NaviCare HMO SNP Member Handbook

January 01, 2026 – December 31, 2026

Your Health and Drug Coverage under NaviCare® HMO SNP, a Medicare HMO Special Needs Plan and Senior Care Options Plan that provides both Medicare- and MassHealth-covered benefits

Member Handbook Introduction

This Member Handbook*, otherwise known as the Evidence of Coverage,* tells you about your coverage under our plan through December 31, 2026. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this Member Handbook.

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

When this Member Handbook says “we”, “us”, “our”, or “our plan”, it means NaviCare HMO SNP.

This document is also available for free in Spanish, Vietnamese, and Khmer. Other languages are available for free upon request.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Enrollee Services at the number at the bottom of this page. The call is free. 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.

Your preferred language or request for material in an alternate format, both written and spoken, or request for information in an alternate format is requested by us on each member’s enrollment form. Your language preference will be captured and stored in our central operating system for all future communications, so you won’t have to make a separate request each time.

You may change your preferred language or communications format by informing a member of your Interdisciplinary Care Team (ICT) or by calling Enrollee Services.

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Disclaimers

- Benefits may change on January 1, 2027.
- NaviCare HMO SNP is a Coordinated Care plan with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in the plan depends on the plan's contract renewal with Medicare.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.
- This document is available for free in Spanish, Khmer, and Vietnamese. Other languages are also available upon request free of charge.
- You can get this document for free in other formats, such as large print, braille, or audio. Call Enrollee Services at 1-877-700-6996 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31). The call is free.
- Your preferred language or request for material in an alternate format, both written and spoken, or request for information in an alternate format is requested by us on each member's enrollment form. Your language preference will be captured and stored in our central operating system for all future communications, so you won't have to make a separate request each time.

  Enrolled members may change their preferred language or communications format by informing a member of their Interdisciplinary Care Team (ICT) or by calling Enrollee Services at 1-877-700-6996 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31).
- Estate Recovery Awareness: MassHealth is required by federal law to recover money from the estates of certain MassHealth members who are age 55 years or older, and who are any age and are receiving long-term care in a nursing home or other medical institution. For more information about MassHealth estate recovery, please visit www.mass.gov/estaterecovery.

Notice of availability of language assistance services and auxiliary aids and services

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-700-6996 (TRS 711) 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1-March 31). The call is free.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-700-6996. Someone who speaks English can help you. The call is free. We also provide free auxiliary aids and services, such as large print, braille, or audio. Just call us at the number above to make this request.

Spanish: Contamos con servicios de intérprete gratuitos para responder cualquier pregunta que tenga sobre nuestro plan de salud o medicamentos. Para obtener un intérprete, solo llámenos al
1-877-700-6996. Alguien que habla español podrá ayudarle. La llamada es gratuita. También ofrecemos ayudas y servicios auxiliares gratuitos, como impresión en letra grande, braille o audio. Solo llámenos al número mencionado arriba para hacer esta solicitud.

Chinese: 我們提供免費口譯服務，以解答您有關我們的健康或藥物計劃的任何問題。如需口譯服務，請撥打 1-877-700-6996。會有說中文的人為您提供幫助。此為免付費電話。我們也提供免費的輔助工具和服務，例如大號字體印刷版、盲文或音訊。請撥打上述電話向我們提出請求。

French: Nous disposons de services d’interprétation gratuits pour répondre à toutes les questions que vous pourriez avoir sur notre régime de santé ou d’assurance médicaments. Pour obtenir un interprète, il vous suffit de nous appeler au 1-877-700-6996. Une personne parlant français pourra vous aider. L’appel est gratuit. Nous fournissons également gratuitement des aides et des services auxiliaires, tels que des documents en gros caractères, en braille ou audio. Il vous suffit de nous appeler au numéro ci-dessus pour en faire la demande.

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch miễn phí để giải đáp mọi thắc mắc liên quan đến chương trình bảo hiểm sức khỏe hoặc chương trình thuốc của chúng tôi. Để yêu cầu chúng tôi bố trí thông dịch viên, vui lòng gọi điện đến số 1-877-700-6996. Một nhân viên nói tiếng Việt sẽ hỗ trợ quý vị. Cuộc gọi này hoàn toàn miễn phí. Chúng tôi cũng cung cấp các công cụ và dịch vụ hỗ trợ miễn phí, chẳng hạn như bản in khổ chữ lớn, chữ nổi Braille hoặc băng thu âm. Quý vị chỉ cần gọi cho chúng tôi theo số điện thoại bên trên để yêu cầu các dịch vụ này.

Korean: 저희는 건강 플랜 또는 의약품 플랜에 관한 질문에 답변해 드릴 무료 통역 서비스를 제공합니다. 통역사를 이용하시려면 1-877-700-6996로 전화해 주십시오. 한국어를 구사하는 직원이 도와드릴 수 있습니다. 통화는 무료입니다. 또한 큰 활자, 점자 또는 오디오와 같은 무료 보조 지원과 서비스도 제공합니다. 이러한 요청을 하시려면 위의 번호로 전화해 주십시오.

Russian: Мы можем предоставить вам бесплатные услуги переводчика, чтобы вы могли получить ответы на все ваши вопросы о нашем плане медицинского обслуживания и обеспечения лекарственными препаратами. Чтобы запросить услуги переводчика, просто позвоните по номеру 1-877-700-6996. Сотрудник, владеющий русским языком, сможет вам помочь. Звонок бесплатный. Мы также предлагаем бесплатные вспомогательные средства и услуги, например материалы, напечатанные крупным шрифтом, шрифтом Брайля или в виде аудиозаписи. Просто позвоните нам по вышеуказанному номеру, чтобы сделать соответствующий запрос.

Arabic:
لدينا خدمات مترجم فوري مجانية للإجابة على أي أسئلة التي قد تكون لديك حول خطتنا للرعاية الصحية أو خطة الأدوية الخاصة بنا. للحصول على مترجم فوري، فقط اتصل بنا على الرقم 1-877-700-6996. يمكن لشخص يتكلم اللغة الإنجليزية أن يساعدك. إن المكالمة مجانية. نحن نقدم أيضًا مساعدات وخدمات مساعدة مجانية، مثل طباعة بأحرف كبيرة، أو بطريقة برايل، أو ملفات صوتية. فقط اتصل بنا على الرقم المذكور أعلاه لتقديم هذا الطلب.

Hindi: हमारे स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास निःशुल्क दुभाषिया सेवाएँ हैं। दुभाषिया पाने के लिए बस हमें 1-877-700-6996 पर कॉल करें। कोई हिन्दी बोलने वाला व्यक्ति आपकी मदद कर सकता है। कॉल निःशुल्क है। हम बड़े प्रिंट, ब्रेल या ऑडियो जैसी निःशुल्क सहायक सामग्री और सेवाएं भी प्रदान करते हैं। इस अनुरोध के लिए बस हमें ऊपर दिए गए नंबर पर कॉल करें।

Italian: Disponiamo di servizi gratuiti di interpretariato per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per chiedere un interprete basta chiamarci al numero 1-877-700-6996. La assisterà un operatore che parla italiano. La chiamata è gratuita. Forniamo inoltre servizi e supporti ausiliari gratuiti, come ad esempio stampa in caratteri grandi, braille o audio. Per questa richiesta basta chiamarci al numero sopra indicato.

Portuguese: Temos serviços de intérprete gratuitos para responder a quaisquer perguntas que possa ter sobre o nosso plano de saúde ou medicamentos. Para obter um intérprete, ligue para 1-877-700-6996. Alguém que fala português poderá prestar assistência. A chamada é gratuita. Também fornecemos recursos e serviços auxiliares gratuitos, como impressão em letras grandes, braile ou áudio. Basta ligar para o número acima e fazer tal solicitação.

Haitian Creole: Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-700-6996. Yon moun ki pale kreyòl ka ede w. Apèl la gratis. Nou bay èd ak sèvis oksilyè gratis tou, tankou gwo lèt, bray oswa odyo. Jis rele nou nan nimewo ki anwo a pou fè demann sa a.

Polish: Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszystkie Państwa pytania dotyczące planu ubezpieczenia zdrowotnego lub refundacji leków. Aby skorzystać z usług tłumacza, należy zadzwonić pod numer 1-877-700-6996. Osoba mówiąca po polsku udzieli Państwu pomocy. Połączenie jest bezpłatne. Zapewniamy również wsparcie i usługi pomocnicze, takie jak materiały pisane dużym drukiem, alfabetem Braille'a lub nagrania głosowe. Aby o nie poprosić, wystarczy zadzwonić pod podany powyżej numer telefonu.

Khmer: យើងមានសេវាកម្មអ្នកបកប្រែផ្តាល់មាត់តតគិតថ្លៃដើម្បីឆ្លើយសំណួរណាមួយ ដែលអ្នកអាចមានអំពីគម្រោងសុខភាព ឬគម្រោងឱសថរបស់អ្នក។ ដើម្បីទទួលបានអ្នក បកប្រែផ្តាល់មាត់ម្នាក់ សូមទូរសព្ទមកយើងតាមលេខ 1-877-700-6996។ នរណាម្នាក់ដែលនិយាយ ភាសាអង់គ្លេស អាចជួយអ្នកបាន។ ការទាក់ទងតាមទូរសព្ទនេះគឺពុំគិតថ្លៃឡើយ។ យើងក៏ផ្តល់ជំនួយបន្ថែម និងសេវាកម្មជំនួយដោយតតគិតថ្លៃផងដែរ ដូចជាអក្សរពុម្ពធំ អក្សរស្ទាប ឬសំឡេង។ ក្រាន់តែទូរសព្ទមកយើងខ្ញុំតាមលេខខាងលើដើម្បីធ្វើការស្នើសុំនេះ។

Greek: Διαθέτουμε δωρεάν υπηρεσίες διερμηνείας για να απαντάμε σε οποιεσδήποτε ερωτήσεις μπορεί να έχετε σχετικά με το πρόγραμμα ιατρικής ή φαρμακευτικής περίθαλψης που παρέχουμε. Για να βρείτε διερμηνέα, απλώς καλέστε μας στον αριθμό 1-877-700-6996. Κάποιος που μιλά αγγλικά μπορεί να σας βοηθήσει. Η κλήση είναι χωρίς χρέωση. Επίσης, παρέχουμε δωρεάν βοηθήματα και βοηθητικές υπηρεσίες, όπως μεγάλη γραμματοσειρά, μπράιγ ή ηχητική μορφή. Απλώς καλέστε μας στον παραπάνω αριθμό για να υποβάλετε αυτό το αίτημα.

Gujarati: અમારી આરોગ્ય અથવા દવા યોજના વિશે તમને હોય શકે તેવા કોઈપણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે મફત દુભાષિયા સેવા છે. દુભાષિયા સેવા મેળવવા માટે, અમને 1-877-700-6996 પર કોલ કરો. ગુજરાતી બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. કોલ મફત છે. અમે મોટા પ્રિન્ટ, બ્રેઇલ અથવા ઑડિઓ જેવી મફત વધારાની સહાય અને સેવાઓ પણ પ્રદાન કરીએ છીએ. આ વિનંતી કરવા માટે અમને ફક્ત ઉપરના નંબર પર કોલ કરો.

Laotian: ພວກເຮົາມີການບໍລິການນາຍແປພາສາຟຣີ ເພື່ອຕອບທຸກຄຳຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບແຜນປະກັນສຸຂະພາບ ຫຼື ແຜນປະກັນຢາຂອງພວກເຮົາ ເພື່ອຂໍນາຍແປພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-877-700-6996. ຈະມີຄົນທີ່ສາມາດເວົ້າພາສາລາວມາຊ່ວຍທ່ານ. ການໂທແມ່ນບໍ່ເສຍຄ່າ. ນອກຈາກນີ້, ພວກເຮົາຍັງໃຫ້ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມແບບບໍ່ເສຍຄ່າອີກດ້ວຍ ເຊັ່ນ: ການພິມເປັນຕົວໃຫຍ່, ຕົວອັກສອນນູນ ຫຼື ສຽງບັນທຶກ. ພຽງແຕ່ໂທຫາພວກເຮົາຕາມເບີຂ້າງເທິງ ເພື່ອຮ້ອງຂໍສິ່ງນີ້.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about NaviCare HMO SNP, a health plan that covers all of your Medicare and MassHealth services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this Member Handbook.

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OMB Approval 0938-1444 (Expires: June 30, 2026)

A. Welcome to our plan

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

SCO is a program run by Massachusetts and the federal government to provide better health care for people who have both Medicare and MassHealth (Massachusetts Medicaid).

B. Information about Medicare and MassHealth

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. MassHealth

MassHealth is the name of Massachusetts Medicaid program. MassHealth is run by Massachusetts and is paid for by Massachusetts and the federal government. MassHealth helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

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

Medicare and the Commonwealth of Massachusetts approved our plan. You can get Medicare and MassHealth services through our plan as long as:

- you're eligible to participate in SCO;

- we offer the plan in your county, **and**
- Medicare and the Commonwealth of Massachusetts allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and MassHealth services isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and MassHealth services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a Navigator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You have access to a Geriatric Support Services Coordinator (GSSC). This is a person who will help you find and get community long-term care and social support services.
    - Both the Navigator and GSSC work with your Interdisciplinary Care Team (ICT) to make sure you get the care you need.
- You're able to direct your own care with help from your care team and Navigator.
- Your care team and Navigator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our plan's service area

NaviCare HMO SNP is available only to individuals who live in our plan service area within the Commonwealth of Massachusetts. 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

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this Member Handbook for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for MassHealth Standard, **an**
- are age 65 or older, **and**
- aren't enrolled in a MassHealth Home and Community-based Services (HCBS) waiver (except a Frail Elder Waiver); **and**
- have no other health insurance.

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;
- 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 and
- not be a refugee as described in 130 CMR 522.002

If you lose eligibility but can be expected to regain it within 30 days, then you're still eligible for our plan.

Call Enrollee Services for more information.

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

When you first join our plan, you get a health risk assessment (HRA), also known as a "Comprehensive Assessment," within 90 days of your enrollment in the plan.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, social determinants of health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit in a location of your choosing, telephone call, or a virtual visit.

We'll send you more information about this HRA.

If NaviCare HMO SNP is a new plan for you, you can keep using your doctors and getting your current services for 90 days or until your HRA and Individualized Care Plan (ICP) are complete. This is called the Continuity of Care period. If you're taking any Medicare Part D drugs when you join our plan, you can get a temporary supply. We'll help you to transition to another drug if necessary.

