2026

Tufts Health Together
with CHA

Member Handbook

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TUFTS Health Plan

a Point32Health company

CHA Cambridge Health Alliance

DISCRIMINATION IS AGAINST THE LAW

TUFTS Health Plan
a Point32Health company

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact Tufts Health Plan at **888.257.1985**.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan
Attention: Civil Rights Coordinator, Legal Dept.
1 Wellness Way
Canton, MA 02021-1166
Phone: 888.880.8699 ext. 48000, [TTY number— 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@point32health.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

tuftshealthplan.com | **888.257.1985**

We can give you information in other formats, such as braille and large print, and also in different languages upon request.

For no-cost translation in English, call **888.257.1985**.

Arabic .888.257.1985 للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم

Chinese 若需免費的中文版本，請撥打 **888.257.1985**。

French Pour demander une traduction gratuite en français, composez le **888.257.1985**.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die folgende Telefonnummer an: **888.257.1985**.

Greek Για δωρεάν μετάφραση στα ελληνικά, καλέστε στο **888.257.1985**.

Haitian Creole Pou tradiksyon gratis nan Kreyòl Ayisyen, rele **888.257.1985**.

Igbo Maka ntụgharị asụsụ n'Igbo na akwụghị ụgwọ, kpọọ **888.257.1985**.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero **888.257.1985**.

Japanese 日本語の無料翻訳については **888.257.1985** に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃ ជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខ 888.257.1985។

Korean 한국어로 무료 통역을 원하시면, **888.257.1985** 로 전화하십시오.

Kru Inyu yangua ndonõl ni Kru sébèl **888.257.1985**.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີ **888.257.1985**.

Navajo Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **888.257.1985**.

Persian برای ترجمه رایگان به فارسی به شماره تلفن888.257.1985 زنگ بزنید.

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer **888.257.1985**.

Portuguese Para tradução grátis para português, ligue para o número **888.257.1985**.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру **888.257.1985**.

Spanish Para servicio de traducción gratuito en español, llame al **888.257.1985**.

Tagalog Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **888.257.1985**.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số **888.257.1985**.

Yorùbá Fún isẹ́ ògbùfọ̀ l'ọ́fẹ̀ ní Yorùbá, pe **888.257.1985**.

Welcome!

With Tufts Health Plan, you get more from your health plan. You have access to thousands of great providers we contract with to bring you high-quality health care, friendly and helpful Member Services Team representatives, and information in your own language. As a Member of our health plan, you get all the benefits of the MassHealth Program, plus additional EXTRAS.

We want you to get the most out of your membership. This handbook is provided to help you understand what you need to know about your health plan. We have capitalized important words and terms throughout this *Member Handbook*. You can find definitions for each of these terms in the Glossary starting on page 59.

Tufts Health Public Plans, Inc., is licensed as a health maintenance organization in Massachusetts but does business under the name Tufts Health Plan.

Contact us

Phone: 888-257-1985 (TTY: 711, for people with partial or total hearing loss), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. The call is free.

Mail: Tufts Health Plan
P.O. Box 524
Canton, MA 02021-1166

Web: tuftshealthplan.com

Member Services Team hours

A Member Services Team representative helps you with any questions you may have. Call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. After hours you can leave a voicemail and we will respond to you on the next business day.

Visit us on the web

Go to tuftshealthplan.com to:

- Find a Primary Care Provider (PCP), Specialist or health center near you
- Find a Behavioral Health Provider near you
- Find forms to request one or several EXTRAS
- Check out our multimedia health and wellness library
- Sign up for your Member portal at tuftshealthplan.com/memberlogin to:
  - Connect with your health plan anywhere 24/7
  - Check your benefits
  - Choose or change your PCP
  - Confirm referrals and approvals (Authorizations)
  - View or print your Member ID card
  - Update your contact information
  - Create a personal private health record to store information about yourself
  - Send us a message when it's convenient for you
- Get important information, such as:
  - How you can file a Grievance or an Appeal
  - How you have the right to request an External Review (Fair Hearing) if we deny an Appeal, as well as your other rights and responsibilities
  - How we help you get the best care possible
  - How we help you get the right care in the right place (Utilization Management) (Note: We never reward our staff for denying care.)
  - How we use information your Providers give us to connect you with the services you need to help make you better or keep you as healthy as possible (Utilization Review)
  - How we may collect, use and release information about you and your health (your Protected Health Information) according to our privacy policy
- Learn much more!

24/7 NurseLine

Our NurseLine is available 24 hours a day, seven days a week, to provide you with general health information and support, including any medical or Behavioral Health (mental health and/or substance use disorder) questions that you may have. You can call the NurseLine at 888-MY-RN-LINE (888-697-6546) (TTY: 711).

Other household members may be eligible for MassHealth

If other people in your home may be eligible for MassHealth, you can call MassHealth Customer Service at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

If you move

If you move or change your phone number, don't forget to update your contact information! You must call MassHealth and Tufts Health Plan to update your address and phone number. This is to help ensure that you get any important information about your health care. You should also put the last names of all health plan Members in your household on your mailbox. The post office might not deliver mail from MassHealth or Tufts Health Plan to someone whose name is not listed on the mailbox. To update your contact information, please call:

- MassHealth Customer Service at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., and
- Your health plan's Member Services Team at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Also, let MassHealth know about any changes in your income, family size, employment or disability status, or if you have additional health insurance.

You can learn about all of MassHealth's health plan options, including Tufts Health Plan, by calling MassHealth Customer Service at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

Translation and other formats

If you have questions, need this document translated, need someone to read this or other printed information to you, want to learn more about any of our EXTRAS and benefits, or need access to Covered Services, call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

We can give you this information in other formats, such as Braille and large type size, and different languages. We have bilingual staff available, and we offer translation services in up to 200 languages. All auxiliary aids and translation services are available upon request and free of charge to Members

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Your ID Cards

Your health plan Member ID Card

All Members get a health plan Member ID Card. Your health plan Member ID Card has important information about you and your benefits and tells Providers and pharmacists that you are a Member.

Please make sure all information is correct on this card. If you have questions or concerns about your health plan Member ID Card, if you lose your Member ID Card, or if you don't get your Member ID Card, call our Member Services Team at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. You can also print an image of your Member ID Card or order an ID Card using the Member portal. Login at tuftshealthplan.com.

Your MassHealth ID Card

As a MassHealth Member, you also receive a MassHealth ID Card. For information about your MassHealth ID Card, call the MassHealth Customer Service Center at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m. Your MassHealth ID Card looks like this:



Important: Remember to always carry your health plan Member ID Card and MassHealth ID Card with you so you have them when you need care. Show both when you get health care or fill a prescription.

Getting the health care you need

Where to get care

Your health plan has a Network of Providers to make sure you get access to Covered Services.

Our plans serve Members in various counties and Service Areas throughout Massachusetts. For a specific list of counties and Service Areas for your plan, call MassHealth Customer Service at 800-841-2900 (TTY: 711).

When choosing a Primary Care Provider (PCP), you can choose any In-network PCP who is in your plan and located in the Region where you live. For more information about our Network, call our Member Services Team at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. For a complete listing of our Providers, visit tuftshealthplan.com.

Access to Covered Services

Access to Covered Services is how fast you should be able to get the care you need based on your situation. Symptomatic care is care you get when you are sick or hurt. Non-symptomatic Care, also called Preventive Care, is care you get when you are well to help you stay healthy.

Your Providers must give you the care you ask for within the following time frames:

Medical services

- Emergency care: immediately
- Urgent Care: within 48 hours of your asking for an appointment

- Primary Care:
    - Non-urgent Symptomatic Care: within 10 days of your asking for an appointment
    - Routine, Non-symptomatic Care: within 45 days of your asking for an appointment
- Specialty care:
    - Non-urgent Symptomatic Care: within 30 days of your asking for an appointment
    - Routine, Non-symptomatic Care: within 60 days of your asking for an appointment

Behavioral Health (mental health and/or substance use disorder) services

- Emergency care: immediately
- Urgent Care: within 48 hours of your asking for an appointment
- Other services: within 14 days of your asking for an appointment
- For services described as an Inpatient Service or 24-hour diversionary services discharge plan, you must get care within these time frames:
- For non-24-hour diversionary services: within two days of discharge
- For medication management: within 14 days of discharge
- For other outpatient services: within seven days of discharge
- For Intensive Care Coordination (ICC) services: within 24 hours of Referral, including self-referral. This includes offering a face-to-face interview with the family.

