this document.

CHAPTER 7:
Your rights and responsibilities

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

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

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from members who require translation services. We can also give you information in braille, in large print, Spanish (other languages available upon request), 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 Enrollee Services.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Appeals and Grievances at 1-800-333-2535, ext. 69950 (TRS 711). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services and drugs

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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 Part D drugs within a reasonable amount of time, Chapter 8 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

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

- Your personal health information includes the **personal information** you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practices*, that talks about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. 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.

The Centralized Enrollee Record (CER) is enrollee-centric and contains all activity and authorizations created by the NaviCare Primary Care Team (PCT) members on your behalf. In addition, activity completed by the Fallon Health Inpatient Nurse Care Specialists/Team while you are in an inpatient setting is also included in this system. This information is part of your Designated Record Set, and under HIPAA, you have certain rights with regards to this information. You and/or Authorized Representatives have the right to request a copy of CER documentation and to request that it be amended or corrected. If you ask that it be corrected or amended, we will consider your request to decide whether the changes should be made. If the record in question is from a provider, we will direct you to your healthcare provider regarding such a request. We are allowed to charge you a fee for making paper copies. See the Notice of Privacy Practices below for information on obtaining copies of your CER and/or amending documentation within CER.

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 Fallon Health's Privacy Officer at 1-800-868-5200.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully.**

Effective January 28, 2020

Fallon Health and its employees are dedicated to maintaining the privacy of your protected health information (PHI), as required by applicable federal and state laws. These laws require us to provide you with this Notice of Privacy Practices, and to inform you of your rights and our obligations concerning PHI, which is information that identifies you and that relates to your physical or mental health condition. We are required to follow the privacy practices described below while this Notice is in effect.

A. **Permitted Disclosures of PHI**. We may disclose your PHI for:

1) **Treatment**. To a physician or other health care provider furnishing treatment to you. For example, we may disclose medical information about you to physicians, nurses, technicians or personnel who are involved with the administration of your care.

2) **Payment**. To establish insurance eligibility benefits for you. We may also provide your PHI to our business associates, claims processing companies and others that process our health care claims.

3) **Health Care Operations**. In connection with our health care operations. This includes quality assessment activities, evaluating provider performance, and other business operations. This may, at times, include disclosure of your information to the sponsor of your health plan. However, we will not use or disclose your genetic information for underwriting purposes.
4) **Emergency Treatment**. If you require emergency treatment or are unable to communicate with us.
5) **Family and Friends**. To a family member, friend or any other person who you identify as being involved with your care or payment for care, or an adult family member who is on your policy, unless you object.
6) **Required by Law**. For law enforcement purposes and as required by state or federal law. For example, the law may require us to report instances of abuse, neglect or domestic violence.
7) **Judicial and Administrative Proceedings**. In the course of judicial or administrative proceedings, including responses to court orders, subpoenas, or other lawful process requests.
8) **Serious Threat to Health or Safety**. If we believe it is necessary to avoid a serious threat to the health and safety of you or the public.
9) **Public Health**. To public health or other authorities charged with preventing or controlling disease, injury or disability, or charged with collecting public health data.
10) **Health Oversight Activities**. To a health oversight agency for activities authorized by law. These activities include audits; civil, administrative or criminal investigations or proceedings.
11) **Research**. For certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your PHI.
12) **Workers' Compensation**. To comply with laws relating to workers' compensation or other similar programs.
13) **Specialized Government Activities**. As required by military command authorities if you are active military or a veteran. We may also be required to disclose PHI to authorized federal officials for the conduct of intelligence or other national security activities.
14) **Organ Donation**. To organ procurement organizations to facilitate organ, eye or tissue donation and transplantation, if you are an organ donor, or have not indicated that you do not wish to be a donor.
15) **Coroners, Medical Examiners, Funeral Directors**. To coroners or medical examiners for the purposes of identifying a deceased person or determining the cause of death, and to funeral directors as necessary to carry out their duties.
16) **Decedents**. To law enforcement about your death if we have cause to believe your death was the result of criminal activity.
17) **Disaster Relief**. Unless you object, to a governmental agency or private entity (such as FEMA or Red Cross) assisting with disaster relief efforts.

