

January 1 – December 31, 2012

Evidence of Coverage:

Your Health Benefits and Services and Prescription Drug Coverage as a Member of Senior Whole Health

This booklet gives you the details about your health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Senior Whole Health, is offered by Senior Whole Health LLC. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Senior Whole Health LLC. When it says “plan” or “our plan,” it means Senior Whole Health.)

Senior Whole Health is a Coordinated Care plan with a contract with the Commonwealth of Massachusetts/EOHHS MassHealth program.

Member Services has free language interpreter services available for non-English speakers (phone numbers are on the back cover of this booklet).

Benefits, formulary, and/or pharmacy network may change on January 1, 2013.

Enrollment is voluntary.

MA-SCO_2012_451 MassHealth approved 2/6/2012

2012 Evidence of Coverage

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SECTION 1 Introduction

Section 1.1	You are enrolled in <i>Senior Whole Health</i>
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You have chosen to get your MassHealth Standard health care and your prescription drug coverage through our plan, *Senior Whole Health*.

There are different types of health plans. *Senior Whole Health* is a specialized Senior Care Options (SCO) plan, which means its benefits are designed for people who are entitled to assistance from MassHealth Standard.

Because you get assistance from MassHealth Standard, you have no out of pocket expense for your health care services. MassHealth Standard also provides other benefits to you by covering health care services such as some kinds of prescription drugs, long term care, and home and community based services. Senior Whole Health 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.

Senior Whole Health is run by a private company. The plan has a contract with the MassHealth program to coordinate your MassHealth Standard benefits. We are pleased to be providing your MassHealth Standard health care coverage, including your prescription drug coverage, long term care, and home and community based services.

Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?
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This *Evidence of Coverage* booklet tells you how to get your MassHealth Standard medical care, long term care, home and community based services, and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, *Senior Whole Health*, is offered by *Senior Whole Health LLC*. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means *Senior Whole Health LLC*. When it says “plan” or “our plan,” it means *Senior Whole Health*.)

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of *Senior Whole Health*.

Section 1.3	What does this Chapter tell you?
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Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan’s service area?

- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4	What if you are new to Senior Whole Health?
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If you are a new member, then it's important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

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

Section 1.5	Legal information about the <i>Evidence of Coverage</i>
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It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in *Senior Whole Health* between January 1, 2012 and December 31, 2012.

MassHealth must approve our plan each year

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

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

Section 2.1	Your eligibility requirements
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You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.2 below describes our service area)
- --and—you are enrolled in MassHealth Standard

- --and—you are age 65 or older
- --and—you do not have End Stage Renal Disease (ESRD)
- --and—you do not have a six-month MassHealth deductible period
- --and—you are not a resident of an intermediate care facility for the mentally disabled
- --and—you are not an inpatient of a chronic or rehabilitation hospital.

Section 2.2	Here is the plan service area for Senior Whole Health
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Senior Whole Health is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes these counties in Massachusetts: Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties.

If you plan to move out of the service area, please contact Member Services.

SECTION 3 What other materials will you get from us?

Section 3.1	Your plan membership card – Use it to get all covered care and prescription drugs
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While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

Front of Member Identification Card



Name: <Cardholder Name>
ID: <Cardholder #> DOB: <xx/xx/xxxx >
PCP Tel: <PCP Tel #> Effective Date: <xx/xx/xxxx>
PCP: <PCP name>
Co-pay: OV(\$0) ER(\$0) RX(\$0)

Issuer 80840
SWH MA
H2224_001



RxBin 003858
RxPCN MD
RxGRP WH3A

Back of Member Identification Card

Non-Machine Readable Card

Any emergency: Call 911 or go to the nearest emergency facility.
Facilities: Contact SWH immediately.

Customer Service
1-888-794-7268 TTY 711
www.seniorwholehealth.com

Submit Claims to: Senior Whole Health Attn: Claims
PO Box 425027 Cambridge MA 02142

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

Here's why this is so important: If you get covered services using your MassHealth card instead of using your *Senior Whole Health* membership card while you are a plan member, you may have to pay the full cost yourself.

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

Section 3.2	The <i>Provider Directory</i>: Your guide to all providers in the plan’s network
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Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory*. This directory lists our network providers. You can choose any of the providers listed in this directory. All of them have agreed to serve *Senior Whole Health* members.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which *Senior Whole Health* authorizes use of out-of-network providers. *Senior Whole Health* provides coverage for MassHealth Standard benefits. See Chapter 3 (*Using the plan’s coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage. It’s important to know who the *Senior Whole Health* providers are since enrollees must go to *Senior Whole Health* providers to get services provided by the plan. All of the providers listed in our *Provider Directory* are available to *Senior Whole Health* members.

If you don’t have your copy of the *Provider Directory*, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at www.seniorwholehealth.com, or download it from this website. Member Services can give you the most up-to-date information about changes in our network providers.

Section 3.3	The <i>Pharmacy Directory</i>: Your guide to pharmacies in our network
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Every year that you are a member of our plan, we will send you either a new *Pharmacy Directory* or an update to your *Pharmacy Directory*. This directory lists our network pharmacies.

What are “network pharmacies”?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

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

Section 3.4	The plan's <i>List of Covered Drugs (Formulary)</i>
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The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which prescription drugs are covered by *Senior Whole Health*. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by MassHealth.

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

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.seniorwholehealth.com) or call Member Services (phone numbers are on the back cover of this booklet).

SECTION 4 Your monthly premium for Senior Whole Health

Section 4.1	How much is your plan premium?
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You do not pay a separate monthly plan premium for *Senior Whole Health*.

Section 4.2	Can we change your monthly plan premium during the year?
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No. We are not allowed to begin charging a monthly plan premium during the year.

