January 1 – December 31, 2024

Evidence of Coverage:

Your Health Benefits and Services and Prescription Drug Coverage as a Member of WellSense Senior Care Options (SCO)

This document gives you the details about your MassHealth (Medicaid) health care long-term care, and/or home and community-based services as applicable and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 855-833-8125 (TTY users should call 711). Hours are Monday-Friday, 8:00 a.m. - 8:00 p.m. (From October 1 to March 31 representatives are available 7 days a weeks, 8:00 a.m. – 8:00 p.m.). This call is free.

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

This document is available for free in other languages. We can provide this document to you in braille, large print, or other languages and/or alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Benefits may change on January 1, 2025.

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

WellSense Senior Care Options (SCO) is a HMO plan with a Medicare Advantage contract and a contract with the Massachusetts Medicaid program. Enrollment in WellSense Senior Care Options (SCO) depends on contract renewal. WellSense Senior Care Options (SCO) is a voluntary MassHealth (Medicaid) program in association with the Executive Office of Health and Human Services (EOHHS) and the Centers for

Medicare and Medicaid Services (CMS). The plan also has a written agreement with the Massachusetts Medicaid program to coordinate your MassHealth (Medicaid) benefits. This information is available for free in other languages. This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing (there is $0 cost for Senior Care Options (SCO) members;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

MassHealth is required by federal law to recover money from the estates of certain MassHealth members who are age 55 years or older, and who are any age and are receiving long-term care in a nursing home or other medical institution. For more information about MassHealth estate recovery, please visit mass.gov/estaterecovery.

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in WellSense Senior Care Options (SCO) which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both MassHealth (Medicaid):

- **MassHealth (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. MassHealth (Medicaid) coverage varies depending on the type of Medicaid you have.

You have chosen to get your health care and your prescription drug coverage through our plan, WellSense Senior Care Options (SCO.)

WellSense Senior Care Options (SCO) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. WellSense Senior Care Options (SCO) is designed for people who have MassHealth (Medicaid.)

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

WellSense Senior Care Options (SCO) is run by a non-profit organization. Like all Senior Care Options Special Needs Plans, the plan has a contract with the Massachusetts MassHealth (Medicaid) program to coordinate your MassHealth (Medicaid) benefits. We are pleased to be providing your MassHealth (Medicaid) health care coverage, including your prescription drug coverage, long-term care and/or home and community-based services.

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

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

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

The words *coverage* and *covered services* refer to the medical care, long-term care and/or home and community-based services and services and the prescription drugs available to you as a member of WellSense Senior Care Options (SCO).

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in WellSense Senior Care Options (SCO) between January 1, 2024 and December 31, 2024.

Each calendar year, MassHealth (Medicaid) allows us to make changes to the plans that we offer. This means we can change the costs and benefits of WellSense Senior Care Options (SCO) after December 31, 2024. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2024.

The Commonwealth of Massachusetts/Executive Office of Health Human Service must approve our plan each year.

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

Section 2.1 Your eligibility requirements

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

- You are eligible for MassHealth (Medicaid) Standard with a SCO-eligible aid category,
- -- and -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it,
- -- and -- You live in our geographic service area (Section 2.3 below describes our service area).
- -- and – You do not reside in an intermediate care facility for behavioral health.
- -- and -- you select a network primary care provider (PCP) and agree to assist your primary care provider in developing an individualized plan of care;
- -- and -- You are not subject to a 6-month deductible period under MassHealth (Medicaid) regulations;
- -- and -- You agree to receive all your services from WellSense Senior Care Options (SCO), except in the case of an emergency or when travelling temporarily out of the service area;
- -- and -- You do not reside in a chronic disease or rehabilitation hospital;
- -- and –You do not have any other comprehensive health insurance coverage that meets a basic benefit standard.
- -- and – You meet the special eligibility requirements described below:

Special eligibility requirements for our plan

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

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

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 1 month, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility). There is $0 cost for Senior Care Options (SCO) members.

Section 2.2 What is Medicaid?

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

Section 2.3 Here is the plan service area for WellSense Senior Care Options (SCO)

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

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

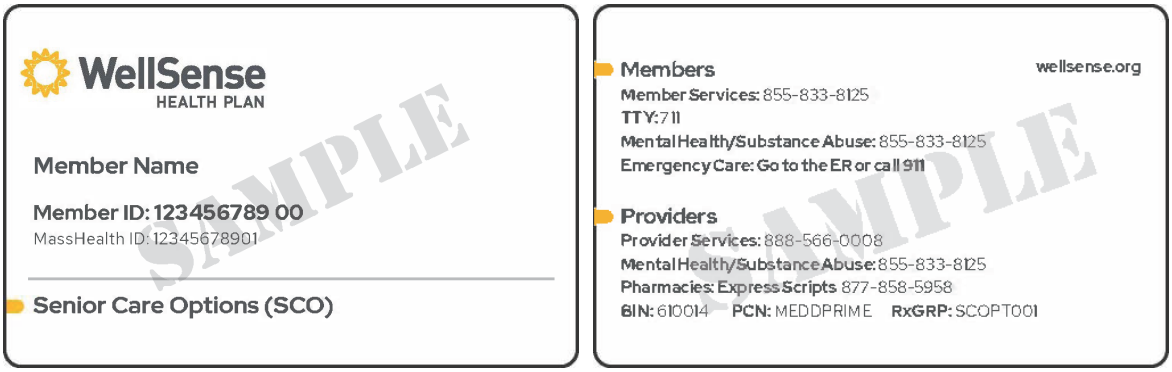
If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area.

It is also important that you call MassHealth (Medicaid) if you move or change your mailing address.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



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

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 Provider and Pharmacy Directory

The Provider and Pharmacy Directory lists our current network providers, MassHealth (Medicaid) providers, network pharmacies and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-

of-area dialysis services, and cases in which WellSense Senior Care Options (SCO) authorizes use of out-of-network providers.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days.

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

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which prescription drugs are covered under the prescription drug benefit included in WellSense Senior Care Options (SCO). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by MassHealth (Medicaid). MassHealth (Medicaid) has approved the WellSense Senior Care Options (SCO) "Drug List."

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

We will provide you a copy of the "Drug List." To get the most complete and current information about which drugs are covered, you can visit the plan's website wellsense.org/sco or call Member Services.

SECTION 4 Keeping your plan membership record up to date

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number

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

If any of this information changes, please let us know by calling Member Services.

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

SECTION 5 How other insurance works with our plan

Other insurance

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

The following section may not apply to you because enrollment in the WellSense Health Plan Senior Care Options (SCO) is restricted to members who

do not have any other comprehensive health insurance. If you have other comprehensive health insurance, you may not be eligible to enroll or remain enrolled in WellSense Health Plan Senior Care Options (SCO).

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

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

- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, and the number of people employed by your employer,:
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

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

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

CHAPTER 2:

Important phone numbers and resources

SECTION 1 WellSense Senior Care Options (SCO) contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

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

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

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

Method	Coverage Decisions and Appeals for Medical Care or Part D prescription drugs – Contact Information
CALL	855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. - 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	877-503-7231
WRITE	Express Scripts 4700 N Hanley, Suite C St. Louis, MO 63134
WEBSITE	wellsense.org/sco

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

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

Method	Complaints about Medical Care – Contact Information
CALL	855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available.
TTY	855-833-8125 Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available.
FAX	617-897-0805
WRITE	WellSense Senior Care Options (SCO) Member Grievances Department 529 Main Street, Suite 500 Charlestown, MA 02129

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider

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

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

Method	Payment Requests – Contact Information
CALL	855-833-8125 Calls to this number are free Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31). Member Services also has free language interpreter services available.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31).
FAX	617-897-0884 for medical requests 608-741-5483 for drug requests
WRITE	For Medical Care Payment Requests: WellSense Senior Care Options (SCO) Member Services Department 529 Main Street, Suite 500 Charlestown, MA 02129 For Drug Payment Requests: Express Scripts Lexington, KY 40512-4718
WEBSITE	wellsense.org/sco

SECTION 2 State Health Insurance Assistance Program (free help, information, and answers to your questions about MassHealth (Medicaid))

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	The SHINE Program (Massachusetts SHIP) – Contact Information – Contact Information
CALL	800-AGE-INFO (800-243-4636), press option 3 or option 5 if you are calling from a cell phone, and leave a message and a representative will respond to you.
TTY	711 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	massoptions.org/massoptions

SECTION 3 MassHealth (Medicaid)

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

Your membership eligibility is based off of:

- MassHealth (Medicaid) determines your eligibility for MassHealth (Medicaid) benefits

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

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

Method	Massachusetts Medicaid program – Contact Information
CALL	800-841-2900 Available 8:00 a.m.- 5:00 p.m. Monday through Friday
WRITE	MassHealth Customer Service Center Health Processing Center PO Box 4405, Taunton, MA 02780 Or, you may go to one of the MassHealth Enrollment Centers in your area.
WEBSITE	www.mass.gov/MassHealth

Method	MassOptions – Contact Information
CALL	1-800-243-4636 Available 9:00 a.m. -5:00 p.m. Monday through Friday
TTY	711 MassOptions works with telephonic interpreter for the deaf, hard of hearing, and speech impaired who want to communicate with us.
WRITE	Please e-mail any questions or concerns to the website address below or visit the website and for to the "How to Contact Us" section- you can chat on-line or send an e-mail.
WEBSITE	massoptions.org On-line chat available at the link above.