In an Emergency

An Emergency is when you believe your life or health is in danger or would be if you don't get immediate care. If you believe that you are having a medical Emergency, take immediate action:

- Call 911 or
- Go to the nearest emergency room right away.

For Behavioral Health Emergencies:

- Call 911,
- Go to the nearest emergency room right away, or
- Call your local Community Behavioral Health Center (CBHC). CBHCs provide 24/7 community-based crisis intervention as an alternative to emergency departments. To find the CBHC closest to you, call or text the Behavioral Health Help Line 24/7 at 833-773-BHHL, as well as online at masshelpline.com.

You can also find a complete listing of emergency rooms and CBHCs in Massachusetts online at tuftshealthplan.com, and in the *Provider Directory*. Call us at 888-257-1985 to get a printed copy of our *Provider Directory*.

Also, make sure to:

- Bring your health plan and MassHealth ID cards with you
- Tell your PCP and, if applicable, your Behavioral Health Provider what happened within 48 hours of an Emergency in order to get follow-up care, if necessary

You don't need approval from your Provider to get Emergency care. You have a right to use any Hospital or other setting for Emergency Services. You can get Emergency care 24 hours a day, seven days a week, when you're traveling within the U.S. and its territories. We also cover Emergency-related ambulance transportation and Post-stabilization Care Services, which help you get better after an Emergency.

A Provider will examine and treat your Emergency health needs before sending you home or moving you to another Hospital, if necessary.

Examples of Medical Emergencies:

- Chest pain
- Bleeding that won't stop
- Broken bones
- Seizures or convulsions
- Dizziness or fainting
- Poisoning or drug overdoses
- Serious accidents
- Sudden confusion
- Severe burns
- Severe headaches
- Shortness of breath
- Vomiting that won't stop

Examples of Behavioral Health Emergencies:

- Feelings of wanting to harm yourself or others
- Hallucinations

Urgent Care situations

An Urgent Care situation is when you experience a health problem that needs attention right away, but you don't believe you are having an Emergency. You may experience a health problem that is serious but does not put your life in danger or risk permanent damage to your health. Your PCP or your Behavioral Health Provider can usually address these medical or Behavioral Health problems.

In urgent situations, call your PCP or Behavioral Health Provider. You can contact any of your Providers' offices 24 hours a day, seven days a week.

If appropriate, make an appointment to visit your Provider. Your Provider must see you within 48 hours for Urgent Care appointments. If your condition gets worse before your PCP or Behavioral Health Provider sees you, call 911 or go to the nearest emergency room. If you have a Behavioral Health concern, you may also call your local CBHC.

When you are in your Service Area, you may be able to go to an In-network urgent care center (UCC). When going to a UCC, you should also try to contact your PCP. To find UCCs in our Provider Network, go to tuftshealthplan.com and use our Find a Provider tool.

Hospital services

If you need hospital services for a condition that is not an Emergency, please ask your Provider to help you get these services. If you need hospital services for an Emergency, don't wait. Call 911 or go to the nearest emergency room right away.

When you're away from home

If you are traveling and need Emergency care, go to the nearest emergency room. If you need Urgent Care, call your PCP's office and follow your Provider's instructions. For other routine health care issues, call your PCP. For routine Behavioral Health issues, call your Behavioral Health Provider. If you are outside of our Service Area, but in the U.S. or its territories, we cover only Emergency care, Post-stabilization Care Services or Urgent Care. We will not cover:

- Non-Emergency tests or treatment that your PCP asked for but that you decided to get outside of the Service Area
- Routine or follow-up care that can wait until your return to the Service Area, such as physical exams, flu shots, stitch removal and Behavioral Health counseling
- Care that you knew you were going to get before you left the Service Area, such as elective surgery
- Services received outside of the U.S. and its territories

A Provider may ask you to pay for care you get outside of our Service Area at the time of service. If you pay for Emergency care, Post-stabilization Care Services or Urgent Care that you get outside of our Service Area, you may ask us to reimburse you, as long as those services were received within the U.S. or its territories. You may also call our Member Services Team at 888-257-1985 (TTY: 711) for help with any bills that you may get from a Provider.

Your health plan Providers

For the most up-to-date information about Providers, visit tuftshealthplan.com and use the Find a Doctor or Hospital tool, or call our Member Services Team at 888-257-1985 (TTY:711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

The Provider Directory

Our *Provider Directory* lists the following types of Providers by county and town:

- Primary care sites
- Primary Care Providers (PCPs)
- Hospitals
- Specialists
- Behavioral Health (mental health and/or substance use disorder) Providers
- Urgent care centers

In our *Provider Directory*, find important information like a Provider's full name, address, phone number, specialty, hours of operation, handicap accessibility and languages spoken.

Our *Provider Directory* also lists all In-network pharmacies, facilities (such as skilled nursing facilities), ancillary Providers (such as chiropractic or Hospice Services), hospital Emergency services, Community Behavioral Health Centers (CBHC) for Behavioral Health, and suppliers of durable medical equipment — including walkers, wheelchairs, hospital beds and home oxygen equipment.

If you want a copy of our *Provider Directory*, please call and ask us to send one to you. We can also give you information about a Provider that we don't list in the *Provider Directory* or information about PCPs and other Providers listed in the *Provider Directory*, such as a Provider's name, address, phone number, hours of operation, handicap accessibility, languages spoken, professional qualifications, specialty, medical school attended, residency completion, and board certification status. Just give us a call at 888-257-1985 (TTY:711). We are happy to help.

Your PCP

A Primary Care Provider (PCP) is the Provider who manages your care. You can choose a doctor, a nurse practitioner or a licensed physician's assistant as your PCP.

As a Member, you must have a PCP. Your PCP is the Provider you should call for any kind of health care need unless you are having an Emergency. You can call your PCP's office 24 hours a day, seven days a week. If your PCP is not available, somebody else at your PCP's office can help you. If you have problems contacting your PCP, please call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. After hours you can leave a voicemail and we will respond to you on the next business day. You can call our 24/7 NurseLine if you would like help deciding whether your illness requires Emergency care. Call anytime at 888-MY-RN-LINE (888-697-6546) (TTY: 711). See page 1 for more information on how to contact us.

To find a PCP and see where the PCP's office is located, please visit tuftshealthplan.com and use the Find a Doctor or Hospital tool. You can also call us at 888-257-1985 to help you find and choose a PCP located in the Region where you live. Here's what your PCP can do for you:

- Give you regular wellness visits and health screenings, including Behavioral Health screenings
- Make sure you get the health care you need
- Arrange necessary tests, laboratory procedures or hospital visits
- Keep your medical records
- Recommend Specialists, when necessary
- Provide information on Covered Services that need Prior Authorization (permission) before you get treatment
- Provide you with any needed Referrals before you get treatment
- Write prescriptions when necessary
- Help you get Behavioral Health services, when necessary

PCP and health plan assignment

The Network of the PCP you have chosen determines the health plan that you belong to. Your PCP belongs to the Cambridge Health Alliance Accountable Care Organization (ACO). An ACO is a team of doctors and health care providers led by your PCP. The team's mission is to help you meet your health goals while making it easier for you to get high-quality care.

If you don't want to stay with your PCP, you can always choose a different PCP in your ACO Network by calling us at 888-257-1985 (TTY: 711) or by using our Member portal at tuftshealthplan.com/memberlogin. You can choose a PCP outside of your ACO Network during your annual Plan Selection Period by contacting MassHealth.

Getting care after office hours

Talk to your PCP to find out about getting care after normal business hours. Some PCPs may have extended office hours. If you need Urgent Care after regular business hours, call your PCP's office. PCPs have covering Providers who work after hours. If you have any problems seeing your Provider, please call us at 888-257-1985 (TTY: 711).

You may go to an urgent care center (UCC) after office hours. When going to a UCC, you should also try to contact your PCP. To find UCCs in our Provider Network, go to tuftshealthplan.com and use our Find a Doctor or Hospital tool.

You can get free health support, like health coaching and information on symptoms, diagnoses or treatments, to help you stay healthy. Support is available 24 hours a day, seven days a week. You can call our 24/7 NurseLine if you would like help deciding whether your illness requires Emergency care. Call anytime at 888-MY-RN-LINE (888-697-6546) (TTY: 711). You can get help in many languages. Remember, the 24/7 NurseLine doesn't replace your PCP.

Specialists

Specialists are Providers who have extra training and who focus on one kind of care or on one part of the body.