Please note we may limit the amount of information we share about you for these purposes in accordance with federal or state laws which may be more restrictive, for example, state laws about HIV/AIDS and mental health records, and federal law about Substance Use Disorder treatment.

We are required to disclose PHI to the Department of Health and Human Services, in accordance with actions they may undertake to investigate, monitor, and enforce our compliance with HIPAA.

B. **Disclosures Requiring Written Authorization**.

1) **Not Otherwise Permitted**. In any other situation not described in Section A, we may not disclose your PHI without your written authorization.

2) **Psychotherapy Notes**. We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.

3) **Marketing and Sale of PHI**. We must receive your written authorization for any disclosure of PHI for marketing purposes or for any disclosure which is a sale of PHI.

C. **Your Rights**. You have the right to:

1) **Receive a Paper Copy of This Notice**. Receive a paper copy of this Notice upon request.

2) **Access PHI**. Inspect and receive a copy of your PHI for as long as we maintain your medical record. You must make a written request to the Privacy Officer at the address listed at the end of this Notice. We may charge you a reasonable, cost-based, fee. In certain circumstances we may deny your request to access your PHI, and you may request that we reconsider our denial. Depending on the reason for the denial, another licensed health care professional chosen by us may review your request and the denial.

3) **Request Restrictions**. Request in writing a restriction on the use or disclosure of your PHI for the purpose of treatment, payment or health care operations, except for in the case of an emergency. You can also request a restriction on the information we disclose to a family member or friend who is involved with your care or the payment of your care. But, we are not legally required to agree to such a restriction.

4) **Restrict Disclosure for Services Paid by You in Full**. Restrict the disclosure of your PHI to a health plan if the PHI pertains to health care services for which you paid your health care provider in full and out of pocket. You must make a written request to the Privacy Officer at the address listed at the end of this Notice.

5) **Revoke**. Request in writing that any Authorization to Release Information you have previously signed be revoked; however, any disclosures made while the Authorization was still in effect cannot be impacted by such revocation.

6) **Request Amendment**. Request in writing that we amend your PHI if you believe it is incorrect or incomplete, for as long as we maintain your medical record. We may deny your request to amend if we did not create the PHI, it is not information that we maintain, it is not information that you are permitted to inspect or copy (such as psychotherapy notes), or we determine that the PHI is accurate and complete.

7) **An Accounting of Disclosures**. Request an accounting of disclosures of PHI made by us (other than those made for treatment, payment or health care operations purposes) during the 6 years prior to the date of your request. You must make a written request, specifying the time period for the accounting, to the Privacy Officer at the address listed at the end of this Notice.
8) **Confidential Communications**. Request that we communicate with you about your PHI by certain means or at certain locations. For example, you may specify that we call you only at your home phone number, and not at your work number. You must make a written request, specifying how and where we may contact you, to the Privacy Officer at the address listed at the end of this Notice.
9) **Notice of Breach**. You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured PHI.

D. **Changes to this Notice**. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you in the next annual mailing.

E. **Questions and Complaints**. If you would like more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding the use, disclosure, or access to your PHI, you may complain to us by contacting the Privacy Officer at the address and phone number at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your PHI. We will not coerce, discipline or otherwise retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Fallon Health
Attention: Privacy Officer
1 Mercantile Street, Suite 400
Worcester, MA 01608

Phone: 1-800-868-5200 (TTY 711)
Fax: 1-508-831-1136

Section 1.4 We must give you information about the plan, its network of providers, and your covered services and how we evaluate new technology to be included as a covered benefit

As a member of NaviCare HMO SNP, you have the right to get several kinds of information from us.