After the first 90 days, you'll need to use doctors and other providers in the NaviCare HMO SNP network. A network provider is a provider who works with the health plan. Refer to **Chapter 3** for more information on getting care from provider networks.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need and want. A care team may include your doctor, a Navigator, or other health person that you choose. Together, you and your Interdisciplinary Care Team (ICT) will make your individualized Care Plan (ICP).

A Navigator is a person trained to help you manage the care you need and want. You get a Navigator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your Navigator and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and long-term services and supports.

The ICP is a critical communication tool that speaks for the enrollee with regard to individual care objectives, in the context of past and present goals and services, to guide and inform future services and needs. The ICP is created based on assessments completed with you by your care team.

Your care plan includes:

- your list of health, independent living and recovery goals, as well as any concerns you may have and the steps needed to address them, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. You'll be at the center of the process of making your care plan.

Your ICT may include but is not limited to your primary care provider (PCP), Navigator, nurse case manager, GSSC, or behavioral health case manager, will work with you to develop your ICP and to ensure you receive the care you need. A nurse with access to your care plan is available 24/7.

Your PCP is responsible for coordinating all your medical health needs and for ordering and monitoring referrals for specialty services when required.

Your ICP includes all of the supportive services and benefits that your ICT 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 ICT reviews, approves, and authorizes changes to your ICP, whether adding, changing, or discontinuing services. Your ICT reassesses your needs at least every 6 months, and more frequently if necessary.

Every year, your care team will work with you to update your care plan in case there's a change in the health services you need and want. Your care plan can also be updated as your goals or needs change throughout the year.

H. Our plan has no premium

Your costs may include the following:

- Monthly Medicare Part B Premium (**Section H1**)

H1. Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in **Section E** above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most NaviCare HMO SNP members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

In addition, there are programs offered through MassHealth 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 benefits (QMB+).)
- Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. (Some people with SLMB are also eligible for full MassHealth benefits (SLMB+).)
- Qualified Individual (QI): Helps pay Part B premiums

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Medicare Part B. **In addition, please contact Enrollee Services or your Navigator and inform them of this change.**

I. This Member Handbook

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

You can ask for a Member Handbook by calling Enrollee Services at the numbers at the bottom of the page. You can also refer to the Member Handbook found on our website at the web address at the bottom of the page.

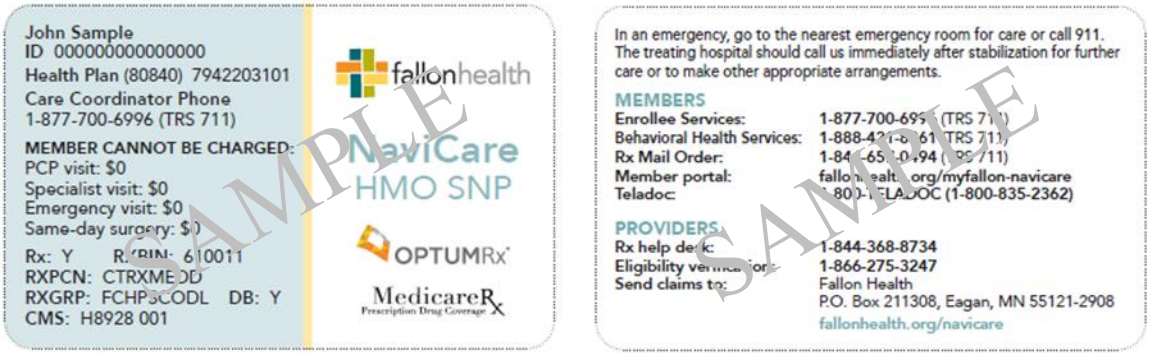
The contract is in effect for the months you're enrolled in our plan between January 01, 2026 and December 31, 2026.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a Provider and Pharmacy Directory, and information about how to access a List of Covered Drugs, also known as a Drug List or Formulary.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and MassHealth services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample member ID card:



If your member ID card is damaged, lost, or stolen, call Enrollee Services at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your MassHealth card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to

show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this Member Handbook to find out what to do if you get a bill from a provider.

J2. Provider and Pharmacy Directory

The Provider and Pharmacy Directory lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a Provider and Pharmacy Directory (electronically or in hard copy form) by calling Enrollee Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the Provider and Pharmacy Directory at the web address at the bottom of the page.

The Provider and Pharmacy Directory lists our current network providers, durable medical equipment suppliers, and pharmacies, including MassHealth 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.

For new enrollees, your care plan must provide a minimum 90-day transition period, during which time the new 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.

Definition of network providers

- Our network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or MassHealth.

Network providers agree to accept payment from our plan for covered services as payment in full. You won't have to pay anything more for covered services.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the Provider and Pharmacy Directory to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Enrollee Services at the numbers at the bottom of the page for more information. Both Enrollee Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. List of Covered Drugs

Our plan has a List of Covered Drugs. We call it the Drug List for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in **Chapter 5, Section E.** Medicare approved the NaviCare HMO SNP Drug List.

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

Each year, we send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Enrollee Services or visit our website at the address at the bottom of the page. You may also locate the most recent NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs electronically on fallonhealth.org/navicare.

J4. The Explanation of Benefits

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take. **Chapter 6** of this Member Handbook gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Enrollee Services at the numbers at the bottom of the page.

NOTE: NaviCare members have no costs for covered services.

You can also get your EOB electronically. To sign up:

1. Register for the OptumRx member portal at optumrx.com.
2. Click on “Sign in” to log into the portal.
3. Click on the “My profile” tab.
4. Select “Communication preferences.”
5. Update your option to “Paperless” for the “Claims, billing and payments” category.

If you ever change your mind and want to go back to getting your EOBs in the mail, you can log back in and change your preference to “Mail” for your EOB.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan’s network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it’s very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse’s employer, or your domestic partner’s employer, or workers’ compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You’re not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Enrollee Services at the numbers at the bottom of the page.

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.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this Member Handbook.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your Navigator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this Member Handbook.

Table of Contents

A. Enrollee Services

CALL	1-877-700-6996. This call is free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) We have free interpreter services for people who don't speak English.
TTY	TRS 711. This call is 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 St., Suite 400 Worcester, MA 01608
WEBSITE	fallonhealth.org/navicare

Contact Enrollee Services to get help with:

- questions about the plan
  - Information on all covered services and other available services or resources
  - How to change plans or how to disenroll from our plan
  - Your rights and responsibilities
  - Provider information, such as location, qualifications, accessibility and the availability of providers
- questions about claims or billing
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.

- Call us if you have questions about a coverage decision about your health care.
- To learn more about coverage decisions, refer to **Chapter 9** of this Member Handbook.

- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this Member Handbook or contact Enrollee Services.
- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section D**).
  - You can call us and explain your complaint at 1-877-700-6996.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to **Section E and Section F of Chapter 9**).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can also call My Ombudsman for help with **any** complaints or to help you file an appeal. (Refer to **Section I** of this chapter for My Ombudsman's contact information.)
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this Member Handbook.
- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.

  - This applies to your Medicare Part D drugs, MassHealth prescription drugs, and MassHealth over-the-counter drugs.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this Member Handbook.
- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this Member Handbook.
- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to **Section G of Chapter 9**.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this Member Handbook.
- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this Member Handbook.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this Member Handbook.
- Access to interpreter services

B. Coverage Decisions for Part D Prescription Drugs

OptumRx is our plan's Pharmacy Benefits Manager (PBM). To request a coverage decision about your Medicare Part D drugs, MassHealth prescription drugs, and MassHealth over-the-counter drugs, you may contact OptumRx directly. The contact information is listed below:

CALL	1-844-657-0494. This call is free. If you need assistance, someone is available 24 hours a day, 7 days a week.
TTY	TRS 711. This call is 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

For more on coverage decisions about your drugs, refer to **Chapter 9** of this Member Handbook.

C. Your Navigator

Navigators are members of the ICT, and work closely with Nurse Case Managers, PCPs, and other providers to help coordinate care, and ensure that enrollees receive needed services, consistent with their individualized care plans. Navigators advocate on behalf of their enrollees and perform a key role in working to reduce gaps in care and educate enrollees on their benefits.

CALL	1-877-700-6996. This call is free. 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31) We have free interpreter services for people who don't speak English.
TTY	TRS 711. This call is 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 HMO SNP 1 Mercantile St., Suite 400 Worcester, MA 01608
WEBSITE	fallonhealth.org/navicare

Contact your Navigator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- questions about getting medical services and long-term services and supports (LTSS)
- questions about getting help with food, housing, employment, and other health-related social needs
- questions about your care plan
- questions about approvals for services that your providers have requested
- questions about the benefits of Flexible Covered Services and how they can be requested

D. SHINE (Serving the Health Insurance Needs of Everyone)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Massachusetts, the SHIP is called SHINE (Serving the Health Insurance Needs of Everyone).

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

CALL	1-800-AGE-INFO (1-800-243-4636) 9 a.m.–5 p.m., Monday–Friday
TTY	1-800-439-2370 *(Massachusetts only)* This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Call the number above for the address of the SHINE program in your area.
WEBSITE	www.mass.gov/health-insurance-counseling

Contact SHINE for help with:

- questions about Medicare
- SHINE counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

E. Quality Improvement Organization (QIO)

Our state has an organization called Acentra Health. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It's not connected with our plan.

CALL	1-888-319-8452
TTY	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Acentra Health QIO 5201 West Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	https://www.acentraqio.com

Contact Acentra Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care, such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

F. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly “wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

G. MassHealth

MassHealth (Massachusetts Medicaid) helps with medical and long-term services and supports costs for people with limited incomes and resources.

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

You can get information about MassHealth from Aging Service Access Point (ASAP). For more information on how to contact Aging Service Access Point (ASAP) see **Section N** of this chapter. In addition, because you are enrolled in both Medicare and MassHealth, you can also reach out to Medicare (see **Section F** of this chapter for contact information) with any questions.

CALL	1-800-841-2900
TTY	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	MassHealth Customer Service 55 Summer Street Boston, MA 02110
EMAIL	membersupport@mahealth.net
WEBSITE	www.mass.gov/masshealth

H. Mass Options

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.

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

I. Ombudsman

My Ombudsman is an independent program that can help you if you have questions, concerns, or problems related to Senior Care Options (SCO). My Ombudsman's services are free. My Ombudsman's staff:

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

CALL	1-855-781-9898 (Toll Free)
MassRelay and Videophone (VP)	Use 7-1-1 to call 1-855-781-9898 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Videophone (VP): 339-224-6831 This number is for people who are deaf or hard of hearing.
WRITE	My Ombudsman 25 Kingston Street, 4th floor Boston, MA 02111
EMAIL	info@myombudsman.org
WEBSITE	www.myombudsman.org

J. Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The Long-Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

CALL	1-617-222-7495
WRITE	1 Ashburton Place, Room 517 Boston, MA 02108

K. Programs to Help People Pay for Drugs

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

K1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

L. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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 their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov

M. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	www.rrb.gov

N. Other resources

You can get information about MassHealth from Aging Service Access Point (ASAP). ASAPs 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. ASAPs provide information and referrals related to caregiving, aging-related medical conditions, legal services, support groups, and other services available to seniors.

You can also find your local ASAP in accordance with your town of residence by using the link below:

www.mass.gov/info-details/find-your-regional-aging-services-access-point-asap

Access Care Partners (formerly WestMass Elder Care, Inc.)
4 Valley Mill Rd.
Holyoke, MA 01040
- Call: 1-800-462-2301. TTY: 1-800-875-0287.
- www.accesscarepartners.org

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 Aging & Wellness, 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: 73 South Church St.
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

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

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your Navigator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this Member Handbook.

Table of Contents

A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this Member Handbook. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this Member Handbook.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and MassHealth. This includes behavioral health, LTSS, and prescription and over-the-counter (OTC) drugs.

Our plan will pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this Member Handbook.
- The care must be **medically necessary**. By medically necessary, we mean that the services are reasonable and necessary:
  - For the diagnoses and treatment of your illness or injury; or
  - To improve the functioning of a malformed body part; **or**
  - Otherwise medically necessary under Medicare law
- In accordance with Medicaid law and regulation and per MassHealth, services are medically necessary if:
  - They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**

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

- If you have questions about if a service is medically necessary or not, you can contact Enrollee Services.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
  - In most cases, your network PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
  - Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you're also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is a network of doctors who collaborate to provide healthcare services. These doctors can work in the same office or across multiple locations, sharing records and office systems to ensure coordinated care. Medical groups can be either single-specialty or multi-specialty, and they may operate independently or as part of a larger healthcare system. Medical groups work with health plans to serve their members, determining how care is provided and managing referrals to specialists within the group. This structure allows for a more integrated approach to patient care, improving efficiency and quality of service.
  - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).

- If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. Authorization must be obtained from the plan prior to seeking care from an out-of-network provider. In this situation, we cover the care at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible.

C. Your Navigator

C1. What a Navigator is

A Navigator is a trained person who works for our plan to provide care coordination services for you.

Navigators are members of the ICT, and work closely with Nurse Case Managers, PCPs, and other providers to help coordinate care, and ensure that enrollees receive needed services, consistent with their individualized care plans. Navigators advocate on behalf of their enrollees and perform a key role in working to reduce gaps in care and educate enrollees on their benefits.

Everyone who enrolls in a Senior Care Options (SCO) plan also has the right to have a Geriatric Support Services Coordinator (GSSC) on their care team.

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

GSSCs don't work for SCO plans. They come from Aging Services Access Points (ASAPs) and are experts in areas like independent living, recovery, and aging. This means that they can work for you and help you advocate for your needs.

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

C2. How you can contact your Navigator

You may contact your Navigator by calling Enrollee Services at 1-877-700-6996 (TRS 711).

C3. How you can change your Navigator

To request a change in Navigator, call Enrollee Services at 1-877-700-6996 (TRS 711).

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care. Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you're also choosing the affiliated medical group.

Definition of a PCP and what a PCP does 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.

A medical group is a network of doctors who collaborate to provide healthcare services. These doctors can work in the same office or across multiple locations, sharing records and office systems to ensure coordinated care. Medical groups can be either single-specialty or multi-specialty, and they may operate independently or as part of a larger healthcare system. Medical groups work with health plans to serve their members, determining how care is provided and managing referrals to specialists within the group. This structure allows for a more integrated approach to patient care, improving efficiency and quality of service.