SECTION 5 Please keep your plan membership record up to date

Section 5.1	How to help make sure that we have accurate information about you
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

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

Let us know about these changes:

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

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1	We make sure that your health information is protected
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

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

Chapter 2. Important phone numbers and resources

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SECTION 1 ***Senior Whole Health* contacts**
(how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

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

Member Services	
CALL	1-888-794-7268 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th. Interpreter services and alternate format materials are available upon request. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th.
FAX	617-494-5599
WRITE	Senior Whole Health 58 Charles Street Cambridge, MA 02141
WEBSITE	www.seniorwholehealth.com

How to contact us when you are asking for a coverage decision, making an appeal, or filing a complaint about your medical care

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

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

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

You may call us if you have questions about our coverage decision, appeals, or complaints process.

Coverage Decisions, Appeals, and Complaints for Medical Care	
CALL	1-888-794-7268 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th. Interpreter services and alternate format materials are available upon request.
TTY	711 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th.
FAX	1-617-494-5554
WRITE	Senior Whole Health 58 Charles Street Cambridge, MA 02141
WEBSITE	www.seniorwholehealth.com

How to contact us when you are asking for a coverage decision, making an appeal, or filing a complaint about your prescription drugs

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

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

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

Coverage Decisions, Appeals, and Complaints for Prescription Drugs	
CALL	1-888-794-7268 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th. Interpreter services and alternate format materials are available upon request.
TTY	711 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th.
FAX	1-617-494-5554
WRITE	Senior Whole Health Attn: Quality Manager 58 Charles Street Cambridge, MA 02141
WEBSITE	www.seniorwholehealth.com

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

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

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

Payment Requests	
CALL	1-888-794-7268 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th. Interpreter services and alternate format materials are available upon request.
TTY	711 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th.
FAX	1-617-494-5554
WRITE	Senior Whole Health Attn: Member Services 58 Charles Street Cambridge, MA 02141
WEBSITE	www.seniorwholehealth.com

SECTION 2**MassHealth**

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

MassHealth is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for MassHealth. All *Senior Whole Health* members must be enrolled in MassHealth Standard.

MassHealth pays for services not covered by Medicare, and will cover certain services once the Medicare benefit is exhausted. See Chapter 4 in this booklet for more information about benefits covered by MassHealth. Call the Member Services number on the back cover of this booklet to learn more about providers of MassHealth covered services.

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

If you have questions about the assistance you get, contact MassHealth.

MassHealth	
CALL	1-800-841-2900 or 617-573-1770
TTY	1-888-821-5225 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	MassHealth 55 Summer Street Boston, MA 02110
WEBSITE	www.mass.gov/masshealth

The Community Care Ombudsman Program helps people enrolled in MassHealth with service or billing problems. They can help you file a grievance or appeal with our plan.

The Community Care Ombudsman Program	
CALL	617-727-7750 or 1-800-243-4636
TTY	1-800-872-0166 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	One Ashburton Place, 5 th Floor, Boston, MA 02108
WEBSITE	www.mass.gov/masshealth/elder

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

The Massachusetts State Long-Term Care Ombudsman Program	
CALL	617-727-7750 or 1-800-243-4636 Call these numbers to find the address and phone number of the LTC ombudsman program in your city or town
TTY	1-800-872-0166 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	One Ashburton Place, 5 th Floor, Boston, MA 02108
WEBSITE	http://www.mass.gov/elder

SECTION 3 **Medicare** (how to get help and information directly from the Federal Medicare program)

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

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

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.” The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance)

Medicare

policies in your area. Select “Health & Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

SECTION 4 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

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

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

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

Serving the Health Information Needs of Elders (Massachusetts SHIP)

CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	1-800-872-0166 (Massachusetts only) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Call the number above for the address of the SHINE program in your area.

Serving the Health Information Needs of Elders (Massachusetts SHIP)	
WEBSITE	www.800ageinfo.com

SECTION 5 Social Security

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

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

SECTION 6 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	http://www.rrb.gov

SECTION 7 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period.

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

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

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

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

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

Section 1.1 What are “network providers” and “covered services”?
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Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

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

Section 1.2 Basic rules for getting your medical care and other services covered by the plan
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As a MassHealth health plan, *Senior Whole Health* must cover all services covered by MassHealth Standard, and other services.

Senior Whole Health will generally cover your medical care as long as:

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

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
 - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
 - If you need medical care that MassHealth requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Plan authorization is required. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

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

Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your care
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What is a "PCP" and what does the PCP do for you?

When you become a member of *Senior Whole Health*, you must choose a plan provider to be your PCP, which stands for **P**rietary **C**are **P**rovider. Your PCP is a licensed physician who meets state requirements and is trained to give you basic medical care. 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. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services also involves checking or consulting with other plan providers about your care and how it is going. In some cases, your PCP will also need to get prior authorization (prior approval) from our plan. The Benefits Chart in Chapter 4 shows which services need prior authorization from the plan. If your PCP determines that you need a service that requires prior authorization from the plan, your PCP will contact Senior Whole Health to get the necessary authorization. Since your PCP

will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

How do you choose your PCP?

When you sign up for our plan you will be asked to select a PCP. The provider you have been seeing may already be part of the *Senior Whole Health* network. If your doctor is not part of *Senior Whole Health*, you will need to choose a new doctor from the network and set up an appointment to see that doctor as soon as possible.

You can choose your PCP from the *Senior Whole Health Provider Directory* at the time you sign up. You can also contact our Member Services department at the toll-free number on the back of this booklet. We will review the names of PCPs in your area, ask you about other doctors you see, and which hospitals you go to. You will be asked to put the PCP's name on your enrollment application. You can change your PCP any time you are a member.

Changing your PCP

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

To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or getting any other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP. The change to your new PCP will take effect immediately. They will also send you a new membership card that shows the name and phone number of your new PCP.

Sometimes a PCP might leave *Senior Whole Health's* network. If this happens, you will have to switch to another PCP who is part of SWH. If your PCP leaves *Senior Whole Health's* network, we will send you a letter to let you know and help you switch to another PCP so that you can keep getting covered services. Member Services can assist you in finding and selecting another provider.

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

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

Section 2.3	How to get care from specialists and other network providers
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

PCPs are responsible for coordinating services and as such, assist with directing members to specialists and other network providers as appropriate. There is no prior approval requirement to get care from network specialists. If you need a service that requires plan prior authorization, the PCP or specialist will contact us to get the necessary prior authorization. Services that require plan prior authorization are identified in Chapter 4 of this booklet. Examples of services that require plan prior authorization include elective (non-emergency) inpatient hospital care, admissions to a skilled nursing facility and home health care.