The *My Ombudsman* helps people enrolled in MassHealth (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	My Ombudsman – Contact Information
CALL	855-781-9898 Available 9:00 a.m. -4:00 p.m. Monday through Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Please e-mail at info@myombudsman.org.
WEBSITE	www.myombudsman.org

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

Method	Massachusetts Long Term Care Ombudsman Program - Contact Information
CALL	617-222-7495, Monday through Friday from 8:45 a.m. to 5:00 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Executive Office of Elder Affairs One Ashburton Place, 5th Floor Boston, MA 02108
WEBSITE	www.mass.gov/MassHealth

SECTION 4 Do you have group insurance or other health insurance from an employer?

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

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

SECTION 5 You can get assistance from Area Agencies on Aging

Counties	Area Agency on Aging	Contact Information
Suffolk	Boston Senior Home Care	Lincoln Plaza 89 South Street, Suite 501 Boston, MA 02111 (617) 456400
Suffolk	Central Boston Elder Services	2315 Washington Street Boston, MA 02119 617 277-7416
Suffolk	Somerville-Cambridge Elder Services	61 Medford Street Somerville, MA 02143 (617) 628-2601
Suffolk	Southwest Boston Senior Services dba Ethos	555 Amory Street Jamaica Plain, MA 02130 (617) 628- 2601
Suffolk	Mystic Valley Elder Services	300 Commercial Street, #19

		Malden, Ma 02148 78324-7705
Hampden	WestMass Elder Care	4 Valley Mill Road Holyoke, MA 01040 (413) 788800
Hampden	Greater Springfield Senior Services	66 Industry Avenue Springfield, MA 01104 (413) 788800
Hampden	Highland Valley Elder Services	320 Riverside Drive Florence, MA 01062 (413) 586-2000
Plymouth	South Shore Elder Services	1515 Washington Street Braintree, MA 02184 (781) 848-3910
Plymouth	Old Colony Elder Services	144 Main Street Brockton, MA 02301 (508) 584-1561
Plymouth	Coastline Elder Services	1646 Purchase Street New Bedford, MA 02740 (508) 999-6400
Barnstable	Elder Services of Cape Cod	68 Route 134 South Dennis, MA 02660 (508) 394-4630 (800) 244-4630 (Cape only) (800) 442-4492 (Mass only)
Bristol	Bristol Elder Services	1 Father Devalles Blvd Unit 8 Fall River, MA 02723 (508) 675-2102

Bristol	Coastline Elder Services	1646 Purchase Street New Bedford, MA 02740 (508) 999-6400
Bristol	Old Colony Elder Services	144 Main Street Brockton, MA 02301 (508) 584-1561

CHAPTER 3:

Using the plan for your medical and other covered services

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

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

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

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **Covered services** include all the medical care, health care services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

WellSense Senior Care Options (SCO) must cover all services covered by Original Medicare and MassHealth (Medicaid).

WellSense Senior Care Options (SCO) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).

- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that our plan is required to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider. Prior authorization may be required. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible.

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

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

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

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

How do you choose your PCP?

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

Changing your PCP

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

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

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

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

Section 2.2 What kinds of medical care and other services can you get without a referral from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

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

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

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions
- A referral (an order from your Primary Care Provider (PCP) to see an in-network specialist for covered services) is not required.
- Prior Authorization from the Plan may be required for out-of-network specialists.
- Some types of services will require getting prior approval from our plan (this is called getting "prior authorization").
- Prior Authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your PCP, other network provider, or you can request the authorization from our plan.
    - The request will be reviewed and a decision will be sent to you and the provider within 14 calendar days after we receive the request for a standard authorization and within 72 hours after we receive the request for an expedited (fast) authorization.
    - Any decision to authorize or deny a prior authorization will be made by a doctor who has appropriate clinical expertise in addressing your medical, behavioral health, or long term services support and needs.
    - Please refer to the Benefits Chart in Chapter 4, Section 2.1 of this booklet for the specific services that require "prior authorization."
- Selecting your network PCP does not limit your use of network providers and facilities.

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

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

- Even though our network of providers may change during the year, MassHealth (Medicaid) requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider. We will send written notification of termination of the provider within 30 calendar days prior to the effective date of termination, or 15 calendar days after the receipt or issuance of the notice from the provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior Authorization may be required.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 8.

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

You must receive your care from a network provider (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network

provider (a provider who is not part of our plan's network) will not be covered. However, you are entitled to receive services from out-of-network providers in cases of emergency/urgent care. If the services you need are not available in-network, you would need a Prior Authorization from the plan. You are also able to receive dialysis treatment if you are traveling outside the plan's service area and are unable to receive treatment from network providers.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. However, the Plan will not pay to return you to the

United States or its territories for your treatment. 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 Medical 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.

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

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

What if it wasn't a medical emergency?

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

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

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

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

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

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

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

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

Our plan covers worldwide emergency and urgent care services outside the United States and its territories. However, the plan does not pay to return you to the United States and its territories for care.

Section 3.3 Getting care during a disaster

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

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

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

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

Section 4.1 You can ask us to pay for covered services

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

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

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

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service.

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

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by MassHealth (Medicaid). Clinical research studies approved by MassHealth (Medicaid) typically request volunteers to participate in the study.

Once MassHealth (Medicaid) approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can

participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in an approved study, the study pays most of the costs for the services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

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

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

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

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

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

The study pays most of the cost for these services as part of the study. Our plan will pay the rest of your covered services that are not related to the study. Like all covered services, you will pay nothing for the covered services you get in the clinical research study.

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

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

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

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

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for inpatient services (non-medical health care services).

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

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

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

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

- The facility providing the care must be certified by Medicare.

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

Inpatient Hospitalization coverage with WellSense Senior Care Options (SCO) has no coverage limitation for this covered service. For more information, please refer to the benefits chart in Chapter 4.

SECTION 7 Rules for ownership of durable medical equipment

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

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

As a member of WellSense Senior Care Options (SCO) however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services for more information.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for oxygen equipment coverage, WellSense Senior Care Options (SCO) will cover:

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

If you leave WellSense Senior Care Options (SCO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

CHAPTER 4:

Medical Benefits Chart (what is covered)

SECTION 1 Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of WellSense Senior Care Options (SCO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 You pay nothing for your covered services

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 1.2 What is the most you will pay for covered medical services?

Note: Because our members get assistance from MassHealth (Medicaid), they are not responsible for paying any out-of-pocket costs.

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

Section 2.1 Your medical long-term care or home and community-based services or other MassHealth (Medicaid)-only benefits as a member of the plan

The Medical Benefits Chart on the following pages lists the services WellSense Senior Care Options (SCO) covers. Prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your MassHealth (Medicaid) covered services must be provided according to the coverage guidelines established by MassHealth (Medicaid).
- Your services (including medical care, services, supplies, equipment, and prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.