Physicians who are board-eligible or board-certified in the specialties of family practice, pediatrics, internal medicine, obstetrics, or gynecology can act as PCPs. Other providers that may serve as a PCP include Nurse Practitioners that have been granted full practice authority in Massachusetts, and Physician Assistants who are serving under the supervision of a physician.

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
- Home care services
- Durable medical equipment and medical supplies
- 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.

Your PCP is responsible for:

- Contributing to your ICP 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 choice of PCP

You may search for a PCP by looking in the Provider and Pharmacy Directory on our website at fallonhealth.org/navicare, or by calling Enrollee Services at the numbers at the bottom of the page. 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 at the numbers at the bottom of the page 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. You can look in the Provider and Pharmacy Directory, or ask Enrollee Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

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.

Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Enrollee Services if you use a specialist or get other covered services that must have PCP approval. Enrollee Services helps you continue your specialty care and other services when you change your PCP.

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Enrollee Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots, COVID-19 vaccines, and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This 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.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are plan-covered services that require immediate medical attention but are not emergencies, provided when you are temporarily outside the service area of the plan, or when 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.
- 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 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 mental 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. For Intensive Outpatient Therapy (IOP) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.
- 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
- Our additional tobacco and smoking cessation program
- Nursing hotline
- Routine eye exams as long as you get them from a plan provider

If you're not sure if you need a referral to get a service or use another provider, ask your Navigator, PCP, or call Enrollee Services at 1-877-700-6996 and TRS 711.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

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 NaviCare HMO SNP.

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 9** 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.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll 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'll notify you if you visited that provider within the past three years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. 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 one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9, Section H and Section K,** for more information.)

D4. 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 the plan. The prior authorization request will be reviewed by NaviCare HMO SNP 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 outside the United States and its territories.

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

- We can't pay a provider who isn't eligible to participate in Medicare and/or MassHealth.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

The GSSC will arrange an in-home assessment to identify the LTSS that will best meet your health needs. Home-based services coordination will include the involvement of Aging Service Access Points (ASAPs) staff. GSSCs may also be able to help you access behavioral health resources and services.

F. Behavioral health (mental health and substance use disorder) services

You have coverage for 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 covered services include:

- Diversionary services, such as:
  - Observation
  - Community support services and treatment
  - Crisis assessment, intervention and stabilization
  - Medically Monitored Intensive Services – Acute Treatment Services (ATS) for Substance Use Disorders
  - Psychiatric day treatment
- Behavioral health emergency services
- Certified Peer Specialist
- Recovery Coaching and Recovery Support Navigators
- Community Support Program (CSP)
- Medication management services
- Day treatment
- Residential programs
- Behavioral Health Outpatient Services

You also have coverage for inpatient hospital, partial hospitalization, and intensive outpatient services that includes behavioral health, substance use disorder services, and rehabilitation services. To learn more, see our plan's Benefits Chart in Chapter 4.

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 United States and its territories. To learn more, see our plan's Benefits Chart in Chapter 4.

G. How to get self-directed care

G1. What self-directed care is

Under self-directed care, you can hire and manage a personal care attendant (PCA) to assist with two or more Activities of Daily Living (ADLs) such as bathing, dressing, grooming, eating, ambulating, toileting, etc. You may elect a legal guardian, a family member, or other person as identified in the service agreement to act on your behalf as your designated surrogate to assist in performing certain PCA management tasks that you may be unable to perform. To learn more, see our plan's Benefits Chart in Chapter 4.

G2. Who can get self-directed care

For PCA services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan. Your ICT will determine if you are suitable for the service and if it should be part of your ICP.

G3. How to get help in employing personal care providers

Your Navigator and/or members of your ICT will connect you with an agency providing PCA services.

G4. How to request that a copy of all written notices be sent to Interdisciplinary Care Team (ICT) participants the member identifies

You may contact Enrollee Services at the phone number at the bottom of the page to request that all written notices be sent to any member of your ICT as it relates to your self-directed care.

H. Transportation services

NaviCare HMO SNP covers worldwide emergency transportation by ambulance when medically necessary. Non-emergency transportation by ambulance is covered with prior authorization from the plan.

In addition, NaviCare covers unlimited rides to and from medical appointments and places where you receive health care, such as your doctor's office, physical therapy, counseling, and hospital visits. NaviCare HMO SNP also provides 48 one-way rides to pharmacies—whether they're privately owned, part of a small chain, or a large retailer like CVS Pharmacy, Walgreens, or Walmart.

These rides must be pre-arranged at least 2 business days in advance through our partner service, and can be provided by the service or by your own friends and family who can receive reimbursement for mileage of pre-approved rides. Rides are limited to a 30 mile radius from your pick-up location based on Fallon Health's transportation partner system.

Through a special supplemental program for the chronically ill, members who have qualifying chronic conditions also have access to 100 one-way rides to run errands, visit friends, attend religious services, and more. Not all members with an eligible condition will qualify. To learn more about "Special Supplemental Program for Chronically Ill (SSBCI), please refer to the "Special Supplemental Benefits for the Chronically Ill" row in our plan's Benefits Chart in Chapter 4 or contact your Navigator.

To learn more about available transportation services, see our plan's Benefits Chart in Chapter 4.

I. Dental and Vision services

NaviCare HMO SNP includes coverage for preventative and comprehensive dental and vision services.

I1. Dental services

All covered preventive and comprehensive dental services must be provided by a plan network provider.

1. Coverage Overview:

As a member of our NaviCare HMO SNP Plan, you are entitled to comprehensive dental services designed to maintain and improve your oral health. Covered services include, but are not limited to:

- Preventive Services: Routine oral examinations, cleanings, and X-rays.
- Basic Services: Fillings, extractions, and periodontal treatments.
- Major Services: Crowns, bridges, dentures, and dental implants.

2. Pre-Authorization Requirements:

Certain dental procedures require pre-authorization to ensure they are medically necessary and appropriate. Comprehensive dental services, such as fillings, implants, root canals, extractions, periodontal and crowns, require prior authorization from the plan's dental benefit administrator, DentaQuest.:

- Dental Implants: Pre-authorization is mandatory for all dental implant procedures. Your dental provider must submit a detailed treatment plan and supporting documentation for review and approval before proceeding with the implant.

Failure to obtain pre-authorization for services that require it may result in a denial of coverage for those services.

3. Network Providers:

To maximize your dental benefits and minimize out-of-pocket costs, it is essential to utilize in-network dental providers. Services rendered by out-of-network providers may result in higher costs or may not be covered. You can access a list of in-network dental providers on our website at the web address at the bottom of the page, or by contacting Enrollee Services at the numbers at the bottom of the page.

I2. Vision Services

Routine eye exams do not require a referral or prior authorization as long as they are provided by a plan network provider. You also have an eyewear allowance of $403 per year to buy up to 2 pairs of prescription eyeglasses, contacts, lenses, frames, and upgrades when purchased from an EyeMed network provider.

You can access a list of EyeMed network providers on our website at the web address at the bottom of the page, or by contacting Enrollee Services at the numbers at the bottom of the page.

To learn more about coverage of dental and vision services, see our plan's Benefits Chart in **Chapter 4**.

J. Covered services in a medical emergency, when urgently needed, or during a disaster

J1. Care in a medical emergency

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

- serious risk to your life; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, worldwide, from any provider with an appropriate state license even if they're not part of our network.

- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. Please call Enrollee Services at the numbers at the bottom of the page to notify us of your emergency.

Covered services in 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. To learn more, refer to the Benefits Chart in **Chapter 4** of this Member Handbook.

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

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

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 our plan's Benefits Chart in Chapter 4, Section 2.1.

The Massachusetts Behavioral Health Help Line can connect you directly to clinical help, when and where you need it. Call them at 1-833-773-2445 or visit www.masshelpline.com.

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.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

J2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

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

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

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.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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 outside the United States and its territories.

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.

J3. 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're still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: fallonhealth.org/navicare.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this Member Handbook for more information.

K. What if you're billed directly for covered services

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this Member Handbook to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

K1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this Member Handbook), **and**

- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this Member Handbook explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Enrollee Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Enrollee Services to find out what the benefit limits are and how much of your benefits you've used.

L. Coverage of health care services in a clinical research study

L1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your Navigator to contact Enrollee Services to let us know you'll take part in a clinical trial.

L2. Payment for services when you're in a clinical research study

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

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare **hasn't** approved, you pay any costs for being in the study.

L3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf).You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

M. How your health care services are covered in a religious non-medical health care institution

M1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

M2. 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're against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's **not voluntary and 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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

You are covered for an unlimited number of days. Refer to our plan's Benefits Chart in **Chapter 4** to learn more.

N. Durable medical equipment (DME)

N1. DME as a member of our plan

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

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you **will** own the 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.

In some limited situations, we won't transfer ownership of the DME item to you. Call Enrollee Services at the phone number at the bottom of the page for more information.

N2. DME ownership if you switch to Original Medicare

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

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

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan**.

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

N3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

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

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

N4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

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

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

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

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.

- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

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

Chapter 4: Benefits chart

Introduction

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

Table of Contents

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this Member Handbook. This chapter also explains limits on some services.

Because you get help from Masshealth, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this Member Handbook for details about our plan's rules.

If you need help understanding what services are covered, call Enrollee Services at 1-877-700-6996 or contact your Navigator.

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this Member Handbook or call Enrollee Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and MassHealth covered services according to the rules set by Medicare and MassHealth.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. **Chapter 3** of this Member Handbook has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this Member Handbook has more information about getting a referral and when you **don't** need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA in italic type.
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.

Other important things to know about our coverage:

- You are covered by both Medicare and MassHealth. Medicare covers health care and prescription drugs. MassHealth covers your cost sharing for Medicare services, including coinsurance and deductibles. MassHealth 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 2026 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 2026, either Medicare or our plan will cover those services.

- Because you get assistance from MassHealth, 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, our plan also provides additional benefits to you as approved in your ICP. 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 lose eligibility but can be expected to regain it within 30 days, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will continue to cover MassHealth benefits that are included under MassHealth Standard, 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 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 Members with Certain Chronic Conditions.

- If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits:
    - Autoimmune disorders
    - Cancer
    - Cardiovascular disorders
    - Chronic heart failure
    - Chronic alcohol use disorder and other substance use disorders
    - Chronic and disabling mental health conditions
    - Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
    - Chronic gastrointestinal disease
    - Chronic kidney disease (CKD)
    - Chronic lung disorders
    - Conditions associated with cognitive impairment

- Conditions that require continued therapy in order for individuals to maintain or retain functioning
- Conditions with functional challenges
- Dementia
- Diabetes mellitus
- HIV/AIDs
- Immunodeficiency and Immunosuppressive disorders
- Neurologic disorders
- Post-organ transplantation
- Severe hematologic disorders
- Stroke

The diagnosis must be on file and recorded with NaviCare prior to receiving Special Supplemental Benefits for the Chronically Ill. Not all members with an eligible condition will qualify.

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 or network provider. Upon validation that eligibility criteria have been met, NaviCare will notify you of your enrollment in these benefits. These benefits are not retrospective.

- Refer to the “Special Supplemental Benefits for the Chronically Ill” row in the Benefits Chart for more information.
- Contact us for additional information.

All preventive services are free. This apple 🍎 shows the preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

	Covered Service	What you pay
🍎	**Abdominal aortic aneurysm screening** We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Abortion services Abortion services are covered under your MassHealth state benefit.	$0
	Acupuncture *For acupuncture treatment of any diagnosis to be covered beyond the 20th visit, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* We pay for acupuncture services: • To treat pain; • As part of SUD treatment; and • for related evaluation and treatment planning office visits We require prior approval after 20 acupuncture treatments in each year for pain or SUD treatment. Your provider may also change or stop your treatment plan if you're not getting better after the first 4 treatments. For chronic low back pain, we pay for up to 12 acupuncture visits in 90 days. Chronic low back pain is defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** **This benefit is continued on the next page.**	$0

	Covered Service	What you pay
	Acupuncture (continued) • not associated with pregnancy. We wil also pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement in the first 12 visits. Acupuncture treatments must be stopped if you don't get better or if you get worse. 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 master's 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. 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.	

	Covered Service	What you pay
	Adult day health services *For adult day health to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers services from adult day health providers at an organized program. These services may include the following: • nursing services and health oversight • therapy • assistance with activities of daily living • nutritional and dietary services • counseling services • activities • case management • transportation	$0
	Adult foster care services *For adult foster care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers services from adult foster care providers in a residential setting. These services may include the following: • assistance with activities of daily living, instrumental activities of daily living, and personal care • supervision • nursing oversight	$0

	Covered Service	What you pay
🍎	**Alcohol misuse screening and counseling** We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0
	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.* Coverage is worldwide. Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0
	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.	$0

Covered Service		What you pay
🍎	**Annual wellness visit** You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0
	Audiologist services *For audiologist services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers audiologist (hearing) exams and evaluations.	$0
🍎	**Bone mass measurement** We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
🍎	**Breast cancer screening (mammograms)** We pay for the following services: • one screening mammogram every 12 months • clinical breast exams once every 24 months	$0

	Covered Service	What you pay
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's referral. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0
🍎	**Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)** We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0
🍎	**Cardiovascular (heart) disease screening tests** We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. MassHealth covers additional blood tests when medically necessary.	$0
🍎	**Cervical and vaginal cancer screening** We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • MassHealth (Medicaid) covers additional Pap tests and pelvic exams when medically necessary.	$0

	Covered Service	What you pay
	Chiropractic services We pay for the following services: adjustments of the spine to correct alignment, office visits, and radiology services. • MassHealth covers chiropractic manipulative treatment and radiology services.	$0
	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.	$0
	Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	$0
🍎	**Colorectal cancer screening** We pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed **This benefit is continued on the next page.**	$0

	Covered Service	What you pay
	Colorectal cancer screening (continued) following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • 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. • 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. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	

Covered Service		What you pay
	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 ICT. These services will be provided following MassHealth regulations and guidelines. Services include but are not limited to: • Alzheimer's/Dementia Coaching • Assistive Technology for Telehealth • 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 Emergency Response System (PERS) • Peer Support • Respite care • Supportive Home Care Aide • Transitional Assistance **This benefit is continued on the next page.**	$0

	Covered Service	What you pay
	Community-based services (In-home care) (continued) • Translation/Interpreting Services • Wander Response System	
	Community health center services The plan covers services from a community health center. Examples include the following: • office visits for primary care provider and specialists • OB/GYN and prenatal care • pediatric services, including EPSDT • health education • medical social services • nutrition services, including diabetes self-management training and medical nutrition therapy • tobacco-cessation services • vaccines not covered by the Massachusetts Department of Public Health (MDPH)	$0
	Companion services *For companion services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Includes socialization, help with shopping and errands, escort to doctor's appointments, nutrition sites, walks, recreational activities, and assistance with preparation and serving of light snacks.	$0

	Covered Service	What you pay
	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.	$0
	Day habilitation services *For day habilitation services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers a program of services offered by day habilitation providers if you qualify because you have an intellectual or developmental disability. At this program, you develop a service plan that includes your goals and objectives and the activities to help you meet them. These services may include the following: • nursing services and health care supervision • developmental-skills training • therapy services • life skills/adult daily living training	$0
	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.	$0

Covered Service	What you pay
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 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.* The plan covers preventive, restorative, and emergency oral health care. We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, NaviCare HMO SNP covers the following dental services as Medicare supplemental benefits: • Preventive/diagnostic: o Comprehensive oral evaluations (New patient or full periodontal visit) o Periodic oral evaluations (Routine or problem-focused visit) o Regular dental cleanings (Prophylaxis) o Fluroide treatment o Bitewing X-rays • Endodontic therapy o Root canal therapy, anterior, premolar, molar root canals, pulpal regeneration, and apicoectomy • Restorative o Amalgam and resin-based composite fillings o Crowns, cores, inlays, onlays and posts, reinforcing pins and crown repair **This benefit is continued on the next page.**	$0 Services must be performed by a DentaQuest provider. Limitations may apply. For more information, contact Enrollee Services.