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of the Senior

Whole Health network. Member Services can assist you in finding and selecting another provider.

We will send you a letter, informing you that the provider is leaving and instructing you to select a new provider from the Provider Directory. Member Services will also contact you by telephone to be sure you have made a selection you are happy with or to help you make a selection by reviewing the options available that will best meet your medical and transportation needs.

Section 2.4	How to get care from out-of-network providers
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If you need specialized medical care MassHealth requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. This includes the services of a provider who is uniquely qualified to provide the particular service you need as well as services provided at a specialty center or a center of excellence. Please contact our plan for prior authorization before seeking care from out-of-network providers. Call Member Services for help (phone numbers are on the back cover of this booklet). If we give you prior authorization to get care from an out-of-network provider, we will cover these services as if you got the care from a network provider.

It is very important to get a prior authorization from our plan before you see out-of-network providers. **If you don't have plan approval before you receive services from an out-of-network provider, *Senior Whole Health* may not cover these services.** If the provider wants you to come back for more care, check first to be sure that the approval from our plan covers more than one visit to the out-of-network provider.

SECTION 3	How to get covered services when you have an emergency or urgent need for care
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Section 3.1	Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

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

If you have a medical emergency:

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

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services. The number is listed on the back of your membership card and on the back cover of this booklet.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

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

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

What if it wasn't a medical emergency?

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

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

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

Section 3.2	Getting care when you have an urgent need for care
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What is “urgently needed care”?

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen

flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

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

In most other situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

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

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

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

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

Section 4.1 You can ask the plan to pay for your covered services

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

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

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

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

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

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

SECTION 5 Rules for getting care covered in a “religious non-medical health care institution”

Section 5.1 What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason.

Section 5.2 What care from a religious non-medical health care institution is covered by our plan?
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

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

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

- The facility providing the care must be certified.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:

- You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
- – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

SECTION 6 Rules for ownership of durable medical equipment

Section 6.1 Will you own your durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

As a member of *Senior Whole Health*, you usually will not acquire ownership of rented durable medical equipment items. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Member Services (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

SECTION 1 Understanding covered services

This chapter focuses on what services are covered. It includes a Benefits Chart that gives a list of your covered services as a member of *Senior Whole Health*. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services.

Section 1.1	You pay nothing for your covered services
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Because you get assistance from MassHealth, you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)

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

Section 2.1	Your medical benefits, long-term care, home and community-based services, as a member of the plan
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The Benefits Chart on the following pages lists the services *Senior Whole Health* covers. The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

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

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

Benefits Chart

Services that are covered for you

What you must pay
when you get these
services

Inpatient Care

Inpatient hospital care

\$0 copay.

Covered services include:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by an approved transplant center that will decide whether you are a candidate for a transplant. If *Senior Whole Health* provides transplant services at a distant location (farther away than the normal community patterns of care) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components of blood are covered beginning with the first pint used.
- Physician services

Prior authorization

required. Except in an emergency your doctor must tell the plan that you are going to be admitted to the hospital.

If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the same cost sharing you would pay at a network hospital: \$0.

Services that are covered for you	What you must pay when you get these services
<p>Note: To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p>	
<p>Inpatient mental health care</p> <ul style="list-style-type: none"> • Covered services include mental health care services that require a hospital stay. • No benefit period or lifetime limit. 	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 11 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood are covered beginning with the first pint. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician services <p>Generally, you will get your SNF care from plan facilities. However,</p>	<p>\$0 copay.</p> <p>Prior authorization required. Except in an emergency your doctor must tell the plan that you are going to be admitted to the SNF.</p> <p>No prior hospital stay is required.</p>

Services that are covered for you	What you must pay when you get these services
<p>under certain conditions listed below, you may be able to get your care from a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. 	
<p>Home health agency care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Hospice care</p> <p>You may receive care from any certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>

Services that are covered for you

What you must pay
when you get these
services

Outpatient Services

Physician services, including doctor's office visits

\$0 copay.

Covered services include:

- Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location
- Consultation, diagnosis, and treatment by a specialist
- Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment
- Telehealth office visits including consultation, diagnosis and treatment by a specialist
- Second opinion by another network provider prior to surgery
- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)

Outpatient hospital services

\$0 copay.

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include:

- Services in an emergency department or outpatient clinic, including same-day surgery
- Laboratory tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself 	
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation. • We cover up to 20 routine office visits or chiropractic manipulation treatments per calendar year. 	<p>\$0 copay.</p> <p>Visits 1-20: No authorization.</p> <p>Visits 20+: Prior authorization required.</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. 	<p>\$0 copay.</p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$0 co-pay.</p> <p>Visits 1-15: No authorization.</p> <p>Visits 15+: Prior authorization required.</p> <p>Authorization required for all out-of-network visits.</p> <p>Must use a Value Options (VO) network provider. Refer to the plan's Provider Directory or contact Member Services for information.</p>

Services that are covered for you	What you must pay when you get these services
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p> <p>Note: Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Outpatient substance abuse services</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan. The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required. 	<p>\$0 copay.</p> <p>Prior authorization required for non-emergency ambulance transportation.</p>

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Not covered outside the United States.</p>	<p>\$0 copay.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered <i>or</i> you must have your inpatient care at the out-of-network hospital authorized by the plan.</p>
<p>Urgently needed care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan’s network of providers is temporarily unavailable or inaccessible.</p> <p>Not covered outside the United States.</p>	<p>\$0 copay.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s referral. The plan also covers intensive cardiac</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>

Services that are covered for you	What you must pay when you get these services
<p>rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Durable medical equipment and related supplies</p> <p>(For a definition of “durable medical equipment,” see Chapter 11 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional 	<p>\$0 copay.</p> <p>Prior authorization required for shoes and inserts.</p>