Sometimes you may need to visit a Specialist, such as a cardiologist (heart doctor), dermatologist (skin doctor) or ophthalmologist (eye doctor), or for Behavioral Health services, a psychologist, psychiatrist, counselor or social worker. Tufts Health Together Members who have special health care needs have access to Specialists in the Tufts Health Together Network who can help manage their special health care needs.

To find a Specialist, talk to your PCP. You can also call us at 888-257-1985 (TTY: 711) or visit tuftshealthplan.com and use the Find a Doctor or Hospital tool to search for a Specialist. We also list Specialists in our *Provider Directory*; call us to get a copy. You should discuss your need to see a Specialist with your PCP first and then call the Specialist to make an appointment.

Referrals for Specialist visits

Before you make an appointment to see a health care Provider for the first time, talk to your Primary Care Provider about staying in your ACO Network. If you are a Provider helping a Member seek care, please ensure that you refer Members within the appropriate ACO Network for their plan.

A Referral is a notification from your PCP to us that you can get care from a different Tufts Health Together Provider. You have access to additional Providers when your ACO does not have a particular specialty available, you have a previous relationship with these Providers, an appointment is not available in time to meet your medical needs, or your PCP feels the Referral is in your best interest. The Referral helps your PCP better guide the care and services you get from the Providers you see. In addition, a Prior Authorization may be required for certain services. (See the Prior Authorization for Services section starting on page 12.)

You won't need PCP Referrals for any outpatient Behavioral Health services, Emergency care services, urgent care centers, Post-stabilization Care Services, Family-planning Services from any MassHealth-contracted Family-planning Services Provider, or any OB/GYN services.

Seeing an Out-of-network Specialist

Your PCP must ask us for and get Prior Authorization before you see an Out-of-network Specialist. You may ask your PCP to ask for Prior Authorization. If you have questions, you can call our Member Services Team at 888-257-1985 (TTY: 711).

You can see an Out-of-network Specialist if:

- A participating In-network Provider is unavailable because of location
- A delay in seeing a participating In-network Provider, other than a Member-related delay, would result in interrupted access to Medically Necessary services
- There is not a participating In-network Provider with the qualifications and expertise that you need to address your health care need

Do not pay an Out-of-network Provider if they bill you for your Covered Services. The Provider should bill Tufts Health Plan directly. If you get a bill from a Provider, call Member Services at 888-257-1985 (TTY: 711). When accessing an out-of-network provider, you are able to obtain the same service or to access a provider with the same type of training and experience.

Please see the Continuity of Care section below if you qualify for Continuity of Care.

Communication between Providers

It's a good idea for your Provider to share information about your care with other Providers. When more than one Provider is involved in your care, sharing information helps them coordinate the services that you get, which can lead to better quality of care. You must give Providers permission to share your information. Your doctor or Behavioral Health therapist can talk with you more about which Providers should receive the information and answer any questions you have before getting your permission.

Getting a Second Opinion

Our Members can get a Second Opinion from a different Provider about a medical or Behavioral Health (mental health and/or substance use disorder) condition or proposed treatment and care plan. You can get a Second Opinion about a medical issue or concern from an In-network Provider without Prior Authorization. We pay for any costs related to your getting a Second Opinion from a contracted In-network Provider or, with Prior Authorization, from a Provider who is not part of our Provider Network. You can see the most up-to-date list of our In-network Providers online at tuftshealthplan.com. Please call us at 888-257-1985 (TTY: 711), Monday

through Friday, from 8 a.m. to 5 p.m., excluding holidays, for help or for more information about finding a Provider to see for a Second Opinion.

Continuity of Care

New Members

If you are a new Member to our Plan, we make sure any care you currently get continues to go as smoothly as possible. If the Provider you are seeing is not part of our Network, our Continuity of Care policy may be able to cover some of your health services, including Behavioral Health (mental health and/or substance use disorder) services. If any of the following situations apply to you, you may continue to get care from a Provider who is not part of our Network. You must call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, and tell us that you want to keep seeing this Provider.

- If you are pregnant, you may continue to see your current pregnancy care Provider through delivery, for immediate post-partum care, and for follow-up appointments within the first six weeks of delivery.
- If you are receiving outpatient medical care or care for a chronic or acute medical condition (with a treatment like dialysis, home health services, chemotherapy and/or radiation), you may continue to see your Provider for up to 30 days after enrollment.
- If you are receiving outpatient Behavioral Health or substance use disorder care, you may continue to see your Provider for up to 90 days after enrollment.
- If your current PCP is not a Provider with our health plan, you may continue to see them for up to 30 days after enrollment.
- If you have significant health care needs or a complex medical condition, including serious or persistent mental illness, you may continue to see your Provider for up to 30 days.
- If you are receiving Inpatient care (medical or Behavioral Health/substance use disorder) from a hospital at the time of your enrollment, you may continue to receive care through your discharge as long as the services delivered are Medically Necessary.
- If you are actively receiving applied behavioral analysis (ABA) services for Autism Spectrum Disorder (ASD) or Down Syndrome, and have a current Prior Authorization for such services in place, you may continue to get these services for 90 days after enrollment.
- If you are actively receiving Early Intensive Behavioral Intervention services and have a current Prior Authorization for such services in place, you may continue to get these services for 90 days after enrollment.
- If you have an existing prescription, we provide any prescribed refills of your medication, unless this prescription requires a Prior Authorization. If a Prior Authorization is required, we provide a 72-hour supply of your medication while your Provider sends us the information that allows us to approve the Prior Authorization. If you were on a prescription for a drug to treat a chronic heart condition, diabetes (insulin), or asthma, you can get a 30-day fill, even if you don't have any prescribed refills on file.
- If, at the time of your enrollment, you were receiving the following services that were authorized by MassHealth, a MassHealth-contracted Managed Care Organization, a MassHealth Accountable Care

Partnership Plan, or a commercial carrier, you may continue to receive these services for 30 days after enrollment. These include:

- Durable medical equipment (DME)
- Prosthetics, orthotics and supplies (POS)
- Physical therapy (PT), occupational therapy (OT) or speech therapy (ST)
- Scheduled surgeries
- Out-of-area specialty services
- Nursing home admissions

Please remember that it is important for you to contact us if you wish to get continued treatment as outlined above. After the specific period of Continuity of Care ends, you can continue to get care or treatment from an In-network Provider. To choose a new Provider, please call us at 888-257-1985 (TTY: 711).

We allow you to get continued treatment by an Out-of-network Provider only if the Provider agrees to our terms related to payment, quality, Referrals, and other policies and procedures.

Existing Members

If your PCP or another Provider is disenrolled from our Network for reasons not related to quality of care or Fraud, or if the PCP or Provider is no longer in practice, we make every effort to tell you at least 30 days before the disenrollment. Whenever possible, we may be able to continue to cover some of your health care services under our Continuity of Care policy, on the condition that any of the following situations apply to you. If you qualify, you must call us at 888-257-1985 (TTY: 711) and tell us that you want to keep seeing this Provider.

- If you are pregnant, you may continue to see your current pregnancy care Provider through delivery, for immediate post-partum care, and for follow-up appointments within the first six weeks of delivery.
- If you are receiving outpatient medical care for a chronic or acute medical condition (with a treatment like dialysis, home health services, chemotherapy and/or radiation), including previously authorized services or Covered Services, you may continue to see your Provider through the current period of active treatment or for up to 90 days after we tell you he or she is no longer part of our Network (whichever period is less).
- You may continue to see your PCP for up to 30 days after the PCP is disenrolled.
- If you have significant health care needs or a complex medical condition, including serious or persistent mental illness, you may continue to see your Provider for at least 30 days.

We allow you to get continued treatment by an Out-of-network Provider only if the Provider agrees to our terms related to payment, quality, Referrals, and other policies and procedures.

Prior Authorization for Services

Your Primary Care Provider (PCP) works with your other Providers to make sure you get the care you need. For some services, your PCP or other Provider needs to ask us for Prior Authorization (permission) before

sending you to get those services. Please see your *Covered Services List*, in Appendix A of this *Member Handbook*, for more details about which services need Prior Authorization.

Your PCP or other Provider will ask us for Prior Authorization when you need a service or need to get care from a Provider that requires prior approval. For these requests, we decide whether the service is Medically Necessary and whether we have a qualified In-network Provider who can give you the service instead. If we don't have an In-network Provider who is able to treat your health condition, we authorize an Out-of-network Provider for you to see. For the most up-to-date listing of all our In-network Providers, go to tuftshealthplan.com and use the Find a Provider tool.

We also may review your care while you are receiving it or after it is done. These reviews are part of our utilization management (UM) program. It is how we make sure services are medically necessary.