Covered Service	What you pay

Dental services (continued)
• Periodontics
  ○ Gingivectomy/gingivoplasty
  ○ Scaling and root planning
  ○ Periodontal maintenance
• Prosthodontic services (fixed):
  ○ Pontic – porcelain or resin, and crowns, inlays, onlays, crowns and retainer, recement or rebond fixed partial denture
• Prosthodontic services (removable):
  ○ Complete, immediate, overdenture, and partial dentures (upper and lower)
  ○ Relines and adjustments of complete dentures
  ○ Repair, replace teeth, rebase, soft liner, tissue conditioning, metal substructure
• Implant services
  ○ Implant placement, abutment, implant supported crown, retainer, removable or fixed denture
• Oral and maxillofacial surgery:
  ○ Extractions (removal of teeth)
  ○ Biopsy and soft tissue surgery
  ○ Alveoplasty
  ○ Bone grafting
• Adjunctive general services
  ○ Sedation and anesthiesia
  ○ Cleaning and inspection of removable dentures – partial and complete
This benefit is continued on the next page.	

Covered Service	What you pay
Dental services (continued) **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. ○ 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. **This benefit is continued on the next page.**	

	Covered Service	What you pay
	Dental services (continued) • 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 2 implants per calendar year. • Implants are covered once per tooth/site per 60 months. Services must be performed by a DentaQuest provider. Additional limitations may apply. For more information, contact Enrollee Services.	
🍎	**Depression screening** We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0

Covered Service	What you pay
Diabetes screening We pay for 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 • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0
Diabetic self-management training, 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.* We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ○ a blood glucose monitor ○ blood glucose test strips ○ lancet devices and lancets ○ glucose-control solutions for checking the accuracy of test strips and monitors **This benefit is continued on the next page.**	$0

Covered Service	What you pay
Diabetic self-management training, services, and supplies (continued) ▪ Our preferred blood glucose monitors are Accu-Chek® glucose monitors and test strips (up to five test strips per day) manufactured by Roche. Plan members can obtain an Accu-Chek® glucose monitor at network pharmacies. ▪ Our preferred continuous blood glucose monitors are Freestyle Libre monitors and supplies. Members must 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. ▪ 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, we pay for the following: ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Enrollee Services. • 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.	

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies *For 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.* Refer to **Chapter 12** of this Member Handbook for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. **This benefit is continued on the next page.**	$0 for Medicare- and MassHealth-covered durable medical equipment and related supplies. Your cost-sharing for Medicare oxygen equipment coverage is $0.

	Covered Service	What you pay
	Durable medical equipment (DME) and related supplies (continued) We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you. Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We don't cover other brands and makers unless your doctor or other provider tells us that you need the brand. If you're new to our plan and using a brand of DME not on our list, we'll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is appropriate for your medical condition. For more information about appeals, refer to **Chapter 9** of this Member Handbook. NaviCare HMO SNP covers a seat lift chair once per lifetime up to $900. You pay all charges over the $900 plan coverage limit.	$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.

	Covered Service	What you pay
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your life; **or** • serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. 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 outside of the United States and its territories.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.

	Covered Service	What you pay
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	$0
	Geriatric Support Services Coordination In-home assessment and home-based services coordination provided by Aging Service Access Points (ASAPs) staff.	$0

	Covered Service	What you pay
	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.* The plan covers services provided by group adult foster care providers for members who qualify**.** These services are offered in a group-supported housing environment and may include the following: • assistance with activities of daily living, instrumental activities of daily living, and personal care • supervision • nursing oversight • care management	$0
🍎	**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. **This benefit is continued on the next page.**	$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

	Covered Service	What you pay
	Health and wellness education programs (continued) • 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 at the bottom of the page.	
	Hearing services, including hearing aids *For audiology services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. The plan also covers the following: • providing and dispensing hearing aids, batteries, and accessories • instruction in the use, care, and management of hearing aids • ear molds • ear impressions • loan of a hearing aid, when necessary • routine hearing exams • diagnostic services • one hearing aid per ear, either one binaural or two monaural, every floating 60 months per MassHealth guidelines	$0 for each Medicare- and MassHealth-covered hearing service.

Covered Service		What you pay
🍎	**HIV screening** We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection.	$0
	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* Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • medication administration • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	$0

	Covered Service	What you pay
	Home health aide services *For home health agency care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers services from a home health aide, under the supervision of a licensed RN or other professional, for members who qualify. Services may include the following: • simple dressing changes • assistance with medications • activities to support skilled therapies • routine care of prosthetic and orthotic devices	$0
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. Some drugs may be covered under Medicare Part D.	$0

	Covered Service	What you pay
	Homeless medical respite services You have access to pre- and post- colonoscopy support to prepare for and recover after a colonoscopy procedure. You have access to recovery support post acute medical issues, case management and health and referral navigation to address other health and social needs, and planning support for transition to settings in the community.	
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care • If you choose to get your hospice care in a nursing facility, NaviCare HMO SNP will cover the cost of room and board. **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **This benefit is continued on the next page.**	$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. $0 for members eligible for hospice consultation services.

	Covered Service	What you pay
	Hospice care (continued) **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this Member Handbook. **Note:** If you need non-hospice care, call your Navigator and/or Enrollee Services to arrange the services. Non-hospice care is care that isn't related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen 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.* We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this Member Handbook to learn more.	$0

	Covered Service	What you pay
	Independent nursing *For independent nursing services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers care from an independent nurse in your home. This would include a nursing visit of more than two continuous hours of nursing services for individuals living in the community.	$0
	Inpatient behavioral health care *For inpatient behavioral health care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* Inpatient services, such as: • inpatient mental health services to evaluate and treat an acute psychiatric condition • inpatient substance use disorder services • observation/holding beds • administratively necessary day services Under this plan, there's no lifetime limit on the number of days a member can have in an inpatient behavioral health care facility.	$0
	Inpatient hospital care *For inpatient hospital care to be covered, your doctor or plan provider must get prior authorization (approval in advance) from the plan.* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're 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 **This benefit is continued on the next page.**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Covered Service		What you pay
	Inpatient hospital care (continued) covers your inpatient hospital stay beyond the 90-day limit as medically necessary. See Chapter 12 for an explanation of "benefit period." We pay for the following services and other medically necessary services not listed here: • 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 • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance misuse services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • blood, including storage and administration. Coverage begins with the first pint of blood that you need. • physician services **This benefit is continued on the next page.**	

	Covered Service	What you pay
	Inpatient hospital care (continued) **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're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at 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.	
	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.* We pay for mental 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 covers your inpatient stay in a psychiatric hospital beyond the Medicare limit.	$0
	Inpatient stay: Covered services in a hospital or skilled nursing facility (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.* 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 **This benefit is continued on the next page.**	$0

	Covered Service	What you pay

	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued)
	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.
	We pay for the following services, and maybe other services not listed here:
	• doctor 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 for fractures and dislocations
	• prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of:
	  ○ an internal body organ (including contiguous tissue), **or**
	  ○ the function of an inoperative or malfunctioning internal body organ.
	• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition
	• physical therapy, speech therapy, and occupational therapy	

	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 Patient Paid Amount financial responsibility may apply. Services are covered in accordance with the MassHealth Nursing Facility regulations.	$0

	Covered Service	What you pay
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this Member Handbook, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	$0

Covered Service	What you pay
Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0
Medical nutrition therapy *Three total visits of supplemental one-on-one medical nutrition 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.* The plan covers nutritional diagnostic therapy and counseling servces to help you manage a medical condition (such as diabetes or kidney disease). MassHealth 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.	$0

	Covered Service	What you pay
	Medically necessary non-emergency transportation *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.* The plan covers transportation you need for medical reasons other than emergencies. This includes chair car, taxi, common carriers, and ambulance (land) services as needed to help you get to a service we pay for (in-state or out-of-state). 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. Plan will cover unlimited trips per year by ambulance (when authorized as medically necessary), van/chairvan, rideshare services 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 our business hours by calling the plan's transportation vendor. We suggest making these arrangements at least 2 business days in advance.	$0
🍎	**Medicare Diabetes Prevention Program (MDPP)** Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Covered Service	What you pay
Medicare Part B drugs *For certain Medicare Part B 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.* These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery 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 our plan authorized • the Alzheimer's drug Leqembi® (generic lecanemab) which is given intravenously (IV) • clotting factors you give yourself by injection if you have hemophilia • 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. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • 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 **This benefit is continued on the next page.**	$0 for Part B covered prescription drugs and Part B covered insulin. $0 for primary care provider or specialist office visits to administer Part B covered prescription drugs.

Covered Service	What you pay
Medicare Part B drugs (continued) • 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). 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 covered under Medicare Part B • calcimimetic and phoshate binder 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 • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have 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-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: fallonhealth.org/navicare-formulary. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **This benefit is continued on the next page.**	

	Covered Service	What you pay
	Medicare Part B drugs (continued) **Chapter 5** of this Member Handbook explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this Member Handbook explains what you pay for your drugs through our plan.	
	Nursing facility care *For nursing facility care to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given 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 • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services **This benefit is continued on the next page.**	$0

	Covered Service	What you pay
	Nursing facility care (continued) • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
🍎	**Obesity screening and therapy to keep weight down** If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0

	Covered Service	What you pay
	Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0
	Orthotic services *For certain orthotic services to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers braces (non-dental) and other mechanical or molded devices to support or correct the form or function of the human body.	$0

	Covered Service	What you pay
	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.* We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration. Coverage begins with the first pint of blood that you need. • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests	$0
	Outpatient drugs Please read **Chapter 5** for information on drug benefits, and **Chapter 6** for information on what you pay for drugs.	$0

	Covered Service	What you pay

	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 pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:
	• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
	  ○ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient."
	  ○ Sometimes you can be in the hospital overnight and still be "outpatient."
	  ○ You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf.
	• Labs and diagnostic tests billed by the hospital
	• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it
	• X-rays and other radiology services billed by the hospital
	• Medical supplies, such as splints and casts
	• Preventive screenings and services listed throughout the Benefits Chart
	• Some drugs that you can't give yourself
		$0

	Outpatient mental 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.* We pay for mental health services provided by: • a state-licensed psychiatrist or doctor **This benefit is continued on the next page.**	$0

Covered Service		What you pay
	Outpatient mental health care (continued) • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws The plan covers services including: • individual, group, and couples/family treatment • medication visit • diagnostic evaluation • family consultation • case consultation • psychiatric consultation on an inpatient medical unit • inpatient-outpatient bridge visit • acupuncture treatment • opioid replacement therapy • ambulatory detoxification (Level II.d) • psychological testing • Dialectical Behavioral Therapy • Emergency Department-based Crisis Intervention Mental Health Services • Electro-Convulsive Therapy • Repetitive Transcranial Magnetic Stimulation (rTMS) • Specialing	

	Covered Service	What you pay
	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.* *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.* We pay for physical therapy, occupational therapy, and speech therapy, and related comprehensive evaluations. You can get outpatient rehabilitation services and therapy services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. NaviCare HMO SNP covers additional outpatient rehabilitation services under the MassHealth benefit.	$0
	Outpatient substance use disorder services *For Intensive Outpatient Program (IOP) to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* 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 **This benefit is continued on the next page.**	$0 for Medicare- and MassHealth-covered individual or group therapy visits $0 for MassHealth-covered acupuncture

	Covered Service	What you pay
	Outpatient substance use disorder services (continued) We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug misuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment MassHealth 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	

	Covered Service	What you pay
	Outpatient surgery *For outpatient surgery to be covered, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. NaviCare HMO SNP covers additional outpatient services under the MassHealth benefit. **Note:** Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient.	$0
	Over-the-Counter (OTC) items (Save Now card to purchase certain Medicare approved over-the-counter items and healthy food) You receive a NaviCare Save Now card with $375 in credits that are applied at the beginning of each calendar quarter (every three months) to purchase NaviCare-approved OTC and health-related 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). **NOTE:** Members who *do not* qualify for the Special Supplemental Benefits for the Chronically Ill can only use the Save Now card toward the purchase of NaviCare-approved OTC items. Members who *do* qualify for the Special Supplemental Benefits for the Chronically Ill will have a portion of the quarterly OTC allowance on the Save Now card designated for the purchase of NaviCare-approved food products at OTC network retailers.	$0 for MassHealth-covered over-the-counter items. Using the Save Now card, you pay $0 for approved over-the-counter items, up to $375 every quarter. You pay all costs over $375 per quarter. Any unused balances at the end of each calendar quarter will not roll over into the following quarter. Please see the **Special Supplemental Benefits for the Chronically Ill (SSBCI)** section in this Benefits Chart for more information.