Services that are covered for you	What you must pay when you get these services
<p>pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</p> <ul style="list-style-type: none"> • Diabetes self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests, when ordered by your provider. • Tests strips, etc. can be obtained with a prescription at a network pharmacy. 	
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood. Coverage begins with the first pint of blood that you need. Coverage of storage and administration also begins with the first pint of blood that you need. • Other outpatient diagnostic tests 	<p>\$0 copay.</p>
<p>Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract 	<p>\$0 copay.</p> <p>Prior authorization required for non-routine services.</p> <p>You must use an in-network Vision Services Provider (VSP) for routine services. Look in your Provider Directory or contact</p>

Services that are covered for you	What you must pay when you get these services
<p>surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</p> <ul style="list-style-type: none"> • \$145 total towards the cost of frames; limited to one pair every 24 months. <p>The following additional routine vision services are covered:</p> <ul style="list-style-type: none"> • Routine eye exams with a network provider for up to 1 visit per calendar year • \$0 co-pay for the cost of routine eye exams with a network provider for up to 1 visit per calendar year. • Does not cover progressive lenses or no-line trifocals. 	<p>Member Services for a listing providers.</p>
Preventive Services	
<p>Preventative Annual Physical exam</p> <p>Includes measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services.</p>	<p>\$0 co-pay.</p>
<p>Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral from your doctor.</p>	<p>\$0 copay.</p>

Services that are covered for you	What you must pay when you get these services
<p>Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>\$0 copay.</p>
<p>Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none">• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months• Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none">• Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none">• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	<p>\$0 copay.</p>
<p>HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none">• One screening exam every 12 months	<p>\$0 copay.</p>
<p>Immunizations</p> <ul style="list-style-type: none">• Pneumonia vaccine• Flu shots, once a year in the fall or winter• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B <p>We also cover some vaccines under our prescription drug benefit.</p>	<p>\$0 copay.</p>

Services that are covered for you	What you must pay when you get these services
<p>Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One screening mammogram every 12 months • Clinical breast exams once every 24 months 	<p>\$0 copay.</p>
<p>Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months 	<p>\$0 copay.</p>
<p>Prostate cancer screening exams</p> <p>Covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>\$0 copay.</p>
<p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>\$0 copay.</p>
<p>Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>\$0 copay.</p>

Services that are covered for you	What you must pay when you get these services
<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services, and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into another calendar year.</p>	<p>\$0 copay.</p>
<p>Smoking and tobacco use cessation (counseling to stop smoking)</p> <p>We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p>	<p>If you haven’t been diagnosed with an illness caused or complicated by tobacco use: \$0 copay.</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: \$0 copay.</p>
<p>Other Services</p>	
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) 	<p>\$0 copay.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) 	
Additional Benefits	
<p>Dental services</p> <p>We cover:</p> <ul style="list-style-type: none"> • extractions (removing teeth), emergency care visits • some oral surgery such as biopsies and soft-tissue surgery • restorative (fillings) • endodontic (root canal) • periodontic (deep scaling) • crowns • dentures (full, partial, or repair) • surgical procedures related to full or partial dentures • diagnostic (x-rays and exams) • preventive (cleanings) 	<p>\$0 copay.</p> <p>Prior authorization required for all services except diagnostic and preventive.</p> <p>You must use a DentaQuest provider. Look in your Provider Directory, or contact Member Services for a list.</p>
<p>Health and wellness education programs</p> <p>We cover \$55/month for Health Club Membership/Fitness Classes.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Adult Day Health and Transportation (minimum 2 days/week)</p> <p>Center-based services that may include nursing services and health oversight, assistance with activities of daily living, nutritional and</p>	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>

Services that are covered for you	What you must pay when you get these services
<p>dietary services, counseling services, activities and transportation at a MassHealth approved site.</p>	
<p>Adult Foster Care (AFC)/Group Adult Foster Care (GAFC)</p> <p>AFC is for members who need daily help with personal care, but want to live in a family setting rather than in a nursing home or other facility. The caregiver provides meals, companionship, personal care assistance, and 24-hour supervision. AFC members live with trained paid caregivers who provide daily care. Caregivers may be individuals, couples, or larger families.</p> <p>GAFC includes personal care services for eligible members with disabilities who live in GAFC-approved housing. Housing may be an assisted living residence or specially designated public or subsidized housing.</p>	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>
<p>Chore Services</p> <p>Assistance with light chores and heavy chores to help members remain at home or promote safety and health.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Companion Services</p> <p>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.</p>	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>
<p>Day Habilitation Services</p> <p>Structured, goal-oriented treatment program of medically oriented, therapeutic and habilitation services for developmentally disabled members.</p>	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>
<p>Dementia day care</p> <p>Structured, secure environment for members with cognitive disabilities approved by Elder Affairs.</p>	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>

Services that are covered for you	What you must pay when you get these services
<p>Environmental Adaptation Services</p> <p>Home adaptations, modifications or adaptive equipment to help member remain independent or improve independence.</p>	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>
<p>Geriatric Support Services Coordination (GSSC)</p> <p>In-home assessment and home-based services coordination provided by a plan contracted ASAP case manager.</p>	<p>\$0 co-pay.</p>
<p>Grocery shopping/delivery services</p> <p>Includes obtaining grocery orders, shopping, delivery and assistance as needed; may include nutritional information and education.</p>	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>
<p>Health/Wellness Education</p> <p>Covers:</p> <ul style="list-style-type: none"> -Written health education materials -Nutritional training -Nutritional benefits -Other wellness services 	<p>\$0 co-pay.</p> <p>Prior authorization required.</p>
<p>Hearing services</p> <p>Coverage includes audiology exams and evaluations, diagnostic services, hearing aids or instruments, and services related to the care and maintenance of hearing aids or instruments.</p>	<p>\$0 copay.</p> <p>Prior authorization required for hearing aids or instruments and related supplies. No authorization required for exams.</p>
<p>Home Assessment</p> <p>Includes home assessments by plan Nurse Care Manager and ASAP GSSC.</p>	<p>\$0 copay.</p>
<p>Home-delivered Meals</p> <p>Includes well balanced meals (meeting Elder Affairs' definition of</p>	<p>\$0 copay.</p> <p>Prior authorization</p>