Other important things to know about our coverage:

- We cover everything that MassHealth (Medicaid) Standard covers, including long-term care, over-the-counter drugs, and home and community-based services.
- You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

Special Supplemental Benefits for the Chronically Ill: Important Benefit Information for Enrollees with Chronic Conditions

- The plan is offering a new special supplemental benefit for the Chronically Ill. This applies to you if you are diagnosed with the following chronic condition(s) identified below and meet certain criteria. You may be eligible for a special supplemental benefit for the chronically ill.
    - Chronic alcohol and other drug dependence;
    - Arthritis
    - Autoimmune disorders including but not limited to:
        - Polyarteritis nodosa,
        - Polymyalgia rheumatic,
        - Polymyositis,
        - Rheumatoid arthritis, and
        - Systemic lupus erythematosus;
    - Cancer, excluding pre-cancer conditions or in-situ status;
    - Cardiovascular disorders limited to:
        - Cardiac arrhythmias,
        - Coronary artery disease,
        - Peripheral vascular disease, and
        - Chronic venous thromboembolic disorder;
    - Chronic heart failure;
    - Dementia;
    - Diabetes mellitus;
    - End-stage liver disease;
    - End-stage renal disease (ESRD) requiring dialysis;

  - Severe hematologic disorders limited to:
    - Aplastic anemia
    - Hemophilia
    - Immune thrombocytopenic purpura
    - Myelodysplastic syndrome,
    - Sickle-cell disease (excluding sickle-cell trait), and
    - Chronic venous thromboembolic disorder;
  - HIV/AIDS;
  - Chronic lung disorders limited to:
    - Asthma
    - Chronic bronchitis,
    - Emphysema,
    - Pulmonary fibrosis, and
    - Pulmonary hypertension;
  - Chronic and disabling behavioral health conditions limited to:
    - Bipolar disorders,
    - Major depressive disorders,
    - Paranoid disorder,
    - Schizophrenia, and
    - Schizoaffective disorder;
  - Neurologic disorders limited to:
    - Amyotrophic lateral sclerosis (ALS),
    - Epilepsy,
    - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia),
    - Huntington's disease,
    - Multiple sclerosis,
    - Parkinson's disease,
    - Polyneuropathy,
    - Spinal stenosis, and
    - Stroke-related neurologic deficit; and
  - Osteoporosis
  - Stroke
  - Other conditions that meet the criteria and are life-threatening or significantly limit the overall health and function of the enrollee.
- Please go to the *Special Supplemental Benefits for the Chronically Ill* row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); and • not associated with surgery. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,	$0 copay

Services that are covered for you	What you must pay when you get these services
• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Adult Day Health and Transportation (minimum 2 days/week) Center-based services that may include nursing services and health oversight, assistance with activities of daily living, nutritional and dietary services, counseling services, activities, and transportations at a MassHealth (Medicaid) approved site. *Prior Authorization is required for Adult Day Health.*	$0 copay
Adult Foster Care (AFC)/Group Adult Foster Care (GAFC) **AFC** is for members who need daily help with personal care, but want to live in a family setting rather than in a 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**.** **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. *Prior Authorization is required for Adult Foster Care (AFC) and Group Adult Foster Care (GAFC**)***	$0 copay

Services that are covered for you	What you must pay when you get these services
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Prior Authorization is required for non-emergency transportation services as described in the paragraph above**.**	$0 copay
Annual wellness visit You can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible.

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) Covered services include: Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Prior Authorization may be required	$0 copay
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: Manual manipulation of the spine to correct subluxation Other medically necessary chiropractic services are covered up to a maximum of 20 visits per benefit year Prior Authorization is required for any services, other than manual manipulation of the spine to correct subluxation, that exceed the 20 visit limit.	$0 copay
Chores Services Assistance with light chores and heavy chores to help members remain at home or promote safety and health.	$0 copay

Colorectal cancer screening

The following screening tests are covered:

- Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.
- Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema.
- Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.
- Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.
- Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.
- Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.
- Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.

Colorectal cancer screening tests include a follow-on screening colonoscopy after a covered non-invasive stool-based colorectal cancer screening test returns a positive result.

There is no coinsurance, copayment, or deductible for a covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Services that are covered for you	What you must pay when you get these services
Companion Services Includes socialization, help with shopping and errands, escort to doctor's appointments, nutrition sites, walks recreational activities, and assistance with preparation and serving of light snacks.	$0 copay
Day Habilitation Services Structured, goal-oriented treatment program of medically oriented, therapeutic and habilitation services for developmentally disabled members. Prior Authorization is required for Day Habilitation Services	$0 copay
Dementia Day Care Structured, secure environment for members with cognitive disabilities approved by Elder Affairs. Prior Authorization is required for Dementia Day Care.	$0 copay

Services that are covered for you	What you must pay when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently covers dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover the following dental services under your MassHealth (Medicaid) benefits: Preventive/Diagnostic Services: • Cleanings, exams, and x-rays Comprehensive Services: • Restorative procedures, such as fillings and crowns • Periodontics, including scaling • Dentures (Prosthodontics), including full and partial sets, relines and repairs • Oral and Maxillofacial surgeries such as teeth removal (extractions) Prior Authorization may be required for some non-routine Dental Services.	$0 copay Replacement dentures are limited to coverage once every seven (7) years unless authorized differently by your Primary Care Provider or Primary Care Team.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Diabetes self-management training is covered under certain conditions.	$0 copay

Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 11 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, and hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 11 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by MassHealth (Medicaid). If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at wellsense.org/sco . Generally, WellSense Senior Care Options (SCO) covers any DME covered from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to WellSense Senior Care Options (SCO) and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your	$0 copay

Services that are covered for you	What you must pay when you get these services
doctor, you can ask him or her to refer you for a second opinion.) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 8, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Prior Authorization is required for Durable Medical Equipment and supplies that cost $500 or more. Prior authorization is required for Diabetic Supplies and Services that cost $500 or more. Prior authorization is required for Diabetic Therapeutic Shoes/Inserts and Services that cost $500 or more.	

Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage is provided for a supplemental benefit that covers world-wide emergency and urgent care services outside the United States and its territories. However, transportation to return to the United States and its territories is NOT covered.	$0 copay If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan.
Environmental Adaption Services Home adaptations, modifications or adaptive equipment to help the member remain independent or improve independence. *Prior Authorization is required for Environmental Adaptation Services.*	$0 copay

Services that are covered for you	What you must pay when you get these services
Geriatric Support Services Coordination (GSSC) In-home assessment and home-based services coordination provided by a plan contracted ASAP case manger.	$0 copay
Grocery Shopping/Delivery Services Includes obtaining grocery orders, shopping, delivery and assistance as needed; may include nutritional information and education	$0 copay
Health and wellness education programs • Fitness Benefit (supplement benefit) • Written health education materials • Nutritional training • Nutritional benefits • Other wellness services • SilverSneakers® is a complete health and fitness program designed for individuals at all fitness levels. Member will have access to participating gyms and fitness centers to help them meet their personal wellness goals. Please note nonstandard fitness centers that usually have an extra fee are not included in your membership. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.	Fitness Benefit: Silver Sneakers Program

Services that are covered for you	What you must pay when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Under the MassHealth (Medicaid) benefit, we also provide the following: • Routine hearing exams • Hearing aids, including evaluation for fitting hearing aids, repairs, and replacements • Audiology exams and evaluations • Diagnostic services Prior Authorizations is required for hearing aids or instrument replacement before they are 5 years old. No Prior Authorization is required for the hearing exams.	$0 copay
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: One screening exam every 12 months	There is no coinsurance, copayment, or deductible for members eligible for preventive HIV screening.

Services that are covered for you	What you must pay when you get these services
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home 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 Prior Authorization is required for Home Health Care Services.	$0 copay
Home Health Aide Services 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. You do not need to be homebound for services to be covered under this benefit. *Prior Authorization is required for Home Health Aide Services.*	$0 copay

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: Professional services, including nursing services, furnished in accordance with the plan of care Patient training and education not otherwise covered under the durable medical equipment benefit Remote monitoring Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier *Prior Authorization is required for Home Health Care Services.*	$0 copay .
Homemaker Includes assistance with shopping, menu planning, meal preparation, laundry, and light housekeeping.	$0 copay

Services that are covered for you	What you must pay when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: Drugs for symptom control and pain relief Short-term respite care Home care	$0 copay
Hospice care (continued) **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. Prior Authorization is required for certain Hospice-related services	

Services that are covered for you	What you must pay when you get these services
Immunizations Covered services include: Pneumonia vaccine Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B COVID-19 vaccine Other vaccines if you are at risk and they meet coverage rules We also cover some vaccines under our prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: Semi-private room (or a private room if medically necessary) Meals including special diets Regular nursing services Costs of special care units (such as intensive care or coronary care units) Drugs and medications Lab tests X-rays and other radiology services Necessary surgical and medical supplies Use of appliances, such as wheelchairs Operating and recovery room costs Physical, occupational, and speech language therapy Inpatient substance use services	$0 copay

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If WellSense Senior Care Options (SCO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components of blood are covered beginning with the first pint used. Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. Prior Authorization is required for Inpatient Hospital care.	