	Covered Service	What you pay
	Oxygen and respiratory therapy equipment *For certain oxygen and respiratory therapy equipment to be covered, your doctor or plan provider must get prior authorization (approval in advance) from the plan.* The plan covers services including oxygen systems, refills, and oxygen therapy equipment rental.	$0
	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. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.	$0
	Personal care attendant services *For personal care attendant services to be covered, your doctor or other plan provider must prior authorization (approval in advance) from the plan.* The plan covers personal care attendant services to assist you with activities of daily living and instrumental activities of daily living if you qualify. **This benefit is continued on the next page.**	$0

	Covered Service	What you pay
	Personal care attendant services (continued) These include, for example: • bathing • meal preparation and eating • dressing and grooming • medication management • moving from place to place • toileting • transferring • laundry • housekeeping You can hire a worker yourself to help you with hands-on tasks. The plan may also pay for a worker to help you with other tasks, that don't need hands-on help. Your Interdisciplinary Care Team will work with you to decide if that service is right for you and will be in your Individualized Care Plan (ICP).	
	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 Over-the-Counter Drug List. MassHealth and NaviCare HMO SNP require a prescription for both drugs and certain over-the-counter drugs.	$0

	Covered Service	What you pay

	Physician/provider 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.
	We pay for the following services:
	• medically necessary health care or surgery services given in places such as:
	  ○ physician's office
	  ○ certified ambulatory surgical center
	  ○ hospital outpatient department
	• consultation, diagnosis, and treatment by a specialist
	• basic hearing and balance exams given by your primary care provider ***or*** specialist, if your doctor orders them to find out whether you need treatment
	• Certain telehealth services, including: primary care; specialist care; outpatient behavioral health services; opioid treatment and outpatient substance use disorder services.
	  ○ 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.
	  ○ 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.
	This benefit is continued on the next page.
		$0 for each Medicare- and MassHealth-covered primary care doctor visit.
		$0 for each Medicare- and MassHealth-covered specialist doctor visit.
		$0 for each MassHealth-covered diagnostic hearing exam.
		$0 for Medicare- and MassHealth-covered dental benefits.
		$0 for the cost of each Medicare- and MassHealth-covered visit via telehealth.
		$0 for the cost of each Medicare- and MassHealth-covered outpatient hospital facility or ambulatory surgical center visit.

	Covered Service	What you pay

	Physician/provider services, including doctor's office visits (continued)
	• telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home
	• telehealth services to diagnose, evaluate, or treat symptoms of a stroke
	• telehealth services for members with a substance use disorder or co-occurring mental health disorder
	• telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
	  ○ You have an in-person visit within 6 months prior to your first telehealth visit
	  ○ You have an in-person visit every 12 months while receiving these telehealth services
	  ○ Exceptions can be made to the above for certain circumstances
	• telehealth services for mental health visits provided by rural health clinics and federally qualified health centers.
	• virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**
	  ○ you're not a new patient **and**
	  ○ the check-in isn't related to an office visit in the past 7 days **and**
	  ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
	This benefit is continued on the next page.	

	Covered Service	What you pay

	Physician/provider services, including doctor's office visits (continued)
	• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**:
	  ○ you're not a new patient **and**
	  ○ the evaluation isn't related to an office visit in the past 7 days **and**
	  ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
	• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient
	• Second opinion by another network provider before surgery
	• Non-routine dental care (covered services are limited to 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.	

	Covered Service	What you pay
	Physician, nurse practitioner, and nurse midwife services The plan covers physician, nurse practitioner, and nurse midwife services. These include, for example: • office visits for primary care and specialists • OB/GYN and prenatal care • diabetes self-management training • medical nutritional therapy • tobacco-cessation services	$0
	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.* We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes The plan also covers podiatric care, including routine foot care, not covered by Medicare under the MassHealth benefit.	$0
	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.	$0

Covered Service		What you pay
	Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services **include:** • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0
	Prostate cancer screening exams We pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0

	Covered Service	What you pay
	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 benefit. Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	$0
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0

	Covered Service	What you pay
	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.	$0
	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.	$0
	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.	$0
🍎	**Remote patient monitoring** The use of select medical devices that transmit digital personal health information in a synchronous or asynchronous manner from an at-risk patient to a treating provider at a distant location, enabling the provider to respond to the patient and manage their condition. RPM is available to members who meet certain clinical criteria.	

Covered Service		What you pay
	Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your **primary care doctor or other qualified health care provider orders one and you meet one of these conditions:** • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
	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, go to **Chapter 12.** **This benefit is continued on the next page.**	$0

	Covered Service	What you pay
	Skilled nursing facility (SNF) care (continued) We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration. Coverage begins with the first pint of blood that you need. • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	
🍎	**Smoking and tobacco use cessation** Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: **This benefit is continued on the next page.**	$0

	Covered Service	What you pay

	Smoking and tobacco use cessation (continued)
	• use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
	• are competent and alert during counseling
	• a qualified physician or other Medicare-recognized practitioner provides counseling
	We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).
	MassHealth covered services include:
	• Face-to-face individual and group tobacco cessation counseling
	• Pharmacotherapy treatment
	  ○ nicotine patches
	  ○ gum
	  ○ lozenges
	Our 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.	

	Covered Service	What you pay
	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. Chronic conditions include: autoimmune disorders, cancer, cardiovascular disorders, chronic alcohol and other drug dependence, chronic and disabling behavioral health conditions, chronic heart failure, 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. Qualifying members will have access to: • $200 of the OTC funds per calendar quarter through their Save Now card designated for purchase of healthy food and produce items at network retailers. Any unused balances at the end of each calendar quarter will not roll over into the following quarter. • 100 one-way trips to non-emergent non-medical approved locations per year, through plan's approved vendor.	$0 for: • Use of $200 per calendar quarter from the Save Now OTC funds designated for the purchase of our-approved food and produce at network retailers. You pay all costs over $200 per calendar quarter. • 100 one-way trips to non-emergent non-medical approved locations per year.

	Covered Service	What you pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0
	Transitional living services program *For transitional living services to be covered, you, your doctor or other plan provider must get prior authorization (approval in advance) from the plan.* The plan covers services provided by a transitional living services provider for members who qualify**.** These services are provided in a residential setting and may include the following: • personal care attendant services • on-site 24-hour nurse oversight • meals • skills trainers • assistance with Instrumental Activities of Daily Living (e.g., laundry, shopping, cleaning)	$0

	Covered Service	What you pay
	Transportation services – plan approved health-related *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.* The plan will cover up to a total of 100 one-way trips per year by ambulance (when authorized as medically necessary), van/chairvan, rideshare services or taxi to locations such as grocery store or religious services for SSBCI qualified members only. 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 eligible members in the vehicle traveling to the same or different location. Transportation, including friends and family reimbursements, must be coordinated and arranged during our business hours by calling the plan's transportation vendor. We suggest making these arrangements at least 2 business days in advance.	$0 for 48 one-way Medicare-covered trips to a retail pharmacy. Trips are limited to 4 one-way per month. Please see the Special Supplemental Benefits for the Chronically Ill (SSBCI) section in this Benefits Chart for more information about additional transportation coverage under that benefit.

	Covered Service	What you pay
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseeen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your time, place, or circumstances, it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). 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 outside the United States and its territories.	$0
🍎	**Vision care** We pay for: • comprehensive eye exams • vision training • eye glasses • contact lenses and other visual aids **This benefit is continued on the next page.**	$0 for Medicare- and MassHealth-covered vision care services, including low vision aids. $0 for supplemental eyewear up to $403.

Covered Service		What you pay
	Vision care (continued) We also pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans • Hispanic Americans For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery. MassHealth-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: ○ Store promotions or coupons ○ The one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery ○ Two pairs of glasses in lieu of bifocals ○ Non-prescription lenses and/or contact lenses ○ Non-prescription sunglasses	There is a $403 plan coverage limit for supplemental eyewear per calendar year. You pay all charges over $403 each year.

	Covered Service	What you pay
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0
	Wellness visit The plan covers wellness checkups. This is to make or update a prevention plan.	$0
	Wigs For members who suffer hair loss as a result of the treatment for any form of cancer or leukemia, wigs are covered. NaviCare will cover up to $400 per calendar year. Members are responsible for amounts that exceed $400.	$0 for Medicare- and MassHealth-covered wigs. $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.

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

Community-based (diversionary) behavioral health care services that our plan covers	
These services include the following: • Medically Monitored Intensive Services - Acute Treatment Services (ATS) for substance use disorders • Clinical Stabilization Services - clinically managed population-specific high intensity residential services • clinical stabilization services for substance use disorders • community crisis stabilization • Community Support Program (CSP), including CSP for homeless individuals, CSP for justice involved, and CSP Tenancy Preservation Program* • Adult Mobile Crisis Intervention (formerly Emergency Services Program (ESP)) You have the option of getting these services through an in-person visit or by telehealth. 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. • Partial Hospitalization (PHP) services ○ “Partial hospitalization” is a structured program of active psychiatric treatment. It’s offered as a hospital outpatient service or by a community mental health center. It’s more intense than the care you get in your doctor’s, therapist’s, or licensed marriage and family therapist’s (LMFT) or licensed professional counselor’s office. It can help keep you from having to stay in the hospital. **This service is continued on the next page.**	

Community-based (diversionary) behavioral health care services that our plan covers (continued)	
Intensive Outpatient (IOP) services and IOP programs ○ Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided at a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that's more intense than the care received in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. ○ An IOP program provides time-limited, comprehensive, and coordinated multidisciplinary treatment and are designed to improve Functional Status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. • Program of Assertive Community Treatment (PACT) • psychiatric day treatment • recovery coaching • recovery support navigators • Residential Rehabilitation Services for Substance Use Disorders, including: ○ Adult RRS ○ Family RRS ○ Young Adult RRS ○ Co-occurring Enhanced RRS (COE-RRS) • Structured Outpatient Addiction Program (SOAP) • Certified Peer Specialist • Enhanced Structured Outpatient Addiction Program (E-SOAP) • Transitional Support Services (TSS) for substance use disorders	

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

Community-based services that our plan covers	
Care transitions assistance The plan pays covers services to help with transitions between care settings for members who qualify. These services may include the following: • coordination of information between your providers • follow-up after your inpatient or facility stay • education about your health condition • referrals	
Community health workers The plan covers services provided by community health workers, which may include the following: • health education in your home or community • getting you the services you need • counseling, support and screenings Services from a community health worker means that you'll be getting help from someone who'll advocate for you and who understands your culture, needs and preferences	

Community-based services that our plan covers	
Day services The plan covers structured day activities at a program to help you learn skills that you need to live as independently as possible in the community. Skills are designed to meet your needs, and may include the following: • daily living skills • communication training • prevocational skills • socialization skills	
Home care services The plan covers home care services provided in your home or community if you qualify. These services may include the following: • a worker to help you with household talks • a worker to help you with your everyday tasks and personal care. Assistance can be hands-on, prompting, or supervising these tasks. • training or activities to improve your community living skills and help you advocate for yourself	
Home modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, welfare and safety or make you more independent in your home. Modifications may include the following: • ramps • grab-bars • widening of doorways • special systems for medical equipment	

Community-based services that our plan covers	
Medication management The plan covers medication management services from a support worker if you qualify. The support worker will help you take your prescription and over-the-counter medications. The service may include the following: • reminding you to take your medication • checking the medication package • watching you take your medication • writing down when you take your medication • opening medications and reading the labels for you	
Nonmedical transportation The plan covers transportation to community services and activities that help you stay independent and active in your community.	
Peer support/counseling/navigation The plan covers training, instruction, and mentoring services if you qualify. These services will help you to advocate for yourself and participate in your community. You may get these services from a peer or in small groups.	
Respite care The plan covers respite-care services if your primary caregiver needs relief or is going to be unavailable for a short-term basis. These services can be provided in an emergency or be planned in advance. If planned in advance, services might be in your home, or during a short-term placement in adult foster care, adult day health, nursing facility, assisted living, rest home, or hospital.	

E. Benefits covered outside of our plan

We don't cover the following services, but they're available through MassHealth.

E1. State Agency Services

Psychosocial Rehabilitation and Targeted Case Management

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

Rest Home Room and Board

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

F. Benefits not covered by our plan, Medicare, or MassHealth

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Medicaid don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this Member Handbook) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this Member Handbook.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not "reasonable and medically necessary", according Medicare and MassHealth standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this Member Handbook for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.

- all services, procedures, treatments, medications and supplies related to Workers' Compensation claims
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged 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 benefit, following MassHealth Program regulations.
- functional medicine services/procedures and supplies (including labs and supplements). Functional medicine includes alternative, holistic, and naturopathic medicine.
- 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
- health services received as a result of war or any act of war that occurs during the member's term of coverage under this Member Handbook
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- personal care services not covered by Medicare or MassHealth, including babysitting, recreation, supervision, verbal prompting or cueing, or vocational training.
- 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.

- radial keratotomy and LASIK surgery. Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. MassHealth benefits and additional supplemental plan coverage for routine eye exams, glasses, contact lenses are covered by the plan, subject to limits.
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and there is a charge from the VA, we'll reimburse the veteran for the difference.
- services that you get from non-plan providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services at a Medicare-approved facilty that you get when you are temporarily outside the NaviCare HMO SNP service area, and care from non-plan providers that is arranged with prior authorization from NaviCare HMO SNP.
- self-referral to providers outside of the plan's network unless for the purpose of emergency care, urgent care and out-of-area dialysis at Medicare -approved facilities.
- transportation to appointments for someone other than the member.
- separate mileage reimbursement for transportation of multiple members within same vehicle traveling to the same or different locations.

Chapter 5: Getting your outpatient drugs

Introduction

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

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this Member Handbook.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5**, **Section D** "If you're in a Medicare-certified hospice program."
- Some prescription drugs are covered for you under your MassHealth benefits. The *NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List*, found on fallonhealth.org/navicare, tells you which drugs are covered (with a prescription) under your MassHealth Standard drug coverage.

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's List of Covered Drugs. We call it the "Drug List" for short. (Refer to **Section B** of this chapter.)

- If it isn't on the Drug List, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9, Section G,** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the Provider and Pharmacy Directory, visit our website or contact Enrollee Services.

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

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for your covered drug.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, contact Enrollee Services right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this Member Handbook.
- If you need help getting a prescription filled, contact Enrollee Services.

A3. What to do if you change your network pharmacy

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

If you need help changing your network pharmacy, contact Enrollee Services.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Enrollee Services.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy, which is 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.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Enrollee Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.) To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Enrollee Services.