Services that are covered for you	What you must pay when you get these services
Nutrition Standards and client's nutritional needs) delivered to members unable to prepare nutritional meals or attend congregate meal site.	required.
<p>Home Health Aides Services</p> <p>Includes simple dressing changes, assistance with meds, activities to support skilled therapies and routine care of prosthetic and orthotic devices under the supervision of a licensed RN or other professional.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Homemaker</p> <p>Includes assistance with shopping, menu planning, meal preparation, laundry and light housekeeping.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Institutional Long term Nursing Home Care (custodial care)</p> <p>Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops.</p>	<p>\$0 copay unless MassHealth determines you have a monthly Patient Paid Amount (PPA) for which you are responsible.</p> <p>Prior authorization required.</p>
<p>Laundry Service</p> <p>Cleaning services provided by a laundry company.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Nutritional assessment</p> <p>Comprehensive assessment conducted by a qualified nutritionist with nutritional plan based on assessment.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Over-the-Counter (OTC) Medications</p> <p>Certain OTC medications are covered. Please see the <i>MassHealth</i></p>	<p>\$0 copay.</p>

Services that are covered for you	What you must pay when you get these services
<p><i>Formulary</i> for details.</p> <p>Prescription required; generics only unless otherwise approved by Senior Whole Health. See formulary.</p>	
<p>Personal Care Attendant (PCA)</p> <p>A consumer-directed program that allows members to hire PCAs to help with Activities of Daily Living (ADLs) such as mobility/transfers, medications, bathing or grooming, dressing or undressing, range of motion exercises, eating, toileting and with Instrumental Activities of Daily Living (IADLs) such as shopping, laundry, meal preparation, housekeeping.</p> <p>Does not cover recreation, babysitting, or vocational training, verbal prompting or cuing, or supervision.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Personal care services</p> <p>Includes bathing, dressing, grooming, foot care, assistance with dentures, shaving, assistance with bedpan, eating, ambulating and transfers.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Personal Emergency Response Systems (PERS)</p> <p>A medical communications system allowing members with a medical emergency at home to activate electronic device to transmit signal to a monitoring station.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Respite Care</p> <p>Includes one or more home care services to temporarily relieve the primary caregiver of a member, in emergencies or planned circumstances, of the daily stresses and demands of caring for a member in efforts to strengthen or support the informal support system. May include short term placement in Adult Foster Care, nursing facilities, rest homes, or hospitals.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>

Services that are covered for you	What you must pay when you get these services
<p>Social Day Care Services</p> <p>Individualized programs of social activity for members requiring daytime supervision at sites other than home.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Substance abuse</p> <p>Certain 24-hour substance abuse treatment services for post medical detoxification defined as Level IIIB and Level IIIC by the Massachusetts Department of Public Health.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p> <p>Value Options (VO) is network provider. Contact Member Services for information.</p>
<p>Tobacco Cessation Services</p> <p>Includes group or individual counseling if requested by your doctor. Nicotine replacement medicine including nicotine patches, gum, lozenges, and certain other medicines if prescribed by your doctor.</p>	<p>\$0 co-pay</p> <p>Prior authorization required.</p> <p>Prescription required for nicotine replacement medicine.</p>
<p>Transportation (non-emergency to medical appointments)</p> <p>Taxi and chair-car or other transport for <i>medical reasons</i> within the member's community, or nearest community if no other resource is available, when member is unable to transport self due to health reasons.</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>
<p>Wander Response System</p>	<p>\$0 copay.</p> <p>Prior authorization required.</p>

SECTION 3 What benefits are not covered by the plan?

Section 3.1	Benefits <i>not</i> covered by the plan (exclusions)
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This section tells you what kinds of benefits are “excluded.” Excluded means that the plan doesn’t cover these benefits. The list below describes some services and items that aren’t covered by the plan under any conditions and some that are excluded by the plan only under specific conditions.

We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will MassHealth. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 8, Section 5 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren’t covered by our plan:**

- Services considered not reasonable and necessary, according to the standards of MassHealth, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered under a MassHealth-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and MassHealth to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under MassHealth.
- Private room in a hospital, except when it is considered medically necessary.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household, except as a benefit as a Personal Care Attendant.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Radial keratotomy, LASIK surgery, and vision therapy.

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- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
 - Acupuncture.
 - Naturopath services (uses natural or alternative treatments).
 - Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

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

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

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SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for drugs
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This chapter explains rules for using your coverage for drugs.

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Benefits Chart, what is covered*) tells about the benefits for drugs during a covered hospital or skilled nursing facility stay.
- We also cover certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

Section 1.2 Basic rules for the plan’s drug coverage
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a network provider (a doctor or other prescriber) write your prescription. (For more information, see Section 2, *Your prescriptions should be written by a network provider.*)
- You must use a network pharmacy to fill your prescription. (See Section 3, *Fill your prescriptions at a network pharmacy or through the plan’s mail-order service.*)
- Your drug must be on the plan’s *List of Covered Drugs (Formulary)* (we call it the “Drug List” for short). (See Section 4, *Your drugs need to be on the plan’s “Drug List.”*)
- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 4 for more information about a medically accepted indication.)

SECTION 2 Your prescriptions should be written by a network provider

Section 2.1 In most cases, your prescription must be from a network provider
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You need to get your prescription (as well as your other care) from a provider in the plan’s provider network. This person would often be your primary care provider (your PCP). It could also be another professional in our provider network.

To find network providers, look in the *Provider Directory*.

The plan will cover prescriptions from providers who are not in the plan’s network only in a few special circumstances. These include:

- Prescriptions you get in connection with covered emergency care.
- Prescriptions you get in connection with covered urgently needed care when network providers are not available.
- Dialysis you get when you are traveling outside of the plan’s service area.

Other than these circumstances, you must have approval in advance (“prior authorization”) from the plan to get coverage of a prescription from an out-of-network provider.