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 provides information about Part D prescription drug coverage and OTC drugs.
    - Family planning services at any contracted family planning provider are covered. You may also see your PCP for family planning services. Any out of network family planning services will require a prior approval from the plan. Call Enrollee Services at 1-877-700-6996 (TRS 711) if you need help finding a provider for family planning services.
- **Information about why something is not covered and what you can do about it.** Chapter 8 provides information on asking for a written explanation on why a medical service, OTC drug, or Part D drug is not covered or if your coverage is restricted. Chapter 8 also provides information on asking us to change a decision, also called an appeal.
- **Information about how we evaluate new technology to include as a covered benefit.**
    - Fallon Health evaluates new medical and behavioral health technologies, new applications of existing technologies and the review of special cases to include for health plan coverage through our Technology Assessment Committee.
    - The Technology Assessment Committee includes physician administrators, practicing physicians from the plan's service area, and plan staff who perform extensive literature review regarding proposed technology. This includes reviewing information from governmental agencies such as the U.S. Food and Drug Administration (FDA), and published scientific evidence.
    - Fallon Health makes use of external research organizations, which perform reviews of available literature regarding a given procedure. When necessary, Fallon Health seeks input from specialists or professionals who have expertise in proposed technologies.
    - For those technologies that can afford improved outcomes to our members without substantially increasing the risks of treatment, technology assessment criteria are developed in accordance with the National Committee for Quality Assurance (NCQA).
    - Fallon Health has a separate but similar process for the evaluation of new drugs and medications, with reviews performed by our Pharmacy & Therapeutics Committee.

Section 1.5 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. 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.** 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.
- **The right to be free of abuse, neglect, and exploitation.** Federal and state laws protect your health and well-being. If you think you are experiencing a situation where you are the recipient of intended or unintended abuse, neglect, or exploitation, please contact your Care Manager, another member of your Primary Care Team or Enrollee Services (phone numbers are printed on the back of this book). If you feel that you are experiencing an instance of abuse, neglect, or exploitation and it is an emergency, please call 911.
- **The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.**

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

Sometimes people become unable to make 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.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **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 who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if 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:

Against a hospital:
Department of Public Health
Division of Health Care Facility Licensure & Certification
Complaint Intake Unit
67 Forest St.
Marlborough, MA 01752
1-800-462-5540
Fax: 1-617-753-8165

Against an individual doctor:
Consumer Protection Coordinator
Board of Registration in Medicine
178 Albion St., Suite 330
Wakefield, MA 01880
1-781-876-8230
TTY: 711 MassRelay
Fax: 1-781-876-8381

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 8 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly**. We are not permitted to use any form of coercion, discipline or otherwise retaliate against you for filing a complaint.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Enrollee Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
- Or, you can **call MassHealth Customer Service** at 1-800-841-2900. TTY users should call 711, Monday–Friday, 8 a.m.–5 p.m.

Section 1.8 How to get more information about your rights and make recommendations regarding our member rights and responsibilities policy

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

- You can **call Enrollee Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.

  - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
- Or, you can **call MassHealth Customer Service** at 1-800-841-2900. TTY users should call 711, Monday–Friday, 8 a.m.–5 p.m.

You have the right to make recommendations regarding Fallon Health's member rights and responsibilities policy. To make recommendations you can call Enrollee Services.

Section 1.9 Behavioral Health Parity

Federal and state laws require that all managed care organizations, including NaviCare HMO SNP, provide behavioral health services to MassHealth members in the same way they provide physical health services. This is what is referred to as "parity." In general, this means that:

1) NaviCare HMO SNP must provide the same level of benefits for any behavioral health and substance use disorder problems you may have as it does for other physical problems you may have;

2) NaviCare HMO SNP must have similar prior authorization requirements and treatment limitations for behavioral health and substance use disorder services as it does for physical health services;

3) NaviCare HMO SNP must provide you or your provider with the medical necessity criteria used by NaviCare HMO SNP for prior authorization upon your or your provider's request; and

4) NaviCare HMO SNP must also provide you within a reasonable time frame the reason for any denial of authorization for behavioral or substance use disorder services.

If you think that NaviCare HMO SNP is not providing parity as explained above, you have the right to file a grievance with NaviCare HMO SNP. For more information about grievances and how to file them, please see Chapter 8 of this document.

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: 1-800-497-4648), Monday–Friday, 8 a.m.–5 p.m.

For more information, please see 130 CMR 450.117(J).

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
    - Chapters 5 gives the details about your Part D prescription drug coverage and OTC drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits. You are excluded from enrolling in our plan if you have access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription and OTC drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. 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 and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
    - If MassHealth (Medicaid) is not paying your Medicare premiums, you must continue to pay your Medicare premiums to remain a member of the plan.
    - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board.

CHAPTER 8:

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than integrated organization determination or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You also can visit the Medicare website (www.medicare.gov).