A6. Using mail-order services to get your drugs

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

Our plan's mail-order service allows you to order up to a 100-day supply. A 30-day supply has the same copay as a one-month supply.

Note: NaviCare members have no costs for covered services.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, call Enrollee Services at the number at the bottom of the page.

Usually, a mail-order prescription arrives within 5 business days after the completed order is received. 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 at the number at the bottom of the page 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.

Mail-order processes

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

1. **New prescriptions the pharmacy gets from you**

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets from your provider's office**

   The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

   - You used mail-order services with our plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or 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 don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling 1-844-657-0494 (TRS 711).

   If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it's shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling 1-844-657-0494 (TRS 711).

3. Refills on mail-order prescriptions

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

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 7-10 business days before your current prescription will run out to make sure your next order is shipped to you in time.

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

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. You may provide your communication preference by calling 1-844-657-0494 (TRS 711).

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 30-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Enrollee Services for more information.

Note: NaviCare members have no costs for covered services.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with Enrollee Services first to find out if there's a network pharmacy nearby.

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

- 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.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to **Chapter 7** of this Member Handbook.

B. Our plan's Drug List

We have a List of Covered Drugs. We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under MassHealth.

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

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

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products 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.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the Drug List.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Enrollee Services.

B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Visit our plan’s website at fallonhealth.org/navicare. The Drug List on our website is always the most current one.
- Call Enrollee Services to find out if a drug is on our Drug List or to ask for a copy of the list.
- Use our “Real Time Benefit Tool” at fallonhealth.org/navicare to search for drugs on the Drug List to get an estimate of what you’ll pay and if there are alternative drugs on the Drug List that could treat the same condition. You can also call Enrollee Services.
- Check the most recent NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List we provided electronically.

B3. Drugs not on our Drug List

We don’t cover all drugs.

- Some drugs aren’t on our Drug List because the law doesn’t allow us to cover those drugs.
- In other cases, we decided not to include a drug on our Drug List.
- In some cases, you may be able to get a drug that isn’t on our Drug List. For more information refer to **Chapter 9.**

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this Member Handbook for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and MassHealth drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.

2. Our plan can't cover a drug purchased outside the United States and its territories, unless administered by a qualified provider in an emergency or urgent care setting to stabilize an emergency medical condition.

3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or MassHealth can't cover the types of drugs listed below. However, some of these drugs may be covered for you under your MassHealth Standard drug coverage; refer to the 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 HMO SNP Over-the-Counter and Additional MassHealth Covered Drugs List
- Drugs used to promote fertility
- 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
- Outpatient drugs made by a company that says you must have tests or services done only by them

C. Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

Note: NaviCare members have no costs for covered services.

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 provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this Member Handbook.

1. Limiting use of a brand name drug or original biological products when a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there's an available generic version.
- However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you **or** wrote "No substitutions" on your prescription for a brand name drug or original biological product *or* told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Enrollee Services at the number at the bottom of the page or on our website at fallonhealth.org/navicare-formulary for more information about prior authorization.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Enrollee Services at the number at the bottom of the page or on our website at fallonhealth.org/navicare-formulary for more information about step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Enrollee Services or check our website at fallonhealth.org/navicare. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this Member Handbook.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, **Section C,** some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

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

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

1. The drug you've been taking:
    - is no longer on our Drug List **or**
    - was never on our Drug List **or**
    - is now limited in some way.
2. You must be in one of these situations:
    - You were in our plan last year.
        - We cover a temporary supply of your drug during the first 108 days of the calendar year.
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30days of medication. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
    - You're new to our plan.
        - We cover a temporary supply of your drug **during the first 108 days of your membership in our plan.**
        - This temporary supply is for up to 30 days.

  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.

- You've been in our plan for more than 108 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - 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.

For MassHealth drugs:

- You're new to the plan.
  - We'll cover a supply of your MassHealth drug for 90 days or until your comprehensive assessment and Care Plan are complete, or less if your prescription is written for fewer days.
  - To ask for a temporary supply of a drug, call Enrollee Services at 1-877-700-6996.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Enrollee Services.

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

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Enrollee Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

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

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).
- If we approve your request, we'll authorize coverage for the drug before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of this Member Handbook.

If you need help asking for an exception, contact Enrollee Services or your Navigator.

E. Coverage changes for your drugs

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

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's Drug List. For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

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

What happens if coverage changes for a drug you're taking?

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

- Check our current Drug List online at fallonhealth.org/navicare **or**
- Call Enrollee Services at the number at the bottom of the page to check our current Drug List.

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

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

A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same. When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9**, **Section G2**, of this handbook.

When these changes happen, we'll:

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

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

- If you should switch to the generic or interchangeable biosimilar or if there's a similar drug on the Drug List you can take instead or
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9**, **Section G2**.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our Drug List. If you're taking the drug, we'll send you a notice after we make the change.

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 9.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

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

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

- If there's a similar drug on our Drug List you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this Member Handbook.

Changes to the Drug List that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you above these types of changes directly during the current year. You'll 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 that will impact you during the next plan year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

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

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

F3. In a Medicare-certified hospice program

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

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this Member Handbook for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

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

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

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

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.

- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Enrollee Services.

G3. Drug management program (DMP) to help members safely use 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 prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, 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 include:

- Requiring you to get all 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'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any 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'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this Member Handbook.)

The DMP may not apply to you if you:

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

Chapter 6: What you pay for your Medicare and MassHealth drugs

Introduction

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

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you’re eligible for MassHealth you get Extra Help from Medicare to help pay for your Medicare Part D drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.” **As a Senior Care Options (SCO) member, MassHealth covers the remaining costs that Medicare doesn’t for Medicare Part D drug costs.**

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

To learn more about drugs, you can look in these places:

- Our List of Covered Drugs.
    - We call this the Drug List. It tells you:
        - Which drugs we pay for
        - If there are any limits on the drugs
    - If you need a copy of our Drug List, call Enrollee Services. You can also find the most current copy of our Drug List on our website at fallonhealth.org/navicare.
- **Chapter 5** of this Member Handbook.
    - It tells how to get your outpatient drugs through our plan.

- It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
- When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call or Enrollee Services for more information.

- Our Provider and Pharmacy Directory.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The Provider and Pharmacy Directory lists our network pharmacies. Refer to **Chapter 5** of this Member Handbook more information about network pharmacies.

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A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

NOTE: NaviCare members have no costs for covered services.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives**. When applicable, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- We also pay for some over-the-counter drugs. You don't have to pay anything for these drugs.
- To find out which drugs our plan covers, refer to our Drug List. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under MassHealth. These drugs are included in the NaviCare HMO SNP Over-the-Counter and Additional MassHealth Covered Drug List.

B. How to keep track of your drug costs

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

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

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

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

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

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

   - When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program
   - When you buy covered drugs at an out-of-network pharmacy
   - When you pay the full price for a covered drug under special circumstances

   For more information about asking us to pay you back for a drug, refer to **Chapter 7** of this Member Handbook.

3. **Send us information about payments others make for you.**

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

   When you get an EOB in the mail, make sure it's complete and correct.

   - **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
   - **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at NaviCare HMO SNP Enrollee Services at 1-800-700-6996. You can also find answers to many questions on our website: fallonhealth.org/navicare.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at NaviCare HMO SNP Enrollee Services at 1-800-700-6996.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.

If you think something is wrong or missing, or if you have any questions, call Enrollee Services. Keep these EOBs. They're an important record of your drug expenses. Note that you 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 7**.

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

With our plan, you pay nothing for covered drugs as long as you follow our rules.

C1. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. There's no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this Member Handbook or our Provider and Pharmacy Directory.

For information about which pharmacies can give you long-term supplies, refer to our plan's Provider and Pharmacy Directory.

D. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our Drug List. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's Drug List or contact Enrollee Services for coverage and cost sharing details about specific vaccines.

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

1. The first part is for the cost of the vaccine itself.
2. The second part is for the cost of giving you the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

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

We recommend that you call Enrollee Services if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine.

Chapter 7: Asking us to pay a bill you got for covered services or drugs

Introduction

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

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A. Asking us to pay for your services or drugs

You shouldn't get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow NaviCare HMO SNP providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **Section B**

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it's your right to be paid back.
    - If you paid for services covered by Medicare, we'll pay you back.
    - If you paid for services covered by MassHealth we can't pay you back, but the provider or MassHealth will. Enrollee Services can help you contact the provider's office. Refer to the bottom of the page for the Enrollee Services phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact Enrollee Services if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
       - If the provider should be paid, we'll pay the provider directly.
       - If you already paid for the Medicare service, we'll pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call Enrollee Services** at the number at the bottom of this page **if you get any bills.**

- Because we pay the entire cost for your services, you aren't responsible for paying any costs. Providers shouldn't bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We'll pay you back for your covered services.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of this Member Handbook to learn more about out-of-network pharmacies.
- 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'd pay at an in-network pharmacy.

5. When you pay the full Medicare Part D prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt 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 Medicare Part D prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our List of Covered Drugs (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this Member Handbook).
  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this Member Handbook).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this Member Handbook.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services or call us. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your Navigator for help. You must send your information to us within one year of the date you received the service, item, or drug.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website fallonhealth.org/navicare, or you can call Enrollee Services and ask for the form.

You must include the following information with your request:

- First and last name
- Member ID
- List of the items or services you are requesting we reimburse
- The name of the service/supply provider
- Date(s) of service
- 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
- For requests to reimburse medical items and services, 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. NaviCare will not honor reimbursement requests for items purchased with gift certificates. NaviCare will not reimburse for coupons.

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 (NDC)
- 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

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

Medical claims (services you get at your provider's office), and fitness or Save Now card:	**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

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay for it. If you already paid for the service or drug, we'll mail you a check. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this Member Handbook explains the rules for getting your services covered. **Chapter 5** of this Member Handbook explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9**.

D. Appeals

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

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this Member Handbook:.

- To make an appeal about getting paid back for a health care service, refer to **Chapter 9, Section F**
- To make an appeal about getting paid back for a drug, refer to **Chapter 9**, **Section G**

Chapter 8: Your rights and responsibilities

Introduction

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

Table of Contents

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

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan. You have the right to be provided with information on all program services and health care options including available treatment options and alternatives, presented in a culturally appropriate manner, taking your functional status, language and cultural needs into consideration.

- To get information in a way that you can understand, call Enrollee Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English including Spanish, Vietnamese, and Khmer, and in formats such as large print, braille, or audio. These options are available for free upon request. To get materials in one of these alternative formats, please call Enrollee Services or write to:

  Fallon Health
  NaviCare Enrollee Services
  1 Mercantile St., Suite 400
  Worcester, MA 01608

We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. Your preferred language or request for material in an alternate format, both written and spoken, or request for information in an alternate format is requested by us on each member's enrollment form. Your language preference will be captured and stored in our central operating system for all future communications, so you won't have to make a separate request each time.

You may change your preferred language or communications format by informing a member of your ICT or by calling Enrollee Services.

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

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- My Ombudsman at 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m.

  - Use 7-1-1 to call 1-855-781-9898. This number is for people who are deaf, hard of hearing, or speech disabled.
  - Use Videophone (VP) 339-224-6831. This number is for people who are deaf or hard of hearing.

- MassHealth Customer Service Center at 1-800-841-2900, Monday through Friday, from 8:00 a.m. to 5:00 p.m. (TTY: 711).
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

A. Su derecho a obtener servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que **todos** los servicios, tanto clínicos como no clínicos, se brinden de manera culturalmente competente y accesible, incluso para aquellas personas con competencia limitada de inglés, habilidades de lectura limitadas, incapacidad auditiva, o las de diversos orígenes culturales y étnicos. También debemos informarle sobre los beneficios de nuestro plan y sus derechos de manera que usted pueda comprender. Debemos informarle sobre sus derechos cada año que se encuentre en nuestro plan. Usted tiene derecho a que se le brinde información sobre todos los servicios del programa y las opciones de atención médica, incluidas las opciones y alternativas de tratamiento disponibles, presentadas de una manera culturalmente apropiada, teniendo en cuenta su estado funcional, idioma y necesidades culturales.

- Para obtener información de una manera que pueda comprender, llame a Servicios para los Inscritos. Nuestro plan cuenta con servicios gratuitos de interpretación para responder preguntas en diferentes idiomas.
- Nuestro plan también puede proporcionarle materiales en otros idiomas que no sean el español, como inglés, vietnamita y jemer, y en formatos como letra grande, braille o audio. Estas opciones están disponibles de forma gratuita si lo pide. Para obtener materiales en uno de estos formatos alternativos, llame a Servicios para los Inscritos o escriba a la siguiente dirección:

  Fallon Health
  NaviCare Enrollee Services
  1 Mercantile St., Suite 400
  Worcester, MA 01608

Debemos proporcionarle información sobre los beneficios del plan en un formato que sea accesible y adecuado a su caso. En el formulario de inscripción de cada miembro, solicitamos su idioma preferido o el material en un formato alternativo para las comunicaciones escritas y

verbales o la solicitud de la información en un formato alternativo. Su preferencia de idioma se registrará y guardará en nuestro sistema operativo central para todas las comunicaciones futuras con el fin de que usted no tenga que realizar una solicitud por separado en cada oportunidad.

Puede cambiar su idioma de preferencia o el formato de las comunicaciones informando a un miembro de su equipo interdisciplinario de atención (ICT) o llamando a Servicios para los Inscritos.

Si tiene alguna dificultad para obtener información sobre nuestro plan debido a problemas de idioma o una discapacidad y desea presentar una reclamación, llame a los siguientes números:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.
- My Ombudsman al 1-855-781-9898, de lunes a viernes, de 9:00 a. m. a 4:00 p. m.
    - Use el 7-1-1 para llamar al 1-855-781-9898. Este número es para personas sordas, con problemas auditivos o con discapacidad del habla.
    - Use el videoteléfono (VP) para llamar al 339-224-6831. Este número es para personas sordas o con problemas de audición.
- Centro de Servicio al Cliente de MassHealth al 1-800-841-2900, de lunes a viernes, de 8:00 a. m. a 5:00 p. m. (TTY: 711).
- Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.