If you pay “out-of-pocket” for a prescription written by an out-of-network provider and you think we should cover this expense, please contact Member Services or send the bill to us for payment. Chapter 6, Section 2.1 tells how to ask us to pay for the drug.

SECTION 3 Fill your prescription at a network pharmacy or through the plan’s mail-order service

Section 3.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan’s network pharmacies. (See Section 3.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Section 3.2 Finding network pharmacies
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How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.seniorwholehealth.com), or call Member Services (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you.

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

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

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

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

Section 3.3	Using the plan's mail-order services
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For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

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

To get order forms and information about filling your prescriptions by mail call Member Services at the numbers on the back cover of this booklet.

Usually a mail-order pharmacy order will get to you in no more than 5 days. However, sometimes your mail-order may be delayed. If this happens, please call Senior Whole Health Member Services and we can arrange for you to get your medications at a retail pharmacy.

Section 3.4	How can you get a long-term supply of drugs?
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The plan offers two ways to get a long-term supply of “mail-order” drugs on our plan’s Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Member Services for more information.
2. For certain kinds of drugs, you can use the plan’s network **mail-order services**. Our plan’s mail-order service requires you to order up to a 90-day supply. See Section 3.3 for more information about using our mail-order services.

Section 3.5	When can you use a pharmacy that is not in the plan’s network?
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Your prescription may be covered in certain situations

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

- When you are out of the plan’s service area and there is no network pharmacy available

In this situation, **please check first with Member Services** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

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

SECTION 4	Your drugs need to be on the plan’s “Drug List”
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Section 4.1	The “Drug List” tells which drugs are covered
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The plan has a “*List of Covered Drugs (Formulary)*.” In this *Evidence of Coverage*, **we call it the “Drug List” for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. We will generally cover a drug on the plan’s Drug List as long as you follow the

other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A “medically accepted indication” is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs

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

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow us to cover certain types of drugs (for more information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 4.2	How can you find out if a specific drug is on the Drug List?
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You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Members Services to find out if we cover it.)
2. Visit the plan’s website (www.seniorwholehealth.com). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan’s Drug List or to ask for a copy of the list. Phone numbers for Member Services are on the back cover of this booklet.

SECTION 5 There are restrictions on coverage for some drugs

Section 5.1 Why do some drugs have restrictions?
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 6.2 for information about asking for exceptions.)

Section 5.2 What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available

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

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

Section 5.3	Do any of these restrictions apply to your drugs?
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The plan’s Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are on the back cover of this booklet) or check our website (www.seniorwholehealth.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8, Section 6.2 for information about asking for exceptions.)

SECTION 6

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

Section 6.1	There are things you can do if your drug is not covered in the way you’d like it to be covered
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Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it’s possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.

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

- If your drug is not on the Drug List or if your drug is restricted, go to Section 6.2 to learn what you can do.

Section 6.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are things you can do:

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

You may be able to get a temporary supply

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

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

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

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 5 in this chapter tells about restrictions).

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

- **For those members who were in the plan last year and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31 day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

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

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

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

You can ask for an exception

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

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your provider want to ask for an exception, Chapter 8, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set to make sure your request is handled promptly and fairly.

SECTION 7 What if your coverage changes for one of your drugs?

Section 7.1	The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from MassHealth for changes we make to the plan's Drug List.

Section 7.2

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

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 8 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 8 What types of drugs are *not* covered by the plan?

Section 8.1 Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” This means neither our plan nor MassHealth pays for these drugs.

We won’t pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 8, Section 6.5 in this booklet.) If the drug is excluded, you must pay for it yourself.

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

- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, the categories of drugs listed below are not covered by our plan.

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

SECTION 9 Show your plan membership card when you fill a prescription

Section 9.1 Show your membership card

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

Section 9.2 What if you don't have your membership card with you?

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

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

SECTION 10 Drug coverage in special situations

Section 10.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

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

Section 10.2 What if you're a resident in a long-term care facility?
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Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *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, please contact Member Services.

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

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31 day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 8, Section 6.4 tells what to do.

SECTION 11 Programs on drug safety and managing medications

Section 11.1 Programs to help members use drugs safely
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

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

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

Section 11.2	Programs to help members manage their medications
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We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

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

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

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

Section 1.1	If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment
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Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

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

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

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

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

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

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

3. If you are retroactively enrolled in our plan.

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

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

- Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Sec. 3.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back.

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

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

- Save your receipt and send a copy to us when you ask us to pay you back.

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

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

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think

should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

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

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

Senior Whole Health
Attn: Member Services
58 Charles Street
Cambridge, MA 02141

Please be sure to contact Member Services if you have any questions. If you receive bills and you don’t know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

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

Section 3.2	If we tell you that we will not pay for the medical care or drug, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 8 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 8. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 8 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.5 in Chapter 8.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.1 of Chapter 8.

SECTION 4	Other situations in which you should save your receipts and send copies to us
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Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs
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There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

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

Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Member Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you have a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call MassHealth Customer Service at 1-800-841-2900 and tell them that you want to file a complaint.

Section 1.2	We must treat you with fairness and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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

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

Section 1.3	We must ensure that you get timely access to your covered services and drugs
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As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). You also have the right to go to any women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers.

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

If you think that you are not getting your medical care or drugs within a reasonable amount of time, Chapter 8, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 8, Sections 5 and 6 tells what you can do.)

Section 1.4	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

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

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the *Provider Directory*.
 - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the back cover of this booklet) or visit our website at www.seniorwholehealth.com.
- **Information about your coverage and rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

- If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 8 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 8 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a prescription drug, see Chapter 6 of this booklet.

Section 1.6

We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises

you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 8 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

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

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

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

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Massachusetts Executive Office of Elder Affairs at 1-800-243-4636 or 1-617-727-7750. TTY users please call 1-800-872-0166.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 8 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 8, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

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

Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

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

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

Section 1.9	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **MassHealth** Customer Service at 1-800-841-2900 or TTY: 1-800-497-4648.