The following services never require Prior Authorization:

- Emergency care services
- Urgent care centers
- Post-stabilization Care Services
- Family-planning Services from any MassHealth-contracted Family-planning Services Provider
- In-network outpatient Behavioral Health (mental health) counseling
- Outpatient group psychotherapy
- Substance use disorder visits
    - Acute Treatment Services – Level 3.7
    - Clinical Stabilization Services – Level 3.5
    - Structured Outpatient Addiction Treatment
    - Partial Hospitalization – Level 2.5
    - Enhanced Acute Treatment Services/Dual Diagnosis Acute Treatment
    - Outpatient psychotherapy for substance use treatment

If you become our Member by changing from another MassHealth plan, and you had already begun treatment (such as ongoing maternity care) with a Provider who does not contract with us, we review that treatment and may approve your continued treatment by the same Provider. For more information, please see the section "Continuity of Care" on page 11.

Standard service Authorizations

We make standard service Authorization decisions as fast as your health condition requires, but no more than 7 days after we get the request. You, your Designated Representative, if you identify one, your Provider or we can extend this time frame by an additional 14 days if:

- You, your Designated Representative, or your Provider asks for an extension, or

- We can show that the extension is in your best interest, we need more information, we believe we'll have the information within 14 days, and we believe the information would lead to approving the request.

If we decide to extend the 7-day time frame, we'll send you a letter explaining the reasons for the extension. We'll also tell you of your right to file a Grievance if you disagree with our decision to take an extension. If we don't act within these time frames, you or your Designated Representative may request an Internal Appeal.

Expedited (fast) service Authorizations

Your Provider can ask for an expedited (fast) service Authorization decision if taking the time for a standard Authorization decision could seriously risk your life, your health, or your ability to get, maintain or regain maximum function. We make expedited Authorization decisions as fast as your health requires, and no more than 72 hours after we get the expedited service request. We will decide an Authorization request for admission or transition to a post-acute care facility or agency by the next business day following receipt of all Necessary Information. You, your Designated Representative, your Provider or we can extend this time frame by an additional 14 days if:

- You, your Designated Representative, or your Provider asks for an extension, or
- We can show that the extension is in your best interest, we need more information, we believe we'll have the information within 14 days, and we believe the information would lead to approving the request.

If we decide to extend the 72-hour time frame, we'll send you a letter explaining the reasons for the extension. We'll also tell you of your right to file a Grievance if you disagree with our decision to take an extension. If we don't act within these time frames, you or your Designated Representative may request an Internal Appeal.

For details on requesting an Internal Appeal or filing a Grievance, please see the section "Your concerns" on page 2.

Prior Authorization approvals and denials

Once we review the request for services, we'll tell your Provider. If we authorize the services, we'll send your Provider an Authorization letter with the services we agree to cover. The Provider giving the services must have this Authorization letter before you get any services requiring an Authorization. Your Provider can ask us for additional Authorization if you need services beyond what we have authorized. If we approve the request for additional services, we'll send your Provider another service Authorization letter.

If we don't authorize any of the services requested, authorize only some of the services requested, or don't authorize the full amount, duration or scope of services requested, we'll send you, your Designated Representative and your Provider a denial letter. We will not pay for any unauthorized services. If you sign a valid waiver with a Provider for unauthorized services, you may be responsible for payment. We'll also send you, your Designated Representative and your Provider a notice if we decide to reduce, suspend or stop providing previously authorized services. If you disagree with any of these decisions, you or your Designated Representative can request an Internal Appeal. For details on requesting an Internal Appeal, please see the section "Your concerns" on page 43.

Covered Services

Services we cover

As our Member, you get some services from us and other services from MassHealth, but we coordinate all the Covered Services and benefits for you. The services you get directly from us include all the Covered Services and benefits listed in your *Covered Services List* for MassHealth Standard/CommonHealth, Family Assistance or CarePlus plans. You can begin getting Covered Services as of the Effective Coverage Date of your enrollment. Please see your *Covered Services List* for details, including Prior Authorization requirements for Members. Note: Benefits are subject to change; see tuftshealthplan.com for the most current information. If you have questions or want to learn more about any of our benefits or Covered Services, call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. We can give you information in other formats, such as Braille, large type size and different languages. We have bilingual staff available, and we offer translation services in 200 languages. All translation services are free to Members.

Make sure you always show your health plan and MassHealth Member ID Cards when you get health care services. You can get Emergency services from any Provider of Emergency services. You can get Family-planning Services from any MassHealth-contracted Family-planning Services Provider. Prior Authorization isn't needed for most Covered Services, including Emergency health care, Post-stabilization Care Services, Family-planning Services, In-network outpatient Behavioral Health (mental health) counseling. Please see your *Covered Services List* for details on services that may need Prior Authorization for MassHealth Standard/CommonHealth, Family Assistance or CarePlus plan Members. We make a decision based on whether you need the services and whether you're getting the services in the right place.

Behavioral Health (mental health and/or substance use disorder) services

We have different levels of Behavioral Health services based on your needs. See all services (including Inpatient, outpatient, substance use disorder and diversionary services) in your *Covered Services List*. As long as you see an In-network Provider, you don't need Prior Authorization for any outpatient substance use disorder therapy/counseling visits, group therapy/counseling visits or In-network outpatient Behavioral Health (mental health) counseling. See a list of Providers who can help you get these services at tuftshealthplan.com.

If you need help finding a Behavioral Health Provider, please call us at 888-257-1985 (TTY: 711).

At any time, if you are having a Behavioral Health Emergency, call 911, go to the closest emergency room or call your local Community Behavioral Health Center (CBHC). For a complete list of emergency rooms and CBHCs throughout the state, please call us at 888-257-1985 (TTY: 711) or visit tuftshealthplan.com. To find the closest CBHC near you, call the Help Line 24/7 by phone and text at 833-773-BHHL, as well as online at masshelpline.com. Every call, text, or chat conversation includes clinical follow up.

Services MassHealth covers

As a benefit from MassHealth, you may be eligible to receive non-Accountable Care Organization/Managed Care Organization Covered Services, such as Medical Respite, Doula, Personal Care Attendant (PCA), or Day Habilitation services. We will help you access these services through education and coordination of efforts by calling us at 888-257-1985 (TTY: 711), or you can call the MassHealth Customer Service Center at 800-841-2900 (TTY: 711).

Please see the *Covered Services List* for details and/or limitations on services MassHealth covers for MassHealth Standard/CommonHealth, Family Assistance or CarePlus plan members.

As a benefit from MassHealth, you may be eligible to get help setting up non-Emergency transportation to go to health care visits. Note: Non-Emergency transportation must be within a 50-mile radius of the Massachusetts state border. We help coordinate this service with MassHealth for you. For help setting up non-Emergency transportation you may qualify for, you must:

- Have an appointment for a Medically Necessary service and
- See a MassHealth Provider.

In addition, you must either:

- Have a medical reason why you can't use public transportation, or
- Be unable to access public transportation or
- Have no one who can take you to your appointment.

For more information on non-Emergency transportation services you may be eligible for, call us at 888-257-1985 (TTY: 711). Be sure to call us well in advance of your appointment so we can best help you.

Preventive Care services for adults age 21 and older

You should visit your Primary Care Provider (PCP) for Preventive Care, also known as Non-symptomatic Care. Examples of covered Preventive Care for adults age 21 and older include:

- Wellness visits: every one to three years
- Behavioral Health Wellness exam every year
- Blood pressure checks: at least every two years
- Cholesterol screening: every five years
- Pelvic exams and Pap smears (for women): the first Pap test and pelvic exam should happen three years after first sexual intercourse or by age 21 and continue every one to three years depending on risk factors
- Breast cancer screening (mammogram, digital breast tomosynthesis, and medically necessary breast magnetic resonance imaging or breast ultrasound): every year after turning 40
- Colorectal cancer screening: every 10 years, starting at age 50
- Flu shot: every year
- Eye exams: once every 24 months
- Dental: call us to ask about your specific dental coverage

Health care for children

Preventive and well-child care for all children

It's important for children, teens and young adults to see their PCP for regular wellness visits so they can stay healthy. Children who are under age 21 should see their PCP for wellness visits at least once every year, even

if they are well. As part of a well-child wellness visits, your child's PCP checks your child's development, health, vision, dental health, hearing, behavioral health and need for immunizations. Your child may see a licensed mental health specialist for an annual behavioral health wellness exam once every year.