A. Quyền tiếp nhận dịch vụ và thông tin nhằm đáp ứng nhu cầu của quý vị

Chúng tôi phải đảm bảo **tất cả** dịch vụ, cả lâm sàng và phi lâm sàng, đều được cung cấp cho quý vị theo cách thức dễ tiếp cận và phù hợp về văn hóa, bao gồm cả cho đối tượng có trình độ tiếng Anh hạn chế, kỹ năng đọc hạn chế, khiếm thính hoặc đối tượng thuộc nhiều nguồn gốc văn hóa và sắc tộc khác nhau. Chúng tôi cũng phải trình bày để quý vị hiểu được các quyền lợi trong chương trình cũng như các quyền của quý vị. Chúng tôi phải thông báo cho quý vị về các quyền của quý vị trong mỗi năm quý vị tham gia chương trình. Quý vị có quyền được cung cấp thông tin về tất cả các dịch vụ và lựa chọn chăm sóc sức khỏe trong chương trình, bao gồm các lựa chọn điều trị và lựa chọn thay thế sẵn có, được trình bày theo cách phù hợp về mặt văn hóa, cân nhắc đến tình trạng chức năng sinh hoạt, ngôn ngữ và nhu cầu văn hóa của quý vị.

- Để nhận thông tin theo cách thức phù hợp, hãy gọi đến bộ phận Dịch Vụ Ghi Danh. Chương trình của chúng tôi có dịch vụ thông dịch miễn phí để giải đáp thắc mắc bằng nhiều ngôn ngữ khác nhau.

- Chương trình của chúng tôi cũng có thể cung cấp cho quý vị tài liệu bằng các ngôn ngữ khác tiếng Anh (như tiếng Tây Ban Nha, tiếng Việt và tiếng Khmer), cũng như ở các định dạng bản in khổ lớn, chữ nổi hoặc âm thanh. Các phiên bản này được cung cấp miễn phí theo yêu cầu. Để nhận tài liệu bằng một trong những định dạng thay thế này, vui lòng gọi cho bộ phận Dịch Vụ Ghi Danh hoặc gửi thư yêu cầu tới:

  Fallon Health
  NaviCare Enrollee Services
  1 Mercantile St., Suite 400
  Worcester, MA 01608

Chúng phải đáp ứng yêu cầu cung cấp thông tin về các quyền lợi của chương trình bằng định dạng dễ tiếp cận và phù hợp với quý vị. Ngôn ngữ ưu tiên, yêu cầu tài liệu bằng định dạng thay thế (cả bằng văn bản và lời nói) hoặc yêu cầu thông tin ở định dạng thay thế là thông tin chúng tôi yêu cầu trên mẫu ghi danh của mỗi hội viên. Lựa chọn ngôn ngữ của quý vị sẽ được ghi lại và lưu trữ trong hệ điều hành trung tâm của chúng tôi để phục vụ tất cả hoạt động liên lạc trong tương lai, nên quý vị không phải yêu cầu cho từng lần riêng biệt.

Quý vị có thể thay đổi ngôn ngữ hoặc định dạng liên lạc ưu tiên của mình bằng cách thông báo cho một thành viên ICT hoặc gọi cho bộ phận Dịch Vụ Ghi Danh.

Nếu quý vị gặp khó khăn trong việc nhận thông tin từ chương trình của chúng tôi do các vấn đề về ngôn ngữ hoặc tình trạng khuyết tật và quý vị muốn nộp đơn khiếu nại, hãy gọi:

- Medicare theo số 1-800-MEDICARE (1-800-633-4227). Người dùng TTY xin gọi số 1-877-486-2048.
- My Ombudsman theo số 1-855-781-9898, Thứ Hai đến Thứ Sáu, từ 9:00 sáng đến 4:00 chiều.
  - Sử dụng 7-1-1 để gọi 1-855-781-9898. Số điện thoại này dành cho những người bị điếc, khiếm thính hoặc khiếm ngôn.
  - Sử dụng Videophone (VP) 339-224-6831. Số điện thoại này dành cho những người bị điếc hoặc khiếm thính.
- Trung Tâm Dịch Vụ Khách Hàng MassHealth theo số 1-800-841-2900, Thứ Hai đến Thứ Sáu, từ 8:00 sáng đến 5:00 chiều. (TTY: 711).
- Văn Phòng Dân Quyền theo số 1-800-368-1019. Người dùng TTY xin gọi 1-800-537-7697.

A. សិទ្ធិរបស់អ្នកក្នុងការទទួលបានសេវាកម្ម និងព័ត៌មានតាមរបៀបដែលបំពេញតម្រូវការរបស់អ្នក។

យើងត្រូវតែធានាថា សេវាកម្ម**ទាំងអស់** ទាំងសេវាព្យាបាល
និងមិនមែនព្យាបាលត្រូវបានផ្តល់ជូនអ្នកទៅតាមលក្ខណៈប្រកបដោយសមត្ថភាពខាងវប្បធម៌
និងអាចចូលប្រើបាន រួមទាំងសម្រាប់អ្នកដែលភាពស្ទាត់ជំនាញខាងភាសាអង់គ្លេសមានកម្រិត
ជំនាញអានមានកម្រិត អសមត្ថភាពក្នុងការស្តាប់ ឬអ្នកដែលមានប្រវត្តិវប្បធម៌
និងជាតិសាសន៍ចម្រុះ។ យើងក៏ត្រូវតែប្រាប់អ្នកអំពីអត្ថប្រយោជន៍នៃគម្រោងរបស់យើង
និងសិទ្ធិរបស់អ្នកតាមរបៀបដែលអ្នកអាចយល់បាន។
យើងត្រូវតែប្រាប់អ្នកអំពីសិទ្ធិរបស់អ្នកជារៀងរាល់ឆ្នាំដែលអ្នកស្ថិតនៅក្នុងគម្រោងរបស់យើង។
អ្នកមានសិទ្ធិទទួលបានការផ្តល់ជូនព័ត៌មានអំពីសេវាកម្មនៅក្នុងកម្មវិធីទាំងអស់
និងជម្រើសនៃការថែទាំសុខភាព រួមទាំងជម្រើសនៃការព្យាបាលដែលមាន និងជម្រើសផ្សេងៗ
ដែលបង្ហាញក្នុងលក្ខណៈសមស្របតាមវប្បធម៌ ដោយគិតគូរអំពីស្ថានភាពមុខងារ ភាសា
និងតម្រូវការវប្បធម៌របស់អ្នក។

- ដើម្បីទទួលបានព័ត៌មានតាមរបៀបដែលអ្នកអាចយល់បាន
  សូមទូរសព្ទទៅផ្នែកសេវារបស់អ្នកចុះឈ្មោះ។
  គម្រោងរបស់យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃដែលអាចឆ្លើយសំណួរជាភាសាផ្សេងៗ។

- គម្រោងរបស់យើងក៏អាចផ្តល់ឱ្យអ្នកនូវឯកសារជាភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស
  រួមទាំងភាសាអេស្ប៉ាញ វៀតណាម និងខ្មែរ និងជាទម្រង់ដូចជាអក្សរពុម្ពធំ
  អក្សរស្ទាបសម្រាប់ជនពិការភ្នែក ឬអូឌីយ៉ូ។
  ជម្រើសទាំងនេះអាចរកបានដោយឥតគិតថ្លៃតាមការស្នើសុំ។
  ដើម្បីទទួលបានឯកសារជាទម្រង់ជំនួសផ្សេងទាំងនេះ សូមទូរសព្ទទៅផ្នែកសេវាចុះឈ្មោះ
  ឬសរសេរទៅកាន់៖

  Fallon Health
  NaviCare Enrollee Services
  1 Mercantile St., Suite 400
  Worcester, MA 01608

យើងត្រូវបានតម្រូវឱ្យ
ផ្តល់ព័ត៌មានជូនអ្នកអំពីអត្ថប្រយោជន៍នៃគម្រោងនេះជាទម្រង់ដែលអាចចូលប្រើបាន
និងសមរម្យសម្រាប់អ្នក។ ភាសាដែលអ្នកពេញចិត្ត ឬសំណើសុំឯកសារជាទម្រង់ជំនួសផ្សេងទៀត
ទាំងការសរសេរ និងការនិយាយ
ឬសំណើសុំព័ត៌មានជាទម្រង់ជំនួសផ្សេងទៀតត្រូវបានស្នើសុំដោយយើងខ្ញុំនៅលើទម្រង់ចុះឈ្មោះសមាជិកនីមួយៗ។ ចំណូលចិត្តភាសារបស់អ្នកនឹងត្រូវបានកត់ត្រា
និងរក្សាទុកនៅក្នុងប្រព័ន្ធប្រតិបត្តិការកណ្តាលរបស់យើងសម្រាប់ការទំនាក់ទំនងទាំងអស់នាពេលអនាគត ដូច្នេះអ្នកនឹងមិនចាំបាច់ដាក់សំណើសុំដាច់ដោយឡែករាល់ពេលនោះទេ។

អ្នកអាចផ្លាស់ប្តូរភាសា ឬទម្រង់ទំនាក់ទំនងដែលអ្នកពេញចិត្ត ដោយជូនដំណឹងដល់សមាជិកនៃក្រុមថែទាំអន្តរជំនាញ (ICT) របស់អ្នក ឬដោយការហៅទូរសព្ទទៅផ្នែកសេវាចុះឈ្មោះ។

ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើង ដោយសារបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់ដាក់ពាក្យបណ្តឹងតវ៉ា សូមទូរសព្ទទៅ៖

- Medicare តាមលេខ 1-800-MEDICARE (1-800-633-4227)។ អ្នកប្រើ TTY គួរទូរសព្ទទៅកាន់លេខ 1-877-486-2048 ។
- កម្មវិធីមន្ត្រីបណ្តឹងសាធារណៈរបស់ខ្ញុំតាមលេខ 1-855-781-9898 ពីថ្ងៃចន្ទ ដល់ថ្ងៃសុក្រ ចាប់ពីម៉ោង 9:00 ព្រឹក ដល់ 4:00 រសៀល
  - ប្រើ 7-1-1 ដើម្បីហៅទូរសព្ទទៅលេខ 1-855-781-9898។ លេខនេះគឺសម្រាប់មនុស្សថ្លង់ ពិបាកស្តាប់ ឬពិការភាពចំពោះការនិយាយ។
  - ប្រើទូរសព្ទជារីដេអូ (VP) 339-224-6831។ លេខនេះគឺសម្រាប់មនុស្សថ្លង់ ឬពិបាកស្តាប់។
- មជ្ឈមណ្ឌលសេវាកម្មអតិថិជន MassHealth តាមលេខ 1-800-841-2900 ពីថ្ងៃចន្ទ ដល់ថ្ងៃសុក្រ ចាប់ពីម៉ោង 8:00 ព្រឹក ដល់ 5:00 ល្ងាច។ (TTY: 711)។
- ការិយាល័យសិទ្ធិស៊ីវិលតាមលេខ 1-800-368-1019។ អ្នកប្រើប្រាស់ TTY គួរហៅទៅលេខ 1-800-537-7697។

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this Member Handbook.
  - Call Enrollee Services or go to the Provider and Pharmacy Directory to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.

- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this Member Handbook.
- You have the right to have access to a network of primary and specialty providers who are qualified and capable of meeting your needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting, as well as access to an ongoing source of primary care.
- You have the right to request a change of Navigator.

Chapter 9 of this Member Handbook tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

C1. How we protect your PHI

You have the right to Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law. We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws. We also must give MassHealth your PHI including information about your prescription drugs. MassHealth can use or share your PHI for certain purposes without your permission, like activities for running the MassHealth program or paying your health care providers for services that you get. There are also times when MassHealth is required by law to release your information. MassHealth does not need your permission to do this.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.
- The Centralized Enrollee Record (CER) is enrollee-centric, comprehensive electronic record that documents your medical, prescription, functional and social status. The CER contains all activity and authorizations created by your Interdisciplinary Care Team (ICT) describing the care provided, clinical assessments, diagnoses determined, medications prescribed, and treatment plans and services provided, treatment goals and outcomes and pharmacy records. In addition, activity completed by the our 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.

If you have questions or concerns about the privacy of your PHI, call Enrollee Services.

Notice of Privacy Practices

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

Effective 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

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services. You have the right to have all plan options, rules, and benefits fully explained, including through the use of a qualified interpreter, if needed.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Enrollee Services. This is a free service to you. We can also give you information in large print, braille, audio, Spanish, Vietnamese, or Khmer. Other languages are available for free upon request.

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

- How to choose or change plans
- Our plan, including:
    - financial information
    - how plan members have rated us
    - the number of appeals made by members
    - how to leave our plan
- Our network providers and our network pharmacies, including:
    - how to choose or change primary care providers
    - qualifications of our network providers and pharmacies
    - how we pay providers in our network
- Covered services and drugs, including:
    - services (refer to **Chapters 3 and 4** of this Member Handbook) and drugs (refer to **Chapters 5 and 6** of this Member Handbook) covered by our plan
    - limits to your coverage and drugs
    - rules you must follow to get covered services and 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.

- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this Member Handbook), including asking us to:
    - put in writing why something isn't covered
    - change a decision we made
    - pay for a bill you got
- Information about how we evaluate new technology to include as a covered benefit.
    - We evaluate 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.
    - We make use of external research organizations, which perform reviews of available literature regarding a given procedure. When necessary, we seek 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).
    - We have a separate but similar process for the evaluation of new drugs and medications, with reviews performed by our Pharmacy & Therapeutics Committee.

You have the right to request and obtain the Member Handbook and the right to receive notice of any significant change in the information provided in the Member Handbook at least 30 days before the effective date of the change.

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this Member Handbook.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this Member Handbook*:*
    - For more information about when you can join a new MA or drug benefit plan.
    - For information about how you'll get your MassHealth benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.

- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this Member Handbook tells how to ask us for a coverage decision.
- **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 ICT or Enrollee Services at the number at the bottom of the page . 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.**

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

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

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever become unable to make decisions for yourself.

Give your doctors written instructions about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it.

- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to 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're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Enrollee Services for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make 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
Fax: 1-781-876-8381

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this Member Handbook tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint. We are not permitted to use any form of coercion, discipline or otherwise retaliate against you for filing a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Enrollee Services to get this information.

You have the right to freely exercise your rights, and to be assured that exercising those rights will not negatively impact the way we and our providers, or the State Agency treat you.

H1. What to do about unfair treatment or to get more information about your rights

You have the right to not be discriminated against based on race, ethnicity, national origin, religion, sex, gender identity, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment. You have the right to be treated with dignity and respect.