SECTION 2	You have some responsibilities as a member of the plan
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Section 2.1	What are your responsibilities?
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Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the back cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 gives the details about your coverage for prescription drugs.
- ***If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know.***
 - We are required to follow rules set MassHealth to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

-
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care of prescription drugs.
 - **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
 - **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
 - **Pay what you owe.** As a plan member, you are responsible for these payments:
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 8 of this booklet for information about how to make an appeal.
 - **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - **Call member services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Member Services are on the back cover of this booklet.

- For more information on how to reach us, including our mailing address, please see Chapter 2.

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

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BACKGROUND

SECTION 1 Introduction

Section 1.1	What to do if you have a problem or concern
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This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered benefits
2. The type of problem you are having:
 - For some types of problems, you need to use the **process for coverage decisions and making appeals**.
 - For other types of problems, you need to use the **process for making complaints**.

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

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

Section 1.2	What about the legal terms?
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There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. In Massachusetts, the SHIP is called SHINE (stands for Serving the Health Information Needs of Elders). This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHINE counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can get help and information from MassHealth

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

- You can call 1-800-841-2900. TTY users should call: 1-800-497-4648.
- You can visit the MassHealth website (www.mass.gov/masshealth).

SECTION 3 Handling problems about your benefits

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

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

To figure out which part of this chapter will help with your problem or concern about your benefits, use this chart:

Is your problem or concern about your benefits or coverage?

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

Yes.

My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and making appeals.”**

No.

My problem is not about benefits or coverage.

Skip ahead to **Section 9** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

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

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

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

Asking for coverage decisions

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

In some cases we might decide a service or drug is not covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

If we say no to all or part of your request, you can request a Fair Hearing from the MassHealth Board of Hearings.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Appeal, you can request a Fair Hearing from the MassHealth Board of Hearings.

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Member Services** (phone numbers are on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or an Appeal on your behalf.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. The form gives that person permission to act on your behalf. It must be signed by you and by

the person who you would like to act on your behalf. You must give us a copy of the signed form.

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

Section 4.3	Which section of this chapter gives the details for <u>your</u> situation?
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There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “Your prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Services (phone numbers are on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5	Your medical care: How to ask for a coverage decision or make an appeal
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Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered)*. To keep things simple, we generally

refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
 - Chapter 8, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon*. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
 - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

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

Section 5.2

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

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

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

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

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

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

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a “fast decision”

- **A fast decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

Deadlines for a “fast” coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

- If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

Section 5.3

**Step-by-step: How to make an Appeal
(how to ask for a review of a medical care coverage decision made by our plan)**

Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”
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Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact us when you are making an appeal about your medical care*.
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*). We will record your appeal request and send you an attestation that you must sign and mail back to us.
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services and ask for the “Appointment of Representative” form. It is also

available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.) While we can accept an appeal request without the form, we cannot complete our review until we receive it.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

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

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

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

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

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, you may file an appeal with the MassHealth Board of Hearings. See section 8 in this chapter for more information.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, you may file an appeal with the MassHealth Board of Hearings. See section 8 in this chapter for more information.

Section 5.5	What if you are asking us to pay you back for a bill you have received for medical care?
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If you want to ask us for payment for medical care, start by reading Chapter 6 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 6 describes the situations in which you may need to ask for reimbursement or to pay a bill you

have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Benefits Chart (what is covered)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

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

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

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

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

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

SECTION 6 Your prescription drugs: How to ask for a coverage decision or make an appeal



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

Section 6.1	This section tells you what to do if you have problems getting a drug or you want us to pay you back for a drug
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Your benefits as a member of our plan include coverage for many outpatient prescription drugs. We call these outpatient prescription drugs. You can get these drugs as long as they are included in our plan’s *List of Covered Drugs (Formulary)* and the use of the drug is a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.)

- **This section is about your drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” every time.
- For details about what we mean by drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your prescription drugs*).

Drug coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	An initial coverage decision about your drugs is called a “ coverage determination. ”
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Here are examples of coverage decisions you ask us to make about your drugs:

- You ask us to make an exception, including:
 - Asking us to cover a drug that is not on the plan’s *List of Covered Drugs (Formulary)*
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)

- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
<p>Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with Section 6.2 of this chapter.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to Section 6.4 of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to Section 6.4 of this chapter.</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to Section 6.5 of this chapter.</p>

Section 6.2	What is an exception?
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If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, 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 will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

- 1. Covering a drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the “Drug List” for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “formulary exception.”
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- You cannot ask for coverage of any “excluded drugs” or other drugs we do not cover. (For more information about excluded drugs, see Chapter 5.)

- 2. Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 5).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”
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- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

Section 6.3	Important things to know about asking for exceptions
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Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4

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

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast decision.” You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4.2 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 6 of this booklet: *Asking us to pay a bill you have received for covered medical services or drugs*. Chapter 6 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor

or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a “fast decision”

Legal Terms	A “fast decision” is called an “ expedited coverage determination. ”
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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 9 of this chapter.)

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

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.

- Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5**Step-by-step: How to make an Appeal****(how to ask for a review of a coverage decision made by our plan)**

Legal Terms	An appeal to the plan about a drug coverage decision is called a plan “redetermination.”
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Step 1: You contact us and make your Appeal. If your health requires a quick response, you must ask for a **“fast appeal.”**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your prescription drugs*). We will record your request, then send you an attestation that you must sign and mail back to us.
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your prescription drugs).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms	A “fast appeal” is also called an “ expedited redetermination. ”
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- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 6.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

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

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

You may file an appeal with the MassHealth Board of Hearings. See section 8 in this chapter for more information.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1	<i>This section is about three services <u>only</u>:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 11, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 11, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Benefits Chart (what is covered)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2**We will tell you in advance when your coverage will be ending**

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

2. **You must sign the written notice to show that you received it.**
 - You or someone who is acting on your behalf must sign the notice. (Section 4.2 tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

Section 7.3**Step-by-step: How to make an Appeal to have our plan cover your care for a longer time**

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call

your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During an Appeal, we review your appeal and decide whether to change the decision made by our plan.