Services that are covered for you	What you must pay when you get these services
Inpatient behavioral health care Covered services include mental health care services that require a hospital stay. Prior Authorization is not required for inpatient behavioral health care.	$0 copay
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: Physician services Diagnostic tests (like lab tests) X-ray, radium, and isotope therapy including technician materials and services Surgical dressings Splints, casts and other devices used to reduce fractures and dislocations Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition Physical therapy, speech therapy, and occupational therapy	$0 copay

Services that are covered for you	What you must pay when you get these services
Institutional Long Term Nursing Home Care (Custodial Care) Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around and using the bathroom. It may also include care that most people do themselves, like using eye drops. *Prior Authorization is required for Institutional Long Term Nursing Home Care.*	$0 copay
Laundry Services Cleaning services provided by a laundry company.	$0 copay

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. Coverage provided when medically necessary such as when the member is unable to meet daily nutritional requirements using traditional foods alone due to injury or illness. Prior Authorization is required for Medical Nutrition Therapy when services do not meet Medicare criteria.	There is no coinsurance, copayment, or deductible.
Medical Supplies Includes coverage for supplies such as incontinence supplies and nutritional supplements. *Prior Authorization is required for Medical Supplies that cost $500 or more.*	$0 copay

Services that are covered for you	What you must pay when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible members under our health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services
Outpatient prescription drugs Members of our plan receive coverage for these drugs through our plan. Covered drugs include: Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan Clotting factors you give yourself by injection if you have hemophilia Immunosuppressive drugs Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug Antigens Certain oral anti-cancer drugs and anti-nausea drugs Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Step Therapy .	$0 copay

Services that are covered for you	What you must pay when you get these services
Outpatient prescription drugs (continued) We also cover some vaccines under our prescription drug benefit. Chapter 5 explains more about the outpatient prescription drug benefit, including rules you must follow to have prescriptions covered.	
Nutritional Assessment Comprehensive assessment conducted by a qualified nutritionist with nutritional plan developed based on assessment.	$0 copay
🍎 **Obesity screening and therapy to promote sustained weight loss** If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	What you must pay when you get these services
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications Dispensing and administration of MAT medications (if applicable) Substance use counseling Individual and group therapy Toxicology testing Intake activities Periodic assessments	$0 copay

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: X-rays Radiation (radium and isotope) therapy including technician materials and supplies Surgical supplies, such as dressings Splints, casts and other devices used to reduce fractures and dislocations Laboratory tests Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. Other outpatient diagnostic tests Prior authorization may be required for certain procedures and tests such as Intensive Modulated Radiation Therapy (IMRT)	$0 copay .

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.	$0 copay

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery Laboratory and diagnostic tests billed by the hospital Behavioral health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it X-rays and other radiology services billed by the hospital Medical supplies such as splints and casts Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. Some services provided in the outpatient hospital setting may require Prior Authorization.	$0 copay

Services that are covered for you	What you must pay when you get these services
Outpatient behavioral health care Covered services include: Behavioral health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other qualified behavioral health care professional as allowed under applicable state laws. Benefits are also available when provided in an outpatient community-based behavioral health setting. You must use a Carelon Behavioral Health (Carelon) provider. Please contact Member Services to coordinate at 855-833-8125, TTY/TDD: 711 Prior authorization is required only for Trans-Magnetic Stimulation.	$0 copay

Services that are covered for you	What you must pay when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Services provided are: • Physical therapy services – evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems. • Occupational therapy services – evaluation and treatment of an enrollee in his or her own environment for impaired physical functions. • Speech and Hearing services – evaluation and treatment of speech, language, voice, hearing, fluency, and swallowing disorders. Prior Authorization is required for outpatient rehabilitation services. Prior Authorization is waived for the initial evaluation for each therapy.	$0 copay

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. *Prior Authorization may be required for certain outpatient surgery services.*	$0 copay
Over-the-Counter (OTC) Items This supplemental benefit is combined with the supplemental benefit for the chronically ill, listed earlier in this chart. We will provide you with one card, worth $115 per month (unused amounts will NOT rollover to the next month within the same calendar year) and this amount may be used for a combination of OTC and/or Food & Produce items. The combined maximum amount you will receive per calendar year will not exceed $1,380 per calendar year.	$115 (combined between OTC and Food & Produce) per month. No monthly rollover.

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community behavioral health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient services is a structured program of active behavioral health therapy treatment provided in a hospital outpatient department, a community behavioral health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. You must use a Carelon Behavioral Health (Carelon) provider. Please contact Member Services to coordinate at 855-833-8125, TTY/TDD: 711. Prior Authorization is only required for Trans-Magnetic Stimulation.	$0 copay
Personal Care Attendant A consumer-directed program that allows members to hire PCAs to help with Activities of Daily Living (ADLs) such as mobility/transfers, medications, bathing or grooming, dressing or undressing, range of motion exercises, eating, toileting and with Instrumental Activities of Daily Living (IADLs) such as shopping, laundry, meal preparation, and housekeeping. Prior Authorization is required for Personal Care Attendant program.	$0 copay

Services that are covered for you	What you must pay when you get these services
Personal Care Services Includes bathing, dressing, grooming, foot care, assistance with dentures, shaving, and assistance with bedpan, eating, ambulating and transfers. Prior Authorization is required for Personal Care Services.	$0 copay
Personal Emergency Response Systems (PERS) A medical communications system allowing members with a medical emergency at home to activate electronic device to transmit a signal to a monitoring station.	$0 copay

Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: • Cardiac Rehabilitation Services • Intensive Cardiac Rehabilitation Services • Pulmonary Rehabilitation Services • SET for PAD services • Urgently Needed Services • Primary Care Physician Services • Chiropractic Services • Occupational Therapy Services • Physician Specialist Services • Individual Sessions for Behavioral Health Specialty Services • Group Sessions for Behavioral Health Specialty Services • Podiatry Services • Other Health Care Professional • Individual Sessions for Psychiatric Services • Group Sessions for Psychiatric Services • Physical Therapy and Speech-Language Pathology Services • Opioid Treatment Program Services • Outpatient Hospital Services • Individual Sessions for Outpatient Substance Use Disorder • Group Sessions for Outpatient Substance Use Disorder	$0 copay

- Kidney Disease Education Services
- Diabetes Self-Management Training
- Other covered Preventive Services
- You have the option of getting these services by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.
- These services can be obtained electronically through real-time audio and video or telephonically.
- Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
- Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location
- Telehealth services for members with a substance use disorder or co-occurring behavioral health disorder, regardless of their location
- Telehealth services for diagnosis, evaluation, and treatment of behavioral health disorders if:
  - You have an in-person visit within 6 months prior to your first telehealth visit
  - You have an in-person visit every 12 months while receiving these telehealth services
  - Exceptions can be made to the above for certain circumstances
- Telehealth services for behavioral health visits provided by Rural Health Clinics and Federally Qualified Health Centers
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  - You're not a new patient **and**
  - The check-in isn't related to an office visit in the past 7 days **and**
  - The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment

Services that are covered for you	What you must pay when you get these services
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) Some services provided by your PCP or other practitioner may require Prior Authorization. For Behavioral Health Services Prior Authorization is only required for Trans-Magnetic Stimulation.	
Podiatry services Covered services include: Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) Routine foot care for members with certain medical conditions affecting the lower limbs Prior Authorization may be required.	$0 copay

Services that are covered for you	What you must pay when you get these services
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: Digital rectal exam Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail. Prior Authorization may be required for certain prosthetic devices.	$0 copay
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Prior Authorization is required for pulmonary rehabilitation services.	$0 copay

Services that are covered for you	What you must pay when you get these services
Respite Care Includes one or more home care services to temporarily relieve the primary caregiver of a member, in emergencies or planned circumstances, of the daily stresses and demands of caring for a member in efforts to strengthen or support the informal support system. May include short-term placement in Adult Foster Care, nursing facilities, rest homes, or hospitals. In addition, you may provide your caregiver with a minimum of 1 day up to a maximum of 3 days off per year and during that time you will be allotted respite care –inpatient or outpatient as needed. *Prior Authorization is required for Respite Care Services.*	$0 copay
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the criteria for such visits. Prior Authorization is required.	There is no coinsurance, copayment, or deductible for covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the covered screening for STIs and counseling for STIs preventive benefit.