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this Member Handbook – or you want more information about your rights, you can call:

- Enrollee Services.
- The SHINE (Serving the Health Insurance Needs of Everyone) program at 1-800-243-4636. For more details about SHINE (Serving the Health Insurance Needs of Everyone), refer to **Chapter 2, Section C**.
- My Ombudsman at 1-855-781-9898 (Toll Free), Monday through Friday from 9:00 a.m. to 4:00 p.m.
    - Use 7-1-1 to call 1-855-781-9898. This number is for people who are deaf, hard of hearing, or speech disabled.
    - Use Videophone (VP) 339-224-6831. This number is for people who are deaf or hard of hearing.
    - Email My Ombudsman at info@myombudsman.org.

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

Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

MassHealth at 1-800-841-2900, Monday through Friday, from 8:00 a.m. to 5:00 p.m. (TTY: 711).

You have the right to make recommendations regarding our member rights and responsibilities policy. To make recommendations, you can call Enrollee Services.

I. 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 9 of this Member Handbook.

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).

J. Your responsibilities as a plan member

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

- **Read this** Member Handbook to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
    - Covered services, refer to **Chapters 3 and 4** of this Member Handbook. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
    - Covered drugs, refer to **Chapters 5 and 6** of this Member Handbook.
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Enrollee Services if you have other coverage. 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're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
    - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - Medicare Part A and Medicare Part B premiums. For most NaviCare HMO SNP members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.

  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call Enrollee Services.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this Member Handbook tells about our service area.
  - We can help you find out if you're moving outside our service area.
  - Tell Medicare and MassHealth your new address when you move. Refer to **Chapter 2** of this Member Handbook for phone numbers for Medicare and MassHealth.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call Enrollee Services for help if you have questions or concerns.**
- **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 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

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

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

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

If you're facing a problem with your services

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

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

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

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

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

Help from the State Health Insurance Assistance Program (SHIP)

You can call the State Health Insurance Assistance Program (SHIP). SHINE counselors can answer your questions and help you understand what to do about your problem. SHINE isn’t connected with us or with any insurance company or health plan. SHINE has trained counselors in every county, and services are free. The SHINE phone number is 1-800-243-4636 and their website is www.mass.gov/health-insurance-counseling. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370 (Massachusetts only).

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from MassHealth

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

Help from My Ombudsman

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

- Can answer your questions or refer you to the right place to find what you need.
- Can help you address a problem or concern with SCO or your SCO plan, NaviCare HMO SNP. My Ombudsman's staff will listen, investigate the issue, and discuss options with you to help solve the problem.
- Help with appeals. An appeal is a formal way of asking your SCO plan, MassHealth, or Medicare to review a decision about your services. My Ombudsman's staff can talk with you about how to make an appeal and what to expect during the appeal process.

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

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

- Visit My Ombudsman online at www.myombudsman.org

C. Understanding Medicare and MassHealth complaints and appeals in our plan

You have Medicare and MassHealth. Information in this chapter applies to **all** your Medicare and MassHealth benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and MassHealth processes.

Sometimes Medicare and MassHealth processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a MassHealth benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** "Coverage decisions and appeals."	**No.** My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B drugs as **medical care.**

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4**, **Section H** of this Member Handbook*).*

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or MassHealth. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in **Section F2** and **Section F3** of this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Enrollee Services** at the numbers at the bottom of the page.
- Call your Navigator.
- Call, email, write, or visit **My Ombudsman**.
    - Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831.
    - Email info@myombudsman.org.
    - Visit My Ombudsman online at www.myombudsman.org.
    - Write to or visit the My Ombudsman office at 25 Kingston Street, 4th floor, Boston, MA 02111.
        - Please refer to the My Ombudsman website or contact them directly for updated information about location, appointments, and walk-in hours.
- **State Health Insurance Assistance Program (SHIP)** for free help. In Massachusetts, the SHIP is called SHINE. SHINE is an independent organization. It is not connected with this plan. The SHINE phone number is 1-800-243-4636. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370 (Massachusetts only).
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Enrollee Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at fallonhealth.org/navicare. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Enrollee Services at the numbers at the bottom of the page.

F. Medical care

This section explains 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 that's described in **Chapter 4** of this Member Handbook in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

> **What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1-877-700-6996, TTY: 711.
- Faxing: 1-508-368-9700 for regular coverage decisions or 1-508-368-9133 for "fast" coverage decisions.
- Writing:

  Fallon Health
  NaviCare Enrollee Services
  1 Mercantile St., Suite 400
  Worcester, MA 01608

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within**:**

- **7 calendar days** after we get your request **for a medical service or item that is subject to our prior authorization rules**.
- **7 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

> The legal term for fast coverage decision is **expedited determination**.

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**.

In limited circumstances we may dismiss your request for a coverage decision, 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'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at 1-877-700-6996.

Additionally, if you need help during the appeals process, you can call My Ombudsman at 1-855-781-9898 (or use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831). My Ombudsman is not connected with us or with any insurance company or health plan.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-877-700-6996 for a standard appeal or for a fast appeal.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at fallonhealth.org/navicare.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
    - We dismiss your request, and
    - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
    - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in **Section F4** of this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up.
- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.

- 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 need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
    - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
    - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a MassHealth service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, MassHealth, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we 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 MassHealth usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in **Section I3** of this chapter
- If your problem is about a service or item that **both Medicare and MassHealth** may cover, you automatically get a Level 2 Appeal with the IRO. 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. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by MassHealth, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **IRE**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The

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

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO 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 get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - 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.
- If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
- An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and MassHealth

A Level 2 Appeal for services that MassHealth usually covers is a Fair Hearing with the state. In MassHealth a Fair Hearing is called an Administrative Appeal. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

If you received a Level 1 Appeal denial related to a service or item that is usually covered by MassHealth Standard, you can file a Level 2 appeal yourself. Level 2 of the appeals process for services that are usually covered by MassHealth Standard 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. The Fair Hearing office gives you their decision in writing and explain the reasons.

- 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 get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this Member Handbook. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you did not follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.

- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and MassHealth usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that MassHealth may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medicaid follow the process in **Section E**.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this Member Handbook for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's Drug List or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**.	Refer to **Section G4**.	Refer to **Section G4**.	Refer to **Section G5**.

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that isn't on our Drug List**
   - We can agree to make an exception and cover a drug that isn't on our Drug List.
2. **Removing a restriction for a covered drug**
   - Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of this Member Handbook for more information).
   - Extra rules and restrictions for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
     - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

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

Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling OptumRx at 1-844-657-0494, writing to OptumRx, Prior Authorization Department, P.O. Box 2975, Mission, KS 66201, or faxing us at 1-844-403-1028. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this Member Handbook.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- 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," locating the "Request for Medicare prescription drug coverage determination form" section, and selecting the "our online version of this form." Complete all the required fields and then click "Submit."

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
    - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.

- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

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

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling 1-877-700-6996 for a standard appeal or for a fast appeal, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
    - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.

- If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.

- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this Member Handbook.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Enrollee Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
    - Be a part of any decisions about the length of your hospital stay.
    - Know where to report any concerns you have about the quality of your hospital care.
    - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
    - You or someone acting on your behalf can sign the notice.

- Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.

- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Enrollee Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Massachusetts, the QIO is Acentra. Call them at 1-888-319-8452. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Enrollee Services at the numbers at the bottom of the page.
- Call SHINE (Serving the Health Insurance Needs of Everyone).

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Enrollee Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-319-8452.

You must ask for this review **within 60 calendar days** after the day the QIO 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.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
    - Call Enrollee Services at the numbers at the bottom of the page.
    - Call the SHINE (Serving the Health Insurance Needs of Everyone)
- **Contact the QIO.**
    - Refer to **Section H2** or refer to **Chapter 2** of this Member Handbook for more information about the QIO and how to contact them.
    - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

> The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Enrollee Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-319-8452.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional MassHealth appeals

You also have other appeal rights if your appeal is about services or items that MassHealth usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process. You can ask the state of Massachusetts for a Level 2 appeal, called a Fair Hearing. A Fair Hearing agency not connected to NaviCare will review your case and make a decision about your appeal. To file a Level 2 Appeal, fill out the enclosed Fair Hearing Request Form received in the letter from the Fair Hearing office. If you ask for a fair hearing, you must send your hearing request to the Board of Health (BOH) no later than 120 calendar days from the date of this letter. If you decide to file an appeal after 120 days, the BOH will decide whether or not to consider your request.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, 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 Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Suspected fraud, waste, or abuse	• Do you believe that a provider is billing inappropriately or incorrectly?
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Enrollee Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.

Complaint	Example
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Enrollee Services at 1-877-700-6996.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Enrollee Services at 1-877-700-6996. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there's anything else you need to do, Enrollee Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll 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, you can contact Enrollee Services at 1-877-700-6996 or contact Fallon Health Member Appeals and Grievances directly 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.
- If you are reporting suspected fraud, waste or abuse, those activities can be reported 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. We will not retaliate against anyone who makes a good faith report of potential fraud or other wrongful acts.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with NaviCare HMO SNP before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

U.S. Department of Health and Human Services Government Center
J.F. Kennedy Federal Building - Room 1875
Boston, MA 02203
Phone: 1-617-565-1340 or 1-800-368-1019 Fax: 1-617-565-3809
Local TDD: 1-617-565-1343
Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act (ADA). You can contact My Ombudsman for assistance by calling 1-855-781-9898 (or using MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831) or emailing info@myombudsman.org.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this Member Handbook.

In Massachusetts, the QIO is called Acentra Health. The phone number for Acentra is 1-888-319-8452.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and MassHealth programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this Member Handbook.

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A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you also have MassHealth, you can end your membership with our plan at any time, in any month of the year.

In addition to this flexibility, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for MassHealth or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Enrollee Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- The State Health Insurance Assistance Program (SHIP), SHINE, at 1-800-243-4636. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-439-2370.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this Member Handbook for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Enrollee Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on pages 245-246.
- **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and MassHealth services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE).**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in a new integrated D-SNP. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-800-841-2900. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users may call 1-800-439-2370. You'll automatically be disenrolled from our plan when your new plan's coverage begins.
2. You can change to: **Original Medicare with a separate Medicare drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in Original Medicare with a separate Medicare drug plan. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare drug plan** **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the SHINE at 1-800-243-4636, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local SHINE Program office in your area, please visit www.mass.gov/health-insurance-counseling.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in Original Medicare. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. You can change to: **Any Medicare health plan** during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in a new Medicare plan. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-800-841-2900.If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

C2. Your MassHealth services

Some people who decide not to join a Senior Care Options (SCO) plan may be able to join a different kind of plan to get their Medicare and MassHealth benefits together.

- If you're age 55 or older, you may be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE) (additional criteria apply). PACE helps older adults stay in the community instead of getting nursing facility care.

To find out about PACE plans and whether you can join one, call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. Keep getting your Medicare and MassHealth services and drugs through our plan until your membership ends.

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in NaviCare HMO SNP ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid and your deeming period has ended. Our plan is for people who qualify for both Medicare and Medicaid. NaviCare HMO SNP will continue your membership for the remainder of the month in which we receive notification from MassHealth about your loss of eligibility, along with one additional calendar month. If you regain your MassHealth Standard coverage during this period, we will not end your membership.

- If you join a MassHealth Home and Community Based Services (HCBS) Waiver program (except a Frail Elder Waiver).
- If you provide fraudulent information on an Enrollment for or you willfully misuse or permit another person to misuse your member ID card.
- If you choose another Medicare health plan with or without prescription drug coverage
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- If you enroll in another Medicare Advantage Plan, or Medicare Part D Plan.
- If you move out of our service area.
- If you move into an Intermediate Care Facility operated by the Massachusetts Department of Developmental Services.
- If you're 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 where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs. As noted in Chapter 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 have or get other comprehensive insurance for drugs or medical care.
- If you're not a United States citizen or aren't lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

- If you lose your eligibility for MassHealth Standard, NaviCare HMO SNP will continue to provide care as long as you can reasonably be expected to regain your MassHealth Standard coverage within one month. We will continue your membership for the remainder of the month in which we receive notification from MassHealth about your loss of eligibility, along with one additional calendar month. If you regain your MassHealth Standard coverage during this period, we will not end your membership.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason).

F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this Member Handbook for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Enrollee Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this Member Handbook.

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A. Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this Member Handbook. The main laws that apply are federal laws about the Medicare and MassHealth programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

  Call your local Office for Civil Rights:

  U.S. Department of Health and Human Services Government Center
  J.F. Kennedy Federal Building - Room 1875
  Boston, MA 02203
  Phone: 1-617-565-1340 or 1-800-368-1019 Fax: 1-617-565-3809
  Local TDD: 1-617-565-1343
  Email: ocrmail@hhs.gov

- If you have a disability and need help accessing health care services or a provider, call Enrollee Services. If you have a complaint, such as a problem with wheelchair access, Enrollee Services can help.

C. Notice about Medicare as a second payer and MassHealth as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that MassHealth is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this Member Handbook with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Enrollee Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this Member Handbook explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

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 drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that's 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. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this Member Handbook explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this Member Handbook explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

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

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently misused medications.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, 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’s quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Enrollee Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this Member Handbook for more information about Enrollee Services.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that aren't covered by this health plan.

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

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Navigators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Enrollee Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you **don't** owe any cost-sharing. Providers shouldn't bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized Care Plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Integrated D-SNP: A dual-eligible special needs plan 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 known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

MassHealth: The Medicaid program of the Commonwealth of Massachusetts. MassHealth is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medical group: A network of doctors who collaborate to provide healthcare services. These doctors can work in the same office or across multiple locations, sharing records and office systems to ensure coordinated care. Medical groups can be either single-specialty or multi-specialty, and they may operate independently or as part of a larger healthcare system. Medical groups work with health plans to serve their members, determining how care is provided and managing referrals to specialists within the group. This structure allows for a more integrated approach to patient care, improving efficiency and quality of service.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a "dually eligible individual".

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this Member Handbook for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Navigator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of this Member Handbook.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of this Member Handbook explains coverage decisions.

Original Biological Product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this Member Handbook explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this Member Handbook for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this Member Handbook.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the List of Covered Drugs and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this Member Handbook for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this Member Handbook.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this Member Handbook to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Special Supplemental Benefits for the Chronically Ill (SSBCI): These benefits are designed to address specific needs of individuals at high risk for hospitalization or adverse health outcomes and may include non-health related services or items which have a reasonable expectation of improving or maintaining the member's health or overall function.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

NaviCare HMO SNP Enrollee Services

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 non-English speakers.
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 St., 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.

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