We pay your child's PCP for child wellness visits and behavioral health wellness exam, so make sure to schedule them. At these wellness visits, your child's PCP can find and treat small problems before they become big ones.

Here are the ages to take a child for full physical exams and screenings:

- At one to two weeks
- At one month
- At two months
- At four months
- At six months
- At nine months
- At 12 months
- At 15 months
- At 18 months

At ages 2 through 20, children should visit their PCP once a year

Children should also visit their PCP anytime you are concerned about a medical, emotional or Behavioral Health need, even if it is not time for a regular wellness visit.

MassHealth requires that PCPs and nurses offer to use standardized screening tools, approved by MassHealth, during well-child visits to check to see whether a child has any Behavioral Health needs. Screening tools are short questionnaires or checklists that a parent or child (depending on the child's age) fills out and then discusses with the PCP or nurse.

Your PCP will discuss the completed screening with you. The screening helps you and your Provider decide whether your child may need further assessment by a Behavioral Health Provider or other medical professional. If you or your doctor or nurse thinks that your child needs to see a Behavioral Health Provider, please call us at 888-257-1985 (TTY: 711). We can give you information and help.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Preventive Pediatric Health Care Screening and Diagnosis (PPHSD) services.

EPSDT/PPHSD services include health care, screening, diagnosis, treatment, and other care you or your child needs to correct or improve defects and physical and mental illnesses and conditions. If you or your child is under age 21 and a PCP discovers a health and/or behavioral health condition, we'll pay for all Medically Necessary treatment that federal Medicaid law covers, even if the services are not in your *Covered Services List*. The treatment must be given by a Provider who is qualified and willing to provide the services, and the Provider must tell us in writing that the services are Medically Necessary. You and your PCP can ask us to help you find an In-network Provider to give you these services and/or how to use Out-of-network Providers, if needed.

See the services we cover on your *Covered Services List*. If we don't cover the treatment services you need, or if your *Covered Services List* doesn't include the services, the Provider providing the treatment services can ask us for Prior Authorization. We pay for the treatment services if we agree the services are Medically Necessary and we give Prior Authorization.

If we don't approve the request for Prior Authorization, you have a right to appeal. For more information about the Grievance and Appeal process, please see the section "Your concerns" on page 42. Talk to your child's PCP, Behavioral Health Provider or other Specialist for help getting these services.

Note: "EPSDT" is the name of the services for members enrolled in MassHealth Standard/CommonHealth. "PPHSD" is the name for members enrolled in MassHealth Family Assistance. There is no difference in the scope of services or legal requirements between the two. Please see the MassHealth for Children and Young Adults webpage for more information.

Behavioral Health services for children

Your child's Behavioral Health Provider does a Behavioral Health assessment, including administering the Child and Adolescent Needs and Strengths (CANS) Tool. The CANS Tool gives Behavioral Health Providers a standardized way of organizing information during Behavioral Health clinical assessments for Members under age 21, and during the discharge-planning process from Inpatient psychiatric hospitalizations and community-based acute treatment services.

Your child's Behavioral Health Provider uses the CANS Tool during an initial assessment — and at least every 180 days after that — while reviewing your child's treatment plan in relation to:

- Outpatient therapy (diagnostic evaluations, individual, family and group)
- In-home therapy services
- Intensive Care Coordination (ICC)

Your child's Behavioral Health Provider also completes the CANS Tool during the discharge-planning process in the following 24-hour level-of-care services:

- Psychiatric Inpatient hospitalizations at acute Inpatient Hospitals, psychiatric Inpatient Hospitals, and chronic and rehabilitation Inpatient Hospitals
- Community-based acute treatment (CBAT) and intensive community-based acute treatment (ICBAT)

For more information about how to get Behavioral Health services or to find a Behavioral Health Provider, you can talk to your PCP or call us at 888-257-1985 (TTY: 711). You can also find this information in our *Provider Directory* and by using the Find a Doctor or Hospital tool at tuftshealthplan.com.

Children's Behavioral Health Initiative (CBHI)

The CBHI is a state initiative to make sure Members, including children and youth under age 21 with significant behavioral, emotional and mental health needs, get any necessary services to do well at home, in school and in the community.

As part of the CBHI, the state has expanded Behavioral Health services for certain children and youth under the age of 21 to include, when Medically Necessary, home- and community-based services, such as:

- Mobile crisis intervention
- In-home therapy
- In-home behavioral services

- Family support and training
- Therapeutic mentoring
- Intensive Care Coordination (ICC)
- Family-based Intensive Treatment (FIT)

A CBHI network offers ICC and family support and training services to MassHealth-eligible youth with serious emotional disturbance (SED) and their families/caregivers. There are 32 agencies across the state that coordinate CBHI services, known as Community Service Agencies (CSAs). For more information about CBHI services or to find a CSA, you can talk to your PCP or call us at 888-257-1985 (TTY: 711).

You can also find this information at tuftshealthplan.com and in our *Provider Directory*.

Your child is also eligible for a full range of Behavioral Health services, including:

- Individual, group or family therapy
- Partial hospitalization care, which is when your child gets some services at a Hospital but still lives at home
- Inpatient care

For more information, please call us at 888-257-1985 (TTY: 711) or visit tuftshealthplan.com.

Dental care for children

MassHealth pays for dental services, such as screenings and cleanings, for children under age 21. Your child's PCP does a dental exam at each child wellness visit until your child is 3 years old. After your child's third birthday, your child's PCP will tell you to start taking your child to the dentist. If your child is younger than 3 years old and the PCP thinks there are problems, the PCP might suggest you bring your child to the dentist sooner.

When your child goes to the dentist, a full dental exam, teeth cleaning and fluoride treatment are provided. Make sure that your child gets:

- A dental wellness visit every six months, starting no later than age 3
- A dental cleaning every six months, starting no later than age 3
- Other needed dental treatments, even before age 3, if your child's PCP or dentist finds problems with your child's teeth or oral health

Fluoride varnish is recommended every six months from when the first tooth comes in (usually at six months) to a child's sixth birthday. This service is primarily intended for children 0-6 but may be covered up to age 21. Doctors, physician assistants, nurse practitioners, registered nurses and licensed practical nurses can apply fluoride varnish.

Children under age 21 and enrolled in MassHealth Standard or CommonHealth plans can get all Medically Necessary treatment that is covered under Medicaid law, including dental treatment, even if MassHealth does not already cover the service.

Children under age 21 and enrolled in MassHealth Family Assistance can get all Medically Necessary services covered under their coverage type, including dental treatment. Talk to your child's PCP or dentist for help in getting these services. Children can see any MassHealth dentist. Children can visit a dentist before age 3.

Early Intervention services

Early Intervention (EI) is a program for children aged 3 or under who have developmental delays or are at risk of a developmental delay or have Down Syndrome. EI services offer individualized, developmentally appropriate activities within the child's and family's everyday life.

Children aged 3 or under can get services from an Early Intervention program through our health plan. Your child may get these services at home or at an Early Intervention center. Early Intervention program staff members include nurses; occupational, physical, and/or speech language therapists; psychologists; and social workers.

Talk to your child's PCP as soon as possible if you think your child has growth or developmental problems. You can also contact your local Early Intervention program directly.

Applied Behavioral Analysis (ABA) services for children

Children under the age of 21 who have been diagnosed with autism spectrum disorder (ASD) or Down Syndrome and have MassHealth Standard or CommonHealth or Family Assistance are covered for applied behavioral analysis (ABA).

ABA services are provided by a team. One member of the team is a licensed applied behavioral analyst. The analyst monitors the child's behavior and creates a plan to help decrease problem behaviors. The team also includes a behavior technician/paraprofessional who helps the child and the caregiver implement the plan. The team works closely with people in the child's life, such as caregivers, schoolteachers and other Providers.

Services for children in the care or custody of the Department of Children and Families (DCF)

If a child enters DCF custody or has been placed out of home under a Voluntary Placement Agreement, a Child in Need of Services (CHINS) decision, or any other court-determined custody, the child is required to have a health care screening within seven days and a full medical examination within 30 days of entering DCF custody or out-of-home placement, unless the EPSDT services schedule calls for an earlier time frame. Whenever possible, both the screening and the examination should be performed by the child's PCP. It is important to contact the PCP as soon as the child enters DCF custody or out-of-home placement in order to get these services within the required time frame. If the PCP does not provide care within these time frames, you may request an Internal Appeal. We describe our Internal Appeal process in the section "Your concerns" on page 43. Please see the MassHealth for Children and Young Adults webpage for more information.