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

Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 11 of this document. Skilled nursing facilities are sometimes called SNFs.) Covered services include but are not limited to: Semiprivate room (or a private room if medically necessary) Meals, including special diets Skilled nursing services Physical therapy, occupational therapy, and speech therapy Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) Blood - including storage and administration. Coverage of whole blood and 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/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) A SNF where your spouse or domestic partner is living at the time you leave the hospital	$0 copay

Services that are covered for you	What you must pay when you get these services
Prior Authorization is required for Skilled Nursing Facility care.	
🍎 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. Our plan provides coverage for nicotine replacement medicine including nicotine patches, gum, and certain other medicines if prescribed by your doctor. A prescription is required for nicotine replacement medicine.	There is no coinsurance, copayment, or deductible for covered smoking and tobacco use cessation preventive benefits.
Social Day Care Services Individualized programs of social activity for members requiring daytime supervision at sites other than home. *Prior Authorization is required for Social Day Care Services.*	$0 copay

Services that are covered for you	What you must pay when you get these services
Special Supplemental Benefits for the Chronically Ill We are providing members who are diagnosed with certain chronic conditions (listed in Section 2.1 of this Chapter) who meet certain criteria defined below, an additional supplemental benefit for Food and Produce. This benefit is combined with the supplemental benefit for Over-The-Counter drugs, devices and services. We will provide you with one card, worth $115 per month (unused amounts will not rollover to the next month within the same calendar year) and this amount may be used for a combination of OTC and/or Food & Produce items. The combined maximum amount you will receive per calendar year will not exceed $1,380 per calendar year.	$115 (combined between OTC and Food & Produce) per month. No monthly rollover.

Services that are covered for you	What you must pay when you get these services
Substance Use Disorder Services The plan covers the following: • Individual and Group Therapy outpatient treatment visits. • Inpatient Substance Use Disorder Treatment • Drugs Used to Treat Opioid Dependence • Acupuncture Treatment • Clinical support services • Structured Outpatient addiction program • Other services required by law or regulation **Community Support Program (CSP) Services for Individuals with Justice Involvement (CSP-JI)** Intensive, and individualized support delivered face-to-face or via telehealth a further specified by EOHHS, which includes: • Assisting in enhancing daily living skills**;** • Providing service coordination and linkages; • Developing a safety plan; • Providing prevention and intervention; • Fostering empowerment and recovery, including linkages to peer support and self-help groups. Prior Authorization is not required for Substance Use Disorder Services. You must use a Carelon Behavioral Health (Carelon) provider. Please contact Member Services to coordinate at 855-833-8125, TTY/TDD: 711.	$0 copay

Services that are covered for you	What you must pay when you get these services
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication Be conducted in a hospital outpatient setting or a physician's office Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copay

Services that are covered for you	What you must pay when you get these services
Transportation (non-emergency to medical appointments) Taxi and chair-car or other transport for covered medical care within the member's community, or nearest community if no other resource is available, when member is unable to transport themself due to health reasons. One-Stop: The plan will cover up to 1 stop on the way home from your medical appointment if you need to pick up medication or medical supplies/devices as a result of your appointment. This stop is limited to no more than 1 hour and must be arranged in advance of your appointment. You can request a One-Stop at the time you schedule your transportation. For members who need a ride in less than 48 hours, the drivers didn't show up or canceled, our vendor may coordinate alternative transportation. Member must call WellSense Senior Care Options (SCO) Member Services to coordinate transportation.	$0 copay
Transportation – Social (Non-Emergency, Non-Medical) Transportation to non-medical, social services is covered. You are allowed to take 10 social trips per month, with a limit of 15 miles one-way. If you only need a ride one-way, that counts as a trip. Member must call WellSense Senior Care Options (SCO), phone number to coordinate transportation.	$0 copay

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. There is $0 cost to Senior Care Options (SCO) members. Coverage is provided for a supplemental benefit that covers world-wide emergency and urgent care services outside the United States and its territories. However, transportation to return to the United States and its territories is NOT covered.	$0 copay

Vision care

Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	$0 copay
Covered services include: • In addition, our plan also covers the following services: One (1) routine eye exam per year One pair/set of eyeglasses (prescription lenses, frames, a combination of lenses and frames) or contact lenses up to the allowed amount per calendar year is covered	
Supplemental Benefits: • $325 allowance per year towards the purchase of eyewear (Lenses and Frames or Contact Lenses) and upgrades o The above supplemental vision services are covered and provided by the plan's vision service provider. If you prefer, you may use	

Services that are covered for you	What you must pay when you get these services
a non-contracted provider; however, these non-contracted providers are unable to bill the plan directly and may charge you the cost up front. If you choose this option you will need to submit documentation for reimbursement (see Chapter 6, Section 2.1 for information on reimbursement) from the plan. Please call Member Services (phone numbers are listed on the back cover of this booklet) for assistance on obtaining eyewear or the reimbursement process.	
Preventive visit – once per lifetime The plan covers a one-time preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. When you make your appointment, let your doctor's office know you would like to schedule your **one-time** preventive visit.	There is no coinsurance, copayment, or deductible for the **one-time** preventive visit.

SECTION 3 What services are covered outside of WellSense Senior Care Options (SCO)?

Section 3.1 Services *not* covered by WellSense Senior Care Options (HMO-D-SNP)

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

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

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

Services not covered	**Not covered under any condition**	**Covered only under specific conditions**
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		May be covered by the plan under the home and community-based services benefit

Services not covered	**Not covered under any condition**	**Covered only under specific conditions**
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined to not be generally accepted by the medical community.		May be covered under an approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Full-time nursing care in your home.	**Not covered under any condition**	
Home-delivered meals		Coverage may be provided by the plan under the plna's home-delivered meals benefit, described in this Evidence of Coverage.
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		May be covered by the plan.
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	

Services not covered	Not covered under any condition	Covered only under specific conditions
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Some services will be covered by the plan.
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease are covered with some limitations.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition**	The plan provides coverage of non-prescription contraceptive supplies under the preventive services benefit.
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered. Additional services are covered by the plan under the chiropractic care benefit.
Routine dental care, such as cleanings, fillings or dentures.		This is covered by the plan under the dental services benefit.

Services not covered	**Not covered under any condition**	**Covered only under specific conditions**
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. The plan provides coverage up to $325 in supplemental coverage for eyeglasses and contact lenses. Additional coverage for routine eye exams, glasses, contact lenses are covered by the plan, subject to limits, under vision care services benefit.
Routine foot care		Some limited coverage provided (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.		Covered by the plan under hearing aid and audiology services benefit.
Services considered not reasonable and necessary	**Not covered under any condition**	

CHAPTER 5:

Using the plan's coverage for outpatient prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for prescription drugs**. Please see Chapter 4 for outpatient drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's drug coverage

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

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

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

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

You may go to any of our network pharmacies.

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

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

What if you need a specialized pharmacy?

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

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

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

Section 2.3 Using the plan's mail-order service

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

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

To get information about filling your prescriptions by mail contact Member Services (phone numbers are printed on the back cover of this booklet).

Usually a mail-order pharmacy order will be delivered to you in no more than 7 days. If your mail order prescription is delayed, we will allow a fill at a network retail pharmacy close to you so you don't go without medication. Please call Member Services (phone numbers are printed on the back cover of this booklet if you are having issues getting your medications.)

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

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

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

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

2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

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

The "Drug List" includes the drugs covered under MassHealth (Medicaid). Our list of the MassHealth (Medicaid) covered drugs is available on our website,

wellsense.org/sco, or you can call Member Services for more information (phone numbers are listed on the back of this booklet).

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

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

Certain drugs may be covered for some medical conditions, but are considered non-formulary for other medical conditions. These drugs will be identified on our "Drug List".

The "Drug List" includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List", when we refer to "drugs," this could mean a drug or a biological product

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

Over-the-Counter Drugs

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

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

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List." In some cases, you may be able to obtain a drug that is not on the "Drug list." For more information, please see Chapter 8.

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

You have 2 ways to find out:

1. Visit the plan's website (wellsense.org/sco). The "Drug List" on the website is always the most current.
2. Call Member Services to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List." If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 What kinds of restrictions?

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

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

Restricting brand name drugs when a generic version is available

Generally, a **generic** drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you *OR* 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. (Your share of the cost may be greater for the brand name drug than for the generic 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**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

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

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

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

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

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

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

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

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

You may be able to get a temporary supply

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

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

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

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

  We will cover a *30-day supply* (outpatient) or one *3-day supply* (long term care) of a particular drug, or less if your prescription is written for fewer days.