You can get help and information from MassHealth (Medicaid)

For information and help in handling a problem, you can also contact MassHealth (Medicaid). If we say no to all or part of an appeal that you file, you may then request a MassHealth (Medicaid) Board of Hearings (BOH) appeal by filling out the Fair Hearing Request Form. You can also call 1-800-841-2900 to fill out your request for a hearing form by telephone. TTY users should call 1-800-497-4648.

SECTION 3 Understanding Medicare and Medicaid complaints and appeals in our plan

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

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

PROBLEMS ABOUT YOUR BENEFITS

SECTION 4 Coverage decisions and appeals

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or** MassHealth Standard (**Medicaid**).

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

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

Section 5.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. 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 care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

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

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 7 of this chapter.

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

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

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

- You **can call us at Enrollee Services**.
- You **can get free help** from Massachusetts' State Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Enrollee Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at (fallonhealth.org/navicare.))

- For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Enrollee Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at (fallonhealth.org/navicare.)) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

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

If you're not sure which section you should be using, call Enrollee Services. You can also get help or information from government organizations such as your SHIP.

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

Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered*). In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.

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

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

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

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

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services 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 do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

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

For standard coverage decisions we use the standard deadlines.
This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a fast complaint. (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

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

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

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

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

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.

- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - **However**, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.** If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We

can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should **not** take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we will send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a MassHealth (Medicaid) service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 Step-by-step: How a Level 2 appeal is done

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

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

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by MassHealth Standard (Medicaid)**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.

- If your problem is about a service or item that could be **covered by both Medicare and MassHealth (Medicaid)**, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 161 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by MassHealth Standard (Medicaid), your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

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

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a free copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2.

- For the fast appeal the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- For the standard appeal if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug,

the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage **within 72 hours** or provide the service within **14 calendar days** after we receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests.**
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:
    - Explaining its decision.
    - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Telling you how to file a Level 3 appeal.

- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
    - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item MassHealth Standard (Medicaid) usually covers:

Step 1: You can ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services that are usually covered by MassHealth Standard (Medicaid) is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.
- If you choose to pursue an external appeal, **you** must submit your written hearing request to the Office of MassHealth (Medicaid), Board of Hearings (BOH) within 120 calendar days from the date of mailing of the NaviCare HMO SNP denial notice (or in the event that the plan did not resolve your appeal in a timely fashion, within 120 days of the date on which the plan's timeframe for resolving that appeal has expired). Our Member Appeals and Grievances may assist you with this process, **but it is your (or your representative's) responsibility to submit the request and to do it within 120 calendar days from the date we mailed the denial notice.** Hearing requests should be sent to:

  Executive Office of Health and Human Services
  Board of Hearings
  Office of MassHealth (Medicaid)
  100 Hancock Street, 6th floor
  Quincy, MA 02171
  Or fax to 1-617-887-8797
- When you make an appeal to the BOH, we will send the information we have about your appeal to them. This information is called your "case file." **You have the right to ask us for a copy of your case file free of charge**.
- You have a right to give the BOH additional information to support your appeal.

Right to continuing services:

- If applicable, you may be eligible to continue receiving requested services from NaviCare HMO SNP during the standard or expedited BOH appeal process. If you want to receive such continuing services, you or your authorized appeal representative must submit your

appeal request within 10 calendar days from the date of our Level 1 Appeal letter and indicate that you want to continue to get these services.

- If the outcome of the external review is not in your favor, you may be financially responsible for the services provided.

Step 2: The Fair Hearing office gives you their answer.

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal.**)

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

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

NaviCare members have no costs for covered services. If you have already paid for a MassHealth (Medicaid) service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

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

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a MassHealth (Medicaid) service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost typically within 30 calendar days with a possible 14-day extension.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 30 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the health care provider within 60 calendar days.

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

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating *covered outpatient prescription drug or Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs or Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

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

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

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

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

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

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

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

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

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

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

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
    - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

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

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form or on our plan's form, which are available on our website (fallonhealth.org/navicare.) Chapter 2 has contact information. You have the option

to fill out and submit the Coverage Determination Request Form online by going to fallonhealth.org/navicare, clicking "Plan documents and forms," and selecting on the "Medicare Part D prescription coverage determination form" link. Complete all the required fields and then click "Submit." To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.