Covered medications and products; pharmacy programs and Prior Authorizations

Pharmacy program

We aim to provide high-quality, cost-effective options for drug therapy. We work with your Providers and pharmacists to make sure we cover the most important and useful drugs and medical devices for many different conditions and diseases. We cover first-time prescriptions and refills. We also cover some over-the-counter (OTC) drugs if your doctor writes a prescription and it is filled at a pharmacy as well as non-drug pharmacy products as listed in the MassHealth Non-Drug Product list. See the MassHealth drug lists to check for covered drugs and products at https://mhdl.pharmacy.services.conduent.com/MHDL/.

Our pharmacy program doesn't cover all drugs, medical devices and prescriptions. Some drugs and medical devices must meet certain clinical guidelines before we can cover them. Your Provider must ask us for Prior Authorization before we cover one of these drugs or medical devices. Please see the section "Prior Authorization for drugs and" immediately below.

Your Provider or pharmacy may not charge you a copayment for covered drugs or medical devices. You are prohibited from paying the pharmacy the full price or cost of the drug for your covered medications, unless the drug is not covered because the pharmacy has verified that you are not eligible for coverage (no longer a Member) or the drug has been deemed not Medically Necessary.

Prior Authorization for drugs and medical devices

Some drugs and medical devices require Prior Authorization, which means your Provider must ask us for approval before we cover the drug. One of our clinicians reviews this request. We cover the drug or medical device according to our clinical guidelines if:

- There is a medical reason you need the particular drug or medical device
- Depending on the drug or medical device, other drugs or medical devices on the MassHealth Drug List have not worked

We allow for one emergency 72-hour supply of your prescription to be filled at the pharmacy while your doctor submits a request for us. If you need an emergency supply, please talk to your pharmacist.

If we don't approve the request for Prior Authorization, you or your Designated Representative, if you identify one, can appeal the decision. See the section "Your concerns" on page 2 for Grievance and Appeal information. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at 888-257-1985 (TTY: 711).

Exclusions

We don't cover certain drugs and medical devices. If it is Medically Necessary for you to take a drug or use a medical device that we don't cover, your Provider must ask us for an exception and get Prior Authorization before we cover the drug or medical device. Your Provider or pharmacy may not charge you a copayment for covered drugs or medical devices. One of our clinicians reviews the request. If we don't approve the request for Prior Authorization, you or your Designated Representative can appeal the decision. See the section "Your

concerns" on page 43 for Grievance and Appeal information. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at 888-257-1985 (TTY: 711).

We don't cover:

- Any drug products used for cosmetic purposes or hair growth, unless medically necessary**
- Cough and cold medications**
- Infertility medications**
- Medications used for male or female sexual dysfunction**
- Less than effective drugs: Drug Efficacy Study Implementation (DESI) drugs**
- Experimental and/or investigational drugs**
- Medical supplies
- Medications used for the treatment of obesity or overweight

Drugs that are not approved by the U.S. Food and Drug Administration or drugs whose manufacturer does not participate in the federal drug rebate program are subject to review for Prior Authorization. Coverage of digital therapeutics and prescription digital therapeutics (PDTs) is limited to that which is covered on the MassHealth Drug List.

* May be covered as a non-pharmacy benefit

** In accordance with guidelines found in the MassHealth regulation 130 CMR 406.413(B): Limitations on Coverage of Drugs, we do not cover drugs used for cosmetic purposes or hair growth (unless medically necessary), cough and cold, infertility, sexual dysfunction, obesity and overweight management, or drugs that are less than effective (DESI), experimental and/or investigational.

Generic drugs

Generic drugs have the same active ingredients as brand-name drugs. When generic drugs are available, we generally won't cover the brand-name drug without Prior Authorization, except in some instances when we prefer the brand over the generic. If you and your Provider feel a generic drug is not right for treating your health condition and that a brand-name drug is Medically Necessary, your Provider can ask for Prior Authorization. One of our clinicians reviews the request. Please see the section "Prior Authorization for drugs and medical devices" on page 25 for more information. If we don't approve the request for Prior Authorization, you or your Designated Representative can appeal the decision. See the section "Your concerns" on page 43 for Grievance and Appeal information. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at 888-257-1985 (TTY: 711). Please refer to the MassHealth Drug List at https://mhdl.pharmacy.services.conduent.com/MHDL/ for the MassHealth Brand Name Preferred over Generic Drug List.

New-to-market drugs

New drugs and devices are reviewed for safety and efficacy and once evaluated, covered products are added to the MassHealth Drug List. A Provider who feels a new-to-market drug or medical device is Medically Necessary for you can submit a request for Prior Authorization. One of our clinicians reviews this request. If we

approve the request, we cover the drug or medical device according to our clinical guidelines. If we don't approve the request, you or your Designated Representative can appeal the decision. See the section "Your concerns" on page 43 for Grievance and Appeal information. If you have questions about our pharmacy program or benefits, please call us at 888-257-1985.

Quantity limits

To make sure the drugs you take or the medical devices you use are safe and that you are getting the right amount, we may limit how much you can get at one time. Your Provider can ask us for Prior Authorization if you need more than what we cover. One of our clinicians reviews the request. We cover the drug or medical device according to our clinical guidelines if there is a medical reason you need this particular amount. We must give Prior Authorization before we cover a larger amount. If we don't approve the request for Prior Authorization, you or your Designated Representative can appeal the decision. See the section "Your concerns" on page 43 for Grievance and Appeal information. For more information, visit tuftshealthplan.com or call us at 888-257-1985 (TTY: 711).

90-Day supply pharmacy program

Tufts Health Together follows MassHealth's 90-day supply program that includes mandatory and allowable dispensing of certain medications. Please refer to the MassHealth Drug List for additional information.

Step therapy program

Step therapy means that before we pay for a certain second-level drug, you first have to try first-level drugs of that type.

We cover some types of drugs only through our step therapy program. Our step therapy program requires you to try first-level drugs before we cover another drug of that type. If you and your Provider feel a certain drug is not right for treating your health condition, your Provider can ask us for Prior Authorization for the other drug. One of our clinicians reviews the request. We cover the drug according to our clinical guidelines. Please see the section "Prior Authorization for drugs and medical devices" on page 25.

Specialty pharmacy program

A specialty pharmacy needs to supply you with some drugs, such as drugs often used to treat chronic conditions like hepatitis C or multiple sclerosis. These types of drugs need additional expertise and support. Specialty pharmacies have knowledge in these areas. These pharmacies can give extra support to Members and Providers.

OptumRx Specialty is our specialty pharmacy. It can provide you with these drugs. In addition to providing specific specialty drugs, OptumRx Specialty can:

- Deliver drugs to your home, your Provider's office, any FedEx or UPS location, or any delivery address you choose (except for a P.O. box)
- Answer your questions
- Provide call center staff including on-call staff pharmacists who can help you 24 hours a day, 7 days a week, including holidays at 844-265-1705

Please visit us at tuftshealthplan.com/member/tufts-health-together-plans/pharmacy/overview and refer to the Specialty pharmacy program to identify any specialty drugs you may be taking. You can't get these drugs at a retail pharmacy.

Pharmacy (drug and medical device) Authorizations

We make decisions as fast as your health needs require and no more than 24 hours after we get the request.

Pharmacy (drug and medical device) Prior Authorization approvals and denials

If we authorize the drug or medical device, we notify you by phone and send you or your Designated Representative and your Provider an Authorization letter. There is no cost to you for authorized drugs or medical devices.

If we don't authorize the drug or medical device requested, or don't authorize the full quantity or duration, we'll notify you by phone and send you, your Designated Representative and your Provider a denial letter. We do not pay for any unauthorized drug or medical device. If you disagree with any of these decisions, you or your Designated Representative can request an Internal Appeal. For details on requesting an Internal Appeal, please see the section "Your concerns" on page 43.

If you get a bill for a Covered Service

According to state and federal regulations and Tufts Health Together's contract with MassHealth, your Provider is not allowed to bill you for any Covered Service. Do not pay your Providers directly and ask for reimbursement from Tufts Health Plan. If you have any questions about whether Tufts Health Plan or MassHealth covers a specific service, or if you get a bill, call us at 888-257-1985 (TTY: 711). We can help.

Utilization Management

Utilization Management (UM) is how we make sure you get the right care and services in the right place.

We base all UM decisions on correct use of care and services, as well as on the existence of coverage. We don't reward Providers, UM clinical staff or consultants for denying care. We don't offer Network Providers, UM clinical staff or consultants any money or financial incentive that could discourage them from making a certain service available to you.