For questions about a temporary supply, call Member Services.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call 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.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's "Drug

List." Or you can ask the plan to make an exception and cover the drug without restrictions.

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

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

Section 6.1 The "Drug List" can change during the year

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

- **Add or remove drugs from the "Drug List**."
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**

We must follow MassHealth (Medicaid's) requirements before we change the plan's "Drug List."

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

Information on changes to drug coverage

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

A. Advance General Notice that plan sponsor may immediately substitute new generic drugs:

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List," but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
    - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you.
- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List." If you are taking that drug, we will tell you right away.
    - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the "Drug List"**
    - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines.
    - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a *one-month supply (30-day*) refill of the drug you are taking at a network pharmacy.

- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.

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

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

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

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), 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 restrictions to your use of the drug.

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

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

Section 7.1 Types of drugs we do not cover

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

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

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

- Our plan cannot cover a drug purchased outside the United States or 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.
- Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below may not be covered by our plan:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs 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 8 Filling a prescription

Section 8.1 Provide your membership information

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

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

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you**. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Prescription drug coverage in special situations

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

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

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

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

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

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

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

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

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

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

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

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

Keep this notice about creditable coverage, because you may need it later. If you enroll in a plan that includes prescription drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

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

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the

limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 8 for information about how to ask for an appeal.

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

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

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

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

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

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

CHAPTER 6:

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

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

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

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. Send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. There is $0 cost to Senior Care Options (SCO) members. If this provider is contracted, you still have the right to treatment.

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

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

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

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

- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid for the service, we will pay you back.

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

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

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

3. If you are retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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 "Drug List" or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

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

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 1 year** of the date you received the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (wellsense.org/sco) or call Member Services and ask for the form.

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

For medical services:

WellSense Senior Care Options (SCO)
Attn: Member Services
529 Main Street, Suite 500
Charlestown, MA 02129
FAX: 617-897-0884

For prescriptions:

Express Scripts
P.O. Box 14718
Lexington, KY 40512-4718
Fax: 608-741-5483

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

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

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

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

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are

asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 8 of this document.

CHAPTER 7:

Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from members who do not speak English. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Appeals and Grievance Department.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

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

If you think that you are not getting your medical care or prescription drugs within a reasonable amount of time, Chapter 8 tells what you can do.

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

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

- Your personal health information includes the **personal information** you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy 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.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

- We are required to release health information to government agencies that are checking on quality of care.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of WellSense Senior Care Options (SCO), you have the right to get several kinds of information from us.

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 5 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is

restricted. Chapter 8 also provides information on asking us to change a decision, also called an appeal.

- **Information about non-covered counseling or referral service**. You have the right to be told whether we have moral or religious reasons that would keep us from covering a counseling or referral service. You may also get information about how you can get these services.

Section 1.5 We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say no.** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To be free from restraint or seclusion**. You have the right to be free from all restraint (being placed under control) or seclusion (being isolated) used to force you, punish you, or get back at you or for anyone else's convenience.

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

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

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

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

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

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

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

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

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no

one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Massachusetts Department of Public Health, Division of Health Care Quality's Complaint Unit by calling 800-462-5540. To file a complaint against an individual doctor, please call the Board of Registration in Medicine at 78876-8200.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 8 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

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

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
    - Chapters 5 and 6 give the details about your prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you *cannot* remain a member of our plan.**

CHAPTER 8:

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

SECTION 1 Introduction

We want you to contact us if you have any concerns with your care or services. Our Member Services Department will help you with your concerns. You also have the right to voice concerns to MassHealth at any time. Call the MassHealth Customer Services Center.

Section 1.1 Inquiries

An Inquiry is any question that you may have about our or Carelon Behavioral Health's operations. We will resolve your Inquiries right away or, at the latest, within one business day of the day we receive your Inquiry. We will let you know about the outcome on the day your Inquiry is resolved. To make an Inquiry, call our Member Services Department, or Carelon Behavioral Health (for Behavioral Health questions).

An Inquiry is not for addressing your dissatisfaction with Carelon Behavioral Health or us. If you are dissatisfied, you have the right to file a Complaint (Grievance). See Section 11.15.

For other types of problems, you need to use our Internal Appeals process. See Sections 1.3–1.12 for the Appeals process.

Each process has a set of rules and deadlines that must be followed by you and by us. These are explained in this Chapter.

Section 1.2 What is an Authorized Representative?

An Authorized Representative is someone you have given permission, in writing, to act on your behalf with respect to an Internal Appeal, an External Appeal, or a Complaint (Grievance). **An Authorized Representative can act on your behalf for all the actions we describe in this Chapter.**

If your Authorized Representative is your family member:

- You can have him or her represent you in your Appeal or Complaint (Grievance).
- The family member can have a standing permission from you.
- This permission will end if you send us a letter telling us that you have cancelled it.

If the Member is deceased, an Authorized Representative can also include the legal representative of his or her estate.

If you pick an Authorized Representative who is not a family member:

- You must send us new written permission each time you want them to represent you.
- We must receive this written permission before our deadline for resolving your Internal Appeal or Complaint ends. We can help you write the letter. Or we can mail you a permission form for you to complete. For a copy of the form, call our Member Services Department, or Carelon Behavioral Health (for Behavioral Health).

Section 1.3 What is an Appeal?

An Appeal is something you may file if you disagree with an Adverse Action taken by us. Common Adverse Actions that can be the basis for an Appeal include:

- We denied or provided limited Authorization for a service requested by your Provider. This includes a decision that the requested service is not a Covered Service.
- We reduced, suspended, or stopped a Covered Service that we Authorized in the past.
- We denied, in whole or in part, payment for a Covered Service.
- We did not provide Covered Services in a timely manner within the times stated in this document.
- We did not make a Prior Authorization decision within the timeframe described in Chapter 4 Section 2.3.
- We did not act within the Internal Appeal times stated in this Chapter 8 for reviewing and sending notice of a decision.

There are two levels of Appeal available:

- The First level: is a request you make **to us** to review an Adverse Action (denial) we have taken. It is called an "Internal Appeal."
- The Second level: is a request you make **to the Board of Hearings (BOH)** to review our Internal Appeal decision. It is called an "External Appeal" or a "Board of Hearings (BOH) Appeal."

Section 1.4 What is an Internal Appeal?

An Internal Appeal is one that you file with us or with Carelon Behavioral Health (for Behavioral Health concerns), if you disagree with an Adverse Action. There are two types of Internal Appeals:

- Standard Internal Appeal

- Expedited (fast) Internal Appeal

In most cases, you will receive a notice letting you know an Adverse Action has been taken. (However, you may file an Internal Appeal when an Adverse Action occurs, even if you did not receive a notice from us or Carelon Behavioral Health.) Our Adverse Action letter will tell you your Appeal rights. Health care professionals who have the right clinical expertise and were not involved in the original Adverse Action make Internal Appeal decisions.

You can file an Internal Appeal in writing, over the phone, or in person. Here's how to file an Internal Appeal:

Appeal Type	Contact Information
For Medical or Pharmacy Appeals	Mail or fax your written Appeal to: WellSense Health Plan 529 Main Street, Suite 500 Charlestown, MA 02129 Attention: Member Appeals. Fax: 617-897-0805
For Behavioral Health Appeals	Mail or fax your written Appeal to: Appeals Coordinator Carelon Behavioral Health 500 Unicorn Park Drive Suite 401, Woburn, MA 01801 Fax: 781-994-7636
To call and request a verbal appeal	**For Medical and Pharmacy Appeals:** call our Member Services Department at 888-566-0010; or the Appeals Department at 617-748-6338, Monday–Friday 8 am. to 6 p.m. **For Behavioral Health Appeals**: call Carelon Behavioral Health's Member Services Department at 888-217-3501, Monday–Thursday 8:30 a.m. to 6 p.m. and Friday 8:30 a.m. to 5 p.m.
To file an In-Person Appeal	Visit us or Carelon Behavioral Health at the office location listed in Chapter 8.

Sections 1.5 and 1.6 explain how you can file your Internal Appeal.

Section 1.5 How and when to file a Standard Internal Appeal

You must file your Standard Internal Appeal with us or Carelon Behavioral Health (for Behavioral Health services) within 60 calendar days of the date of our written notice of Adverse Action (denial) to you. If you ask for an Appeal over the phone or in person, it must be followed by a written and signed Appeal request (unless the request is for an Expedited (fast) Internal Appeal – see Section 1.6). You may name someone to file the

Appeal for you. This includes naming your Provider or an Authorized Representative. To name someone, you must send us a letter stating whom you wish to name.