Step-by-Step: How to make an Appeal:

Legal Terms	A “fast” review (or “fast appeal”) is also called an “expedited appeal.”
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Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

SECTION 8 Appealing to the MassHealth Board of Hearings

You may request a fair hearing through the MassHealth Board of Hearing appeal process when you disagree with a decision we have made about your benefits. For pursuit of a MassHealth Board of Hearing Appeal, MassHealth must receive your request for a fair hearing no later than 30 calendar days from the mailing date of the written denial notice from Senior Whole Health.

If your appeal was expedited (reviewed quickly) during our plan's internal appeal process, the Board of Hearings must get your fair hearing request form within 20 calendar days of the mailing date of Senior Whole Health's final written notice to you for your appeal to be expedited at the Board of Hearings. However, if the Board of Hearings gets your fair hearing request form between 21 and 30 calendar days of the mailing date of the plan's final written notice to you, then the Board of Hearings will process your appeal using standard appeal times.

The request along with a copy of Senior Whole Health's final denial notice must be sent to:

Executive Office of Health & Human Services
Board of Hearings
100 Hancock Street, 6th Floor
Quincy, MA 02171
Or Fax to (617) 847-1204

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

If you do not agree with the fair hearing decision, you will have further appeal rights under MassHealth. You will be notified of those appeal rights if this happens.

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

You may also contact Senior Whole Health Member Services for more information about your appeal rights or to request a copy of the MassHealth Fair Hearing Request Form. Please call 1-888-794-7268, TTY: 711. We are available 24 hours a day, 7 days a week.

At the same time you may also appeal to our plan, in which case you should follow instructions for the appeals process (see Sections 5 and 6 of this chapter).

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns



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

Section 9.1 What kinds of problems are handled by the complaint process?
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This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems,
you can “make a complaint”**

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?
 - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

*The next page has more examples of
possible reasons for making a complaint*

Possible complaints

(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

Section 9.2**The formal name for “making a complaint” is “filing a grievance”****Legal
Terms**

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

Section 9.3

Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Please call us at 1-888-794-7268, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th. TTY users, please call 711.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, put your complaint in writing, we will respond to your complaint in writing.
- You, or a representative you choose, can file your complaint at any time by calling Senior Whole Health or writing to us at the following address:

Senior Whole Health
Attn: Quality Manager
58 Charles Street
Cambridge, MA 02141
Fax: 1-617-494-5599

We will send you a written acknowledgement that we have received your complaint and we will keep a record of it.

- We will respond to your request for an expedited grievance within 24 hours (if our decision to deny or delay making and expedited decision puts your life or health at risk) whenever:
 - We extend the time frame to make an organization determination or reconsideration; or
 - We refuse to grant a request for an expedited organization determination or reconsideration
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a “fast complaint” is also called an “expedited grievance.”
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Step 2: We look into your complaint and give you our answer.

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

You may also file a complaint with MassHealth. Please call MassHealth Customer Service at 1-800-841-2900 and tell them that you want to file a complaint

Chapter 9. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our plan
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Ending your membership in *Senior Whole Health* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

Section 2.1	You can end your membership at any time
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You can end your membership in *Senior Whole Health* at any time.

- **When can you end your membership?** Because you get assistance from MassHealth Standard, **you can end your membership in *Senior Whole Health* at any time.**
- **What type of plan can you switch to?**
 - You will return to MassHealth Standard coverage.
 - Contact your State MassHealth Office to learn about your MassHealth plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can contact **MassHealth** Customer Service at 1-800-841-2900.
- You can contact the Massachusetts Senior Care Options Unit at 1-888-885-0484. TTY users, please call 1-888-821-5225.

SECTION 3	How do you end your membership in our plan?
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Section 3.1	You may ask to be disenrolled or you may enroll in another plan
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You may end your membership in our plan by contacting Senior Whole Health Member Services and asking 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 Member Services if you need more information on how to do this.)
- --or--you can contact **MassHealth** Customer Service at 1-800-841-2900.

SECTION 4	Until your membership ends, you must keep getting your medical services and drugs through our plan
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Section 4.1	Until your membership ends, you are still a member of our plan
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If you leave *Senior Whole Health*, it may take time before your membership ends and your new MassHealth coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

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

SECTION 5 ***Senior Whole Health* must end your membership in the plan in certain situations**

Section 5.1	When must we end your membership in the plan?
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***Senior Whole Health* must end your membership in the plan if any of the following happen:**

- If you are no longer eligible for MassHealth Standard. As stated in Chapter 1, section 2.1, our plan is for people who are eligible for MassHealth Standard. We will send you a letter if you lose your MassHealth Standard or other special eligibility requirements.
- If you move out of our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
 - We cannot make you leave our plan for this reason unless we get permission from MassHealth first.
- If you let someone else use your membership card to get medical care.

Where can you get more information?

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

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

Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health
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What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call MassHealth Customer Service at 1-800-841-2900.

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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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 make a complaint about our decision to end your membership. You can also look in Chapter 8, Section 9 for information about how to make a complaint.

Chapter 10. Legal notices

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SECTION 1 **Notice about governing law**

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 **Notice about nondiscrimination**

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Chapter 11. Definitions of important words

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

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

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

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

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

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

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

Custodial Care – Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also

include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

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

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

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

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

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

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

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

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

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

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

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

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

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

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

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

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

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

Premium – The periodic payment to an insurance company or a health care plan for health or prescription drug coverage.

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

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

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

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

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

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

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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

Urgently Needed Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.



Senior Whole Health Member Services

CALL	1-888-794-7268 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are open weekdays, Monday through Friday, from 8 A.M. to 8 P.M., and also on Saturdays and Sundays from October 15th to February 14th.
FAX	1-617-494-5599
WRITE	Senior Whole Health (HMO SNP) 58 Charles Street Cambridge, MA 02141
WEBSITE	www.seniorwholehealth.com

Serving Health Information Needs of Elders (*Massachusetts SHIP*)

Serving Health Information Needs of Elders (SHINE) is a state program that gets money from the Federal government to give free local health insurance counseling.

CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	1-800-872-0166 (Massachusetts only) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Call the number above for the address of the SHINE program in your area.
WEBSITE	www.800ageinfo.com