  If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

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

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

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

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

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-800-333-2535, ext. 69950**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Coverage Determination Redetermination Request Form*, which is available on our website, fallonhealth.org/navicare. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- You have the option to fill out and submit a Part D appeal request online by going to fallonhealth.org/navicare, clicking on "Plan documents and forms, selecting "Medicare Part D appeal form" link. Complete all of the required fields and then click "Submit."
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already

bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

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

Within two calendar days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice.

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

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.

- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Enrollee Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

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

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for Massachusetts in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

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

You can get a sample of the **Detailed Notice of Discharge** by calling Enrollee Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says no, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to **Level 2** of the appeals process.

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying** *for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

Legal Term
Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a fast track appeal to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop care.

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

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

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for Massachusetts in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, you may still have appeal rights. Contact the Quality Improvement Organization.

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

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say no to your Level 1 appeal - and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Additional MassHealth (Medicaid) appeals

You also have other appeal rights if your appeal is about services or items that MassHealth Standard (Medicaid) usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or attorney adjudicator who works for the Federal** government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you

to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Suspected Fraud Waste or Abuse	• Do you believe that a provider is billing inappropriately or incorrectly?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Enrollee Services? • 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 Enrollee Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.

Complaint	Example
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited grievance.**

Section 11.3 Step-by-step: Making a complaint

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

- **Usually, calling Enrollee Services is the first step.** If there is anything else you need to do, Enrollee Services will let you know.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- To use the grievance procedure, you may file your grievance orally or in writing. Send your written grievance to Fallon Health Member Appeals and Grievances, 1 Mercantile St., Suite 400, Worcester, MA 01608. For oral grievances, call Fallon Health at 1-800-325-5669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31), and ask them to file a grievance for you. "Expedited" ("fast") grievance requests can be made and are processed 24 hours a day, seven days a week by leaving a voice message at this number. You can also fax your grievance request to 1-508-755-7393. If we do not accept your request for an expedited determination or redetermination, you may file an expedited ("fast") grievance. If we do not accept your request for an expedited ("fast") grievance, we will respond to you within 24 hours. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- **Whether you call or write, you should contact Enrollee Services right away.** You can make the complaint at any time after you had the problem you want to complain about.
- **If you are reporting suspected fraud, waste or abuse, those activities can be reporting by calling.** Our Enrollee Services phone number is 1-877-700-6996 (TRS 711). Hours are 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31), calling the plan's Compliance Hotline at 1-888-203-5295 or by emailing InternalAudit-FWAInquiries@fallonhealth.org. The Plan will not retaliate against anyone who makes a good faith report of potential fraud or other wrongful acts.

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.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 11.5 You can also tell Medicare and MassHealth (Medicaid) about your complaint

You can submit a complaint about NaviCare HMO SNP directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

You may also call *My Ombudsman* at 1-855-781-9898 or visit their website at www.myombudsman.org. *My Ombudsman* is an independent program to help when you have questions or need help getting benefits and services, and can explain how to file a complaint.

CHAPTER 9:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in NaviCare HMO SNP may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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

Section 2.1 You may be able to end your membership because you have Medicare and MassHealth (Medicaid)

- Most people with Medicare can end their membership only during certain times of the year. Because you have MassHealth (Medicaid), you can end your membership in our plan any month of the year. You also have options to enroll in another Medicare plan any month including;
    - Original Medicare *with* a separate Medicare prescription drug plan,
    - Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
    - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

    Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

    Contact MassOptions to learn about your MassHealth (Medicaid) plan options (telephone numbers are in Chapter 2, Section 6 of this document).
- Other Medicare health plan options are available during the **Annual Enrollment Period**. Section 2.2 tells you more about the Annual Enrollment Period.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the Annual Open Enrollment Period). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan, with or without prescription drug coverage.
    - Original Medicare *with* a separate Medicare prescription drug plan

      OR

    - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
    - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
    - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have MassHealth (Medicaid).
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with MassHealth (Medicaid).

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage,
- Original Medicare *with* a separate Medicare prescription drug plan,
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with MassHealth (Medicaid) and "Extra Help".