- The date you call us to request a verbal appeal of an Adverse Action will be the date of the Appeal request. When we receive your Internal Appeal, a specialist will send you a letter stating that we have received your Appeal. Our staff will begin work on resolving your Appeal right away.
- You may lose your right to Appeal if you do not file your Internal Appeal within the 60-calendar-day timeframe.
- You may request that services or benefits you currently receive continue while you are waiting for the results of your Appeal. This is called "Continuing Services." To ask for this while you are waiting, you must specifically request Continuing Services and file your Internal Appeal with us within 10 calendar days from the date you receive our notice of Adverse Action. Your Provider cannot request Continuing Services for you.

How quickly will you receive a decision on your Standard Internal Appeal?

We will resolve your Standard Internal Appeal within 30 calendar days from the day we receive it. This is the case unless the timeframe is extended. You, we, or Carelon Behavioral Health can extend the timeframe by up to 14 calendar days. We explain more about this in Section 1.7. We will notify you in writing of our decision.

Section 1.6 How and when to file an Expedited (fast) Internal Appeal

An Expedited Internal Appeal is when you ask that your Appeal be resolved more quickly than the time for resolving a Standard Internal Appeal. You can do this if you or your Provider feel that waiting for a standard resolution would put your health at serious risk. You or your Provider may request an Expedited (fast) Internal Appeal. To file for this, follow the instructions for filing a Standard Internal Appeal in Section 1.5 above. When you contact us, tell us that you would like an Expedited Internal Appeal.

We will never penalize a Provider who requests or supports a Member's Expedited Internal Appeal.

In most cases, we will agree to give you an Expedited Internal Appeal if your Provider requests it or supports it. However, we may not agree if the request is unrelated to your health condition. If your Provider is not involved in your request, then we have the right to decide if the Appeal will be processes as an Expedited Internal Appeal.

How quickly will you receive a decision on your Expedited (fast) Internal Appeal?

If we accept your request for an Expedited Internal Appeal, we will decide it as quickly as your health condition requires. But our decision will be no later than 72 hours after the date we receive your request—unless the timeframes are extended as stated in Section 1.7. We will notify you in writing of our decision. We will also try to contact you by phone to tell you about the decision. If you disagree with our decision, you can file an External Appeal with the Board of Hearings. See Section 1.13.

If your request does not qualify for an Expedited Internal Appeal, we will notify you in writing. We will then process your Internal Appeal as a Standard Internal Appeal within the standard 30-calendar-day timeframe stated in Section 1.5. You have the right to file a Complaint (Grievance) if you disagree with our decision not to process your Internal Appeal as an Expedited Internal Appeal. See Section 1.15 about how to file a Complaint.

Section 1.7 Can Internal Appeal timeframes be extended?

You may ask to extend the timeframes for resolving Standard or Expedited Internal Appeals by up to 14 calendar days. We also may ask to extend the timeframes for resolving your Internal Appeal by 14 calendar days if we feel that it would benefit your Appeal. The reasons we may ask to extend the timeframes include:

- The additional time is in your best interest.
- We need more information that we believe will lead to approving your request.
- We think the more information we are looking for will be sent to us within 14 calendar days.

When we choose to extend a timeframe, we will send you a notice. If you disagree with the decision, you may file a Complaint. See Section 1.15 about filing a Complaint.

Section 1.8 When can we dismiss your Internal Appeal?

We may dismiss (decide not to consider) your Internal Appeal if:

- Someone else files an Internal Appeal for you and we do not receive your written permission for that person to serve as your Authorized Representative before the timeframe for resolving your Internal Appeal ends. Written permission is not required when your Provider serves as your Authorized Representative for an Expedited Internal Appeal; or
- You filed your Internal Appeal after the deadline in Sections 1.5 and 1.6 (60

calendar days after the notice of Adverse Action); or, if you did not receive our notice of Adverse Action (because, for example, you moved), you filed your Internal Appeal more than 60 days after learning on your own about our Adverse Action.

We will notify you of an Internal Appeal dismissal.

Section 1.9 Can you dispute when we dismiss an Internal Appeal?

If you believe that you asked for your Internal Appeal within 60 calendar days and you have proof of your request, you have the right to:

- Dispute our dismissal of your Appeal; and
- Request us to continue with your Appeal.

To do this, you must submit a letter to us or to Carelon Behavioral Health (for Behavioral Health concerns) within 10 calendar days of notice to dismissal. In the letter, you can ask us to reconsider the dismissal. We will review your request. We will then notify you of our decision.

Section 1.10 Continuing Services during your Internal Appeal Process

If your Internal Appeal involves a decision by us to change a service that we authorized in the past, including a decision to reduce, suspend, or end a service, you can ask us to continue to cover the requested services during the Internal Appeal process. These services are called "Continuing Services." If you want to receive Continuing Services, you must:

- Submit your (Standard or Expedited) Internal Appeal request within 10 calendar days from the date of our Adverse Action letter. This is the letter we sent you explaining that we decided to change a service that we Authorized in the past; and
- State in your request that you want to get Continuing Services.

Section 1.11 Your rights during the Internal Appeal Process

We will provide you a reasonable chance to present evidence in person and in writing. This includes facts and law about your case. We will also allow you to see your files

before and during the Internal Appeal process. We can also help you with interpreter or translation services during the Internal Appeal process. There is no cost to you.

What do you do if you disagree with our or Carelon Behavioral Health's decision on your Internal Appeal?

If you disagree with the decision, you may file an External Appeal with the Board of Hearings (BOH). See Section 1.13.

Section 1.12 What if we do not resolve your Internal Appeal within the required timeframes?

If we do not decide your Internal Appeal within the required timeframes, you can file an External Appeal with the BOH. See Section 1.13.

Section 1.13 How to file an External Appeal with the Board of Hearings (BOH)

You cannot request an External Appeal with the Board of Hearings without first going through our Internal Appeal process as described above. If you are unhappy with the results of your Internal Appeal, you have the right to request an External Appeal with the BOH. The BOH is within the state's Office of Medicaid. If you want the BOH to give you an expedited (fast) hearing, you should file a request for an External Appeal with the BOH within 20 calendar days of an Expedited Internal Appeal decision from us. Otherwise, you have 120 calendar days from our Internal Appeal decision to file for a standard hearing with the BOH. Please note that if you file between 21 and 120 calendar days from the date of our Internal Appeal decision, the BOH will process your External Appeal within their standard timeframe.

The letter we send you telling you our Internal Appeal decision, will include the form (and other information) you will need to file your request for an External Appeal with the BOH—if you choose to file one.

After your BOH Appeal is filed, you will receive a free copy of your case file before the hearing. You may bring witnesses, present testimony and evidence, and question other witnesses at this hearing. Staff from the BOH will schedule hearings.

The following rules also apply:

- If the BOH reverses our decision to deny, reduce, limit, suspend, or end services that were not provided during the time of the Internal Appeal or External Appeal, we will approve the services as quickly as your health

condition requires. In any event, we will approve the services no later than 72 hours from the date we receive BOH notice that it reversed our decision.
- If you receive "Continuing Services" while the BOH Appeal was happening, we will pay for those services.

Section 1.14 How to request Continuing Services during the External Appeal to the Board of Hearings (BOH)

If your BOH Appeal involves a decision by us or by Carelon Behavioral Health to change a service that we authorized in the past, including a decision to reduce, suspend, or end a service, you can choose to continue getting the requested services during the BOH Appeal process. These services are called Continuing Services. If you want to get Continuing Services during the BOH Appeal process, you must file your BOH Appeal within 10 calendar days from the date of our letter to you that explained our decision on your Appeal. If you do not want to keep getting the requested services during your BOH Appeal, you must check Box A in Section III of the BOH Appeal form.

Whenever you Appeal our decision to deny, reduce, limit, suspend or end health care services, you have a right to Continuing Services while your BOH Appeal is happening.

If we continue your services during the BOH Appeal process, the services must be continued until one of the following occurs:

- You withdraw your BOH Appeal request, in writing;
- The BOH makes a decision that is not favorable to you; or
- The original approval of services expires (ends) or service limits are met.

Section 1.15 How to file a Complaint (Grievance) and what to expect from us

What is a Complaint (Grievance)?

We use the words "Complaint" and "Grievance" to mean the same thing. You can report a Complaint to us at any time if you are not happy with us or a Provider, for any reason. (Note: the Adverse Actions described in Section 1.2 are Appeals, not Complaints.) Here are some common types of Complaints:

- You are not satisfied with the quality of care or services you receive.
- You are not satisfied with the way you were treated by our staff or Network Providers.
- We extended the time to decide a Prior Authorization request or Internal Appeal and you disagree with this decision.

- We did not approve your request for an Expedited (fast) Internal Appeal, we processed it as a Standard Internal Appeal, and you do not agree with this decision.
- You believe our staff or Network Providers did not respect your rights.

How to file a Complaint (Grievance)

You may file a Complaint in writing, over the telephone, or in person. Here's how to do this:

To File a Complaint	Contact Information
In writing or by fax	**For all medical Complaints** WellSense Health Plan– MassHealth 529 Main Street, Suite 500 Charlestown, MA 02129 Attention: Member Grievances Fax: 617-897-0805 **For all Behavioral Health Complaints** Carelon Behavioral Health Appeals Department P.O. Box 1856 Hicksville, NY 11802 Fax: 781-994-7636
By phone	**For all medical Complaints** If you want to submit a Complaint (Grievance) over the telephone, you may call our Member Services Department at 888-566-0010. **For all Behavioral Health Complaints** Call Carelon Behavioral Health at 888-217-3501
In Person	**If you want to submit a medical Complaint in person, we are located at:** WellSense Health Plan 529 Main Street, Suite 500

	Charlestown, MA 02129 **If you want to submit a Behavioral Health Complaint in person, Carelon is located at:** Carelon Behavioral Health Attn: Appeals and Grievance Department 500 Unicorn Park Drive, Suite 401 Woburn, MA 01801
Directly with MassHealth	Call MassHealth Customer Services Department at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m.

When can we dismiss your Complaint (Grievance)?

We may dismiss your Complaint if someone else files it for you and we did not receive permission for that person to be your Authorized Representative before our 30-calendar day timeframe for resolving your Complaint ends. If this happens, we will send you a letter saying that we will not consider your Complaint.

How quickly will we respond to your Complaint (Grievance)?

Once we or Carelon Behavioral Health receive your Complaint, we or Carelon Behavioral Health will send you a letter within one business day saying we received it. We or Carelon Behavioral Health will start to work right away to address your Complaint. We or Carelon Behavioral Health will send you a written response within 30 calendar days from the date we received your Complaint.

What do you do if you do not speak English?

We or Carelon Behavioral Health will help you with free interpreter or translation services during the Complaint process. If you have any questions about the Complaint process, please call our Member Services Department or Carelon Behavioral Health.

CHAPTER 9:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in WellSense Senior Care Options (SCO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

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

Section 2.1 You can end your membership at any time.

You can end your membership in WellSense Health Plan's Senior Care Options (SCO) at any time.

What type of plan can you switch to? If you decide to change to a new plan, you can choose any of the following types of Medicaid Plans:

- Another MassHealth (Medicaid) health plan, with or without prescription drug coverage
- Original, or fee-for-service MassHealth (Medicaid)
  - Contact your Massachusetts Medicaid Office, or MassOptions, to learn about your MassHealth (Medicaid) plan options. Telephone numbers are in Chapter 2, Important phone numbers and resources, Section 1 of this booklet.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.
- **Where can you get more information about when you can end your membership?** If you have any questions or would like more information on when

you can end your membership, you can call member Services to request a disenrollment form. Phone numbers are printed in the back of this booklet.

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

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

You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).

--or--You can contact MassHealth Senior Care Options (SCO) for more information about enrollment: 888-885-0484, TTY/TDD: 888-821-5225.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership WellSense Senior Care Options (SCO) ends, and your new MassHealth (Medicaid) coverage begins, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 WellSense Senior Care Options (SCO) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

WellSense Senior Care Options (SCO) must end your membership in the plan if any of the following happen:

- If you are no longer eligible for MassHealth (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for MassHealth Standard (Medicaid.) If you lose your MassHealth Standard (Medicaid) with SCO-eligible aid category coverage, WellSense Senior Care Options (SCO) will grant you one additional month of coverage with our plan beyond your loss of MassHealth Standard (Medicaid) coverage. If you do not regain your MassHealth Standard (Medicaid) coverage within that time period, you membership with WellSense Senior Care Options (SCO) will end
- If you move out of our service area
- If you are away from our service area for more than six months
    - If you move or take a long trip, 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 are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from MassHealth (Medicaid) first.)

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Member Services.

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

WellSense Senior Care Options (SCO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call MassHealth: 888-885-0484, TTY/TDD: 888-821-5225.

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

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

CHAPTER 10:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html .

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, WellSense Senior Care Options (SCO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises

under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 11:

Definitions of important words

Adult Community Crisis Stabilization (ACCS) – ACCS is a community-based program that serves as a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides 24-hour, short-term, staff-secure, safe, and structured crisis stabilization and treatment services for individuals 18 years of age and older with mental health and/or substance use disorders. Stabilization and treatment include the capacity to provide induction onto the bridging for medications for the treatment of opioid use disorder (MOUD and withdrawal management for opioid use disorders (OUD) as clinically indicated. The ACCS program is an integrated part of the CBHC model.

Adult Mobile Crisis Intervention (AMCI) (formerly known as Emergency Services Program (ESP)) – AMCI provides adult community-based Behavioral Health crisis assessment, intervention, stabilization and follow-up for up to three days. AMCI services are available 24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences), and provided via Telehealth to individuals age 21 and older when requested by the member or directed by the 24/7 BH Help Line and clinically appropriate. AMCIs operates ACCS programs with a preference for location services. AMCI services must have capacity to accept adults voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

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. **Behavioral Health Supports for Justice Involved Individuals (BH-JI)** – BH-JI supports that help Members with justice involvement, including those members who are currently incarcerated or detained in a correctional facility, released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probationer the Massachusetts Parole Board, in accessing health care services, and primarily behavioral health services.

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have

not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. Please Note: As a member of this SCO plan, you do not have any cost-sharing. Because you also have MassHealth Standard (Medicaid), you do not have to pay for covered services.

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.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles. Please Note: As a member of this SCO plan, you do not have any cost-sharing. Because you also have MassHealth Standard (Medicaid), you do not have to pay for covered services.

Community Behavioral Health Center (CBHC) – A comprehensive community behavioral health center offering crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evening and weekends. CBHCs include an Adult Mobile Crisis Intervention (AMCI), Youth Mobile Crisis Intervention (YMCI), Adult Community Crisis Stabilization (Adult CCS) and Youth Community Crisis Stabilization (YCCS).

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage. There is $0 cost for Senior Care Options (SCO) members.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. There is $0 cost for Senior Care Options (SCO) members.

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

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

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out

of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. There is $0 cost for Senior Care Options (SCO) members.

Deductible – The amount you must pay for health care or prescriptions before our plan pays. Please Note: As a member of this SCO plan, you do not have any cost-sharing. Because you also have MassHealth Standard (Medicaid), you do not have to pay for covered services.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription. There is $0 cost for Senior Care Options (SCO) members.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Dual Eligible Individual – An adult aged 65 or older, who is eligible for and enrolled in Medicare Parts A and B and eligible for and enrolled in MassHealth Standard coverage. This includes Qualified Medicare Beneficiaries with full Medicaid (QMB Plus) and Low-Income Medicare Beneficiaries with full Medicaid (SLMB Plus) aged 65 or older and with MassHealth Standard coverage.

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

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

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

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

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

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or

less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

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

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) –A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Justice Involvement – Enrollees with Justice Involvement shall be those individuals released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or Massachusetts Parole Board.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. **Please Note:** Because our members also get assistance from MassHealth (Medicaid), members do not have an out of pocket cost.

MassHealth (Medicaid) (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your

Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help

people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and MassHealth (Medicaid) benefits through the plan.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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

Primary Care Physician (PCP) –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization –Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

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

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

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

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

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

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

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or

when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

WellSense Senior Care Options (SCO) Member Services

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

Massachusetts State Health Insurance Assistance Program SHINE (Serving the Health Insurance Needs of Everyone) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	800-AGE-INFO (800-243-4636), press option 3 or option 5 if you are calling from a cell phone, and leave a message and a representative will respond to you.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	massoptions.org/massoptions
WEBSITE	massoptions.org/massoptions/