If you have questions about UM or want more information on how we determine the care we authorize, please call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. Our staff is available to discuss UM issues during these business hours, as well as to respond to voicemails and faxes. If you leave a voicemail or send a fax during non-business hours, we respond the next business day. We can also give you information in different languages. We have bilingual staff available, and we offer translation services for up to 200 languages free to Members.

Clinical guidelines and review criteria

Utilization Review criteria are guidelines that we use to help us decide what services you need based on the information we get from your doctor and other clinicians.

When deciding what services are Medically Necessary, we make consistent and objective decisions. Local practicing Providers help us create clinical guidelines and Utilization Review criteria. We also use standards

that national accreditation organizations develop. We review these guidelines every other year, or more often as new drugs, treatments and technologies become generally accepted. We always look at what's best for you first.

Evaluating experimental and/or investigational drugs, technology and procedures

Experimental and/or investigational drugs and procedures are new kinds of treatment. We decide whether to cover new drugs and procedures based on scientific evidence and what doctors and other clinicians recommend.

As new technologies come up, we have a process to consider whether or not to cover new (experimental) procedures, including clinical trials. Before we decide to cover new procedures, equipment and prescription drugs, we look at how safe they are and how well these treatments work. For a list of non-covered experimental and/or investigational drugs and procedures, go to tuftshealthplan.com.

Qualifying clinical trials

We cover costs of routine Member items and services provided in connection with qualifying clinical trials relating to treatments for serious or life-threatening conditions. Eligible expenses are all items and services provided under the trial, including those to prevent, diagnose, monitor or treat complications as well as anything related to the provision of the investigational item/service. Excluded are items and services provided only for data collection/analysis purposes and not otherwise Medicaid covered.

A qualifying clinical trial is a clinical trial (in any phase of development) conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is approved by NIH, CDC, AHRQ, VA, DoD, DoE, pursuant to an investigational new drug exemption or the drug trial is exempt.

Care Management

Care Management is everything we do to help you manage your medical, social and Behavioral Health conditions more effectively to improve your health.

Our Care Management services include helping you make and keep appointments, obtain your health information, and coordinate your care with your Provider(s). Care Management includes health and wellness support, transition of care, and Integrated Complex Care Management. Our Care Management services are meant to support the care you get from your Primary Care Provider (PCP) or other Providers but are not meant to replace it. Please remember to continue to schedule regular and ongoing visits with your Providers.

Care managers from Tufts Health Plan or your Provider group will work closely with your Providers to coordinate your care and make sure you get the care you need when you need it.

Our care managers are available to answer any of your questions. If you are a new Member and have been working with a care manager with your prior carrier, we would like to arrange for you to work with one of our care managers. If this is the case, or if you would like to speak to one of our care managers, you can ask your PCP or you can call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Health and wellness support

We offer wellness services at no cost to you. These services may include but are not limited to:

- Providing you with general health information. visit https://www.healthwise.net/tufts for education and tools to help you make informed decisions on your health.
- Nutrition counseling from your own registered dietitian. As a member, you have access to a personalized nutrition coaching program called NationsNutrition at no cost to you. This program can help you build healthy habits and reach your health and weight goals. It can also help you fit healthy eating into your schedule and budget. Visit NationsNutrition at https://tuftshealthtogether.nationsbenefits.com/nutrition or call 844-398-9510 for more information or to sign up. Access to the Ovia Health app, which provides information on the full spectrum of women's and family health through different stages of life, such as:
    - Reproductive health
    - Family planning
    - Starting a family
    - Pregnancy
    - Balancing life as a working parent
    - Menopause

    Visit https://tuftshealthplan.com/member/tufts-health-together-plans/member-news/added-support-to-help-you-live-a-healthier-life for more information or to get started download the Ovia app and select "I have Ovia Health as a benefit" during signup.
- Participate in engaging wellness classes with various topics. Classes are available at no cost and easy to access via Zoom. They are available live and on demand. To get started or for more information visit https://tuftshealthplan.com/living-well/health-and-wellness-webinars
- Covering children and adolescents under age 21 for Early Periodic Screening, Diagnosis and Treatment (EPSDT) services

Visit the Your Health section of our website at tuftshealthplan.com/member/tufts-health-together-plans/your-health/overview to learn more.

Maternal and child health program

We work closely with you and your Provider(s) to make sure you get ongoing prenatal care if you're pregnant. We can help coordinate care for you and your newborn after you deliver, using such programs as Visiting Nurse Association (VNA) or Early Intervention Partnership Program and Women, Infants and Children (WIC) if you qualify.

Note: Members who become pregnant should notify MassHealth and/or our health plan to help ensure you have the right coverage for you and your child. For information about the benefits and services we offer pregnant Members, see page 33.

Help with quitting smoking

Members who want to kick the habit can get medications and counseling from the Massachusetts Tobacco Cessation & Prevention Program (MTCP) and MassHealth. For more information about quitting smoking, talk to your PCP. You can also call the MTCP for help at 800-QUITNOW.

Visit the Your Health section of our website at tuftshealthplan.com/member/tufts-health-together-plans/your-health/overview and select smoking cessation to learn more.

24/7 Nurse Line

We have a 24-hour Nurse Line for help with health questions seven days a week. When you call our 24/7 NurseLine at 888-MY-RN-LINE (888-697-6546) (TTY: 711), you can talk with a caring and supportive health care professional at any hour and at no cost. Our 24/7 NurseLine is staffed by registered nurses.

Our 24/7 NurseLine staff can give you information and support on health care issues like symptoms, diagnoses, treatments, tests, test results and procedures your Provider orders. Our 24/7 NurseLine staff can also help triage calls after hours and contact your Provider in the event that there is a need for further follow-up.

Our 24/7 NurseLine staff doesn't give medical advice. They are not a replacement for your Provider.

Care needs screening

We contact members new to Tufts Health Plan to complete their care needs screening. Once your screening is complete, we can better understand your health and create a plan to meet your needs.

Based on your screening, an associate may reach out to see whether you would like to work with us. Our staff are helpful and supportive members of your integrated care team. These calls can help you find and manage non-medical resources you may need, like peer support and counseling, or food and housing resources.

Transition of care

When you leave a 24-hour-care facility (such as an Inpatient acute medical or behavioral facility), we help you with a transition plan (the care you need to help you keep getting better at home). We work with Providers, such as a VNA or other home care agency or durable medical equipment providers, to make sure you get the services you need when you need them in order to improve your overall health.

The transition plan of care also includes:

- Teaching you about your condition and medication
- Teaching you about managing your disease and what you can expect
- Providing you with individual and integrated care
- Developing a plan to help you get the services you need

Your Provider can make a Referral for you to get transition-of-care services or you can self-refer by calling us at 888-257-1985 (TTY: 711) or by visiting tuftshealthplan.com.

If you'd like to opt out of transitions of care services while you are mid-program, please tell your Care Manager that you are no longer interested.

Integrated Care Management (ICM)

To make sure you get the best possible care and results, we use an Integrated Care Management model. This means that, when appropriate, our Behavioral Health, medical and Community Health Workers work closely with each other and with you to coordinate the care you need.

Care Management can help if you have complex and/or specific medical needs and conditions. If you have a physical disability, a special health condition (like a high-risk pregnancy, cancer or HIV/AIDS), a Behavioral Health condition or any other chronic health condition, you can:

- Get health information just for you from a care manager
- Get help finding out what resources and benefits you can get
- Work with one of our care managers to coordinate your care with your Provider/Specialist

Our team of dedicated health care professionals includes nurses, Behavioral Health Providers and Community Health Workers. This team understands how to work with you if you have special health care needs and helps make sure you get care in the right place — at home, at a Provider's office, at a Hospital, in school, in person or by phone — to help you get and stay healthy.

This team works with you to answer your questions, address your needs, develop a plan to get you feeling better and teach you to monitor your health. Some care managers make home visits, explain how to manage a condition, and arrange for services and equipment. Other care managers may also help with any medical, behavioral, social and financial needs.

We provide the following types of Integrated Care Management (ICM) services:

- Medical Care Management (includes Complex Care Management and Pregnancy Care Management)
- Behavioral Health Care Management (includes Peer Recovery Specialists)
- Community Health Services

Complex Care Management

Our Complex Care Management program is for Members with hard-to-manage, unstable and/or long-lasting medical conditions. Members in these programs get help from a team of dedicated health professionals, community organizations and state agencies. They help Members receive appropriate care to get better and to stay healthy, and help identify and reduce or remove social barriers to appropriate care. Complex Care Management may include visits to a Member's home, school and work, as well as to shelters, residential homes, Provider offices and community agencies. We also offer disease management in the form of coaching and education for our Members with asthma, heart failure, chronic kidney disease, and chronic obstructive pulmonary disease within our complex care program.

Members with the following conditions may benefit from Complex Care Management:

- Multiple health conditions
- Intensive-care needs
- Cancer
- HIV/AIDS
- Organ transplantation
- Severe disability or impairment
- Frequent admissions or emergency room visits
- High-risk pregnancy

Our care managers can provide you with personalized support, coaching and education, while also identifying the services that benefit you. They work with you and your Providers to make sure you get the right care in the right place.

Our care managers can give you or your caregiver valuable information and help coordinate your care. Call us at 888-257-1985 (TTY: 711) to talk to a care manager.

If you'd like to opt out of complex care management while you are mid-program, please tell your Care Manager that you are no longer interested.

Behavioral Health Care Management (includes Peer Recovery Specialists)

We can offer you Behavioral Health Care Management if you:

- Have a behavioral health, mental health/and/or substance use disorder diagnosis
- Have had a recent Behavioral Health Inpatient hospital admission
- Have not accessed or cannot access community-based services
- Experience a loss
- Are newly diagnosed with a major mental illness
- Have special needs or cultural issues that require multiple agencies to coordinate service delivery

Our Behavioral Health care managers are licensed clinicians who can help you by coordinating your care among your Providers, and by:

- Monitoring your treatment
- Reviewing your need for ongoing care
- Participating with your health care team on discharge planning
- Giving you information about community-based services

- Provide support and education around your behavioral health condition

Together, we can help make sure you get the best care. We work with you to:

- Continue improving your and your family's health
- Make sure you have timely and easy access to the appropriate level of Behavioral Health care
- Involve you in your treatment planning and recovery
- Make sure your care continues smoothly when you change Providers or plans

Call us at 888-257-1985 (TTY: 711) if you want information or have questions about Behavioral Health Care Management.

Disease Management

We offer Disease Management services to help Members with conditions like asthma, diabetes, heart failure, chronic kidney disease/end stage renal disease, and COPD (chronic lung disease). Our Care Managers are licensed healthcare professionals who are here to support you. They can help you understand your condition, manage your symptoms, and answer questions about your medications.

We work with you to create a care plan based on your needs and goals. We will help you set goals, track your progress, and find ways to improve your health. We can also connect you with your doctor, community resources, and helpful programs, including apps, text programs, and online tools that support healthy habits like better nutrition and weight management.

If you would like extra support, we can provide one-on-one coaching over the phone with a qualified Care Manager. During these calls, you will learn more about your condition, how your medications work, and ways to better manage your symptoms. We can also send you easy-to-understand educational materials to support your learning.

Our program uses proven medical guidelines to make sure you get the best care possible. We focus on helping you stay as healthy as you can and avoid unnecessary hospital or emergency room visits.

Disease Management services are available to all Members, including children. You may be invited to join the program based on your health history, or you can ask to join at any time.

Members may be referred to the program in different ways, including through their doctor, care team, claims information, or by family members or caregivers.

Our goal is to help you feel better, stay healthy, and take control of your care with the support you need.

Asthma

A Care Management Team member can give you information and tools to help you understand asthma and its causes, triggers and symptoms. We can help you learn how to spot the warning signs of a flare-up (attack) before it happens and to look for problems in your home that may make your asthma worse. The Care Manager may also speak with you about an asthma action plan and take other steps to make sure you get the services you need.

We can also provide one-on-one telephonic coaching with a qualified Care Manager if you are interested in learning how to better manage your asthma. Telephonic coaching teaches you about the disease, identifying triggers and medications.

We send you helpful information about items such as controller and rescue medications and asthma action plans.

Diabetes

Care Managers are available to help you manage type 1, type 2 or gestational (when you are pregnant) diabetes. Diabetes supplies and lab work are Covered Services, including hemoglobin A1c and lipids tests and yearly dilated eye exams. We also offer telephonic diabetes education. A Care Manager can provide education, coaching and answers your questions about diabetes. Care Managers also provide information that increases your knowledge of your diabetes and helps you focus on areas of diabetes where you feel you need better understanding. The Care Management Team can help you arrange appointments with your PCP and any Specialists you may need to see. You can also take American Diabetes Association-approved diabetes classes. Our Care Management Team is happy to assist you in finding the classes closest to your community.

Chronic Obstructive Pulmonary Disease (COPD)

Care Managers are available to provide one-on-one telephonic coaching. If you are interested in learning how to improve the management of your COPD, we will discuss the use of inhalers, methods to avoid going to the emergency room, and tests that help you achieve your best respiratory health. We will send you educational materials and direct you to internet-based education sites. We will also reach out to and coordinate care with your Providers as needed.

Heart Failure

Care Managers are available to help you better understand and manage heart failure. We can provide one-on-one telephonic coaching to teach you about your condition, your medications, and ways to manage your symptoms. A Care Manager may talk with you about recognizing early warning signs, such as sudden weight gain, swelling, or shortness of breath, so you can take action before your symptoms get worse.

We can help you learn how to follow your care plan, including managing your diet, fluids, and activity level. We will also send you educational materials and tools to support your daily care. The Care Management Team can help coordinate care with your PCP and specialists to make sure you receive the services you need and help you avoid unnecessary hospital visits.

Chronic Kidney Disease (CKD) / End Stage Renal Disease (ESRD)

Care Managers are available to help you understand and manage chronic kidney disease or end stage renal disease. We offer one-on-one telephonic coaching to teach you about your condition, treatment options, and medications. A Care Manager can explain how to manage your diet, fluids, and other lifestyle changes that support kidney health.

If you are receiving dialysis or need specialty care, we can help coordinate appointments and services with your providers. We will also send you educational materials to help you better understand your condition and treatment plan. The Care Management Team is here to support you, answer your questions, and help you stay on track with your care.

If you'd like to opt out of disease management while you are mid-program, please tell the care manager that you are no longer interested.

For more information on disease management, visit tuftshealthplan.com/TogetherDM or call us at 888-257-1985 (TTY: 711).

Community Health Services

Community Health Worker (CHW) consults may be prompted by events that could adversely impact the health and well-being of a member. CHWs are frontline public health workers who apply their unique understanding of the experience, language, and culture of the populations they serve to act as liaisons between health and social services and the community, helping to facilitate members' access to care and guiding them in navigating the health care system. CHWs may:

- Get information about and apply for food assistance programs, including SNAP (food stamps)
- Learn about and request benefits such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), if eligible
- Help Navigate the Department of Transitional Assistance (DTA) and/or the Social Security Administration
- Provide information about programs that help cover utility costs (electricity and heating assistance)
- Connect to additional community-based services beyond those offered through our program
- Identify disability-related resources
- Access transportation options for medically necessary appointments, if eligible(based on your area/availability)
- Receive health education and information tailored to your specific needs
- Explore available community resources and public benefits
- Support coordination and communication with your healthcare providers
- Learn about alternatives and community resources for ongoing care when benefits are limited or exhausted

To get Community Health Services or for more information, call us at 888-257-1985 (TTY: 711).

Medical Respite Services

We cover medical respite services for members experiencing homelessness. These services provide short-term, facility-based care to support recovery from illness or injury when a safe home environment is not available. Services are covered when determined Medically Necessary and provided by an approved medical respite provider. Please call Member Services at 888-257-1985 (TTY: 711) for more information on these services.

Health Related Social Needs (HRSN) Services

As a Tufts Health Plan CHA member, you may be able to get help with food and housing support through MassHealth's Health Related Social Needs (HRSN) Services program. For example, you could get help with purchasing fruits and vegetables and help searching for housing. Please see your Covered Services List, in Appendix A of this Member Handbook, for more details about HRSN Services. Please call Member Services at 888-257-1985 (TTY: 711) for more information. You can also reach out to your Primary Care Provider at Cambridge Health Alliance and ask to speak with a Patient Resource Coordinator or Care Manager to be

screened and referred to the services. Please call Member Services at 888-257-1985 (TTY: 711) for more information on being screened and referred to these services.

Maternity programs

Our maternity programs are designed to support you during your pregnancy and complement the care provided by your obstetrical (OB) team and other Providers. Our staff assists you in planning for a healthy pregnancy, labor and delivery. Once your pregnancy has been confirmed, we ask your OB/GYN Provider to submit a Pregnancy Notification Form after your first prenatal visit. The form collects important information that allows our care managers to understand how to best support your pregnancy. You can also call