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Enrollee Services.**
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from NaviCare HMO SNP when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from NaviCare HMO SNP when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan o If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. o If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll** Contact Enrollee Services if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from NaviCare HMO SNP when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your MassHealth Standard (Medicaid) benefits, contact MassHealth (Medicaid) at 1-800-841-2900, TTY 711, Monday–Friday, 8 a.m.–5 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your MassHealth (Medicaid) coverage.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership NaviCare HMO SNP ends, and your new Medicare and MassHealth (Medicaid) coverage begins, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 NaviCare HMO SNP must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

NaviCare HMO SNP must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you are no longer eligible for MassHealth Standard (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and MassHealth (Medicaid). NaviCare HMO SNP will continue your membership for the remainder of the month in which we receive notification from MassHealth (Medicaid) about your loss of eligibility, along with one additional calendar month. If you regain your MassHealth Standard (Medicaid) coverage during this period, we will not end your membership.
- If you move out of our service area.
- If you are away from our service area for more than six months
    - If you move or take a long trip, call Enrollee Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage. As noted in Chapter 1 Section 2.1, you are excluded from enrolling in our plan if you have access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Enrollee Services.

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

NaviCare HMO SNP is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

CHAPTER 10:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

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. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Enrollee Services. If you have a complaint, such as a problem with wheelchair access, Enrollee Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, NaviCare HMO SNP, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about MassHealth estate recovery provisions

MassHealth is required by federal law to recover money from the estates of certain MassHealth members who are age 55 years or older, and who are any age and are receiving long-term care in a nursing home or other medical institution. For more information about MassHealth estate recovery, please visit www.mass.gov/estaterecovery.

CHAPTER 11:
Definitions of important words

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See "**Interchangeable Biosimilar**").

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.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,000 for Part D covered drugs during the covered year. NOTE: NaviCare members have no costs for covered services.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Complaint — The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. NOTE: NaviCare members have no costs for covered services.

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

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

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

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

Deductible – The amount you must pay for health care or prescriptions before our plan pays. NOTE: NaviCare members have no costs for covered services.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription. NOTE: NaviCare members have no costs for covered services.

Dual Eligible Special Needs Plans (D-SNP) – A type of plan that enrolls individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the individual's eligibility.

Dually Eligible Individuals – A person who is eligible for Medicare and MassHealth (Medicaid) coverage.

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

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

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

Enrollee 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 Enrollee Services.

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

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

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount. NOTE: NaviCare members have no costs for covered services.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) –A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are also known as full-benefit dually eligible individuals.

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

Integrated Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Formulary or Drug List) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

MassHealth (Medicaid) (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Maximum Out-of-Pocket Amount – The most that you would pay out-of-pocket during the calendar year for covered services if you were in a plan that required member cost-sharing for covered services. NOTE: NaviCare members have no costs for covered services. Amounts you pay for your Medicare Part A and Part B premiums (or the amounts paid for you by MassHealth (Medicaid) or another third party) do not count toward the maximum out-of-pocket amount.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement. NOTE: NaviCare members have no costs for covered services.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs. NOTE: NaviCare members have no costs for covered services.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose "Extra Help", you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. NOTE: NaviCare members have no premium.

Primary Care Provider (PCP) –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization –Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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

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

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

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and MassHealth (Medicaid), who reside in a nursing home, or who have certain chronic medical conditions.

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

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

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

NaviCare HMO SNP Enrollee Services

Method	Enrollee Services – Contact Information
CALL	1-877-700-6996 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) Enrollee Services also has free language interpreter services available for multiple languages.
TTY	TRS 711 Calls to this number are free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31)
FAX	1-508-368-9013
WRITE	NaviCare Enrollee Services Fallon Health 1 Mercantile Street, Suite 400 Worcester, MA 01608
WEBSITE	fallonhealth.org/navicare

Serving the Health Insurance Needs of Everyone (SHINE) (Massachusetts' SHIP)

SHINE is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-243-4636
TTY	MassRelay 711 or 1-800-439-0183 (voice) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. TTY/ASCII: 1-800-439-2370
WRITE	SHINE Program Executive Office of Elder Affairs One Ashburton Place, 3rd floor Boston, MA 02108
WEBSITE	www.mass.gov/health-insurance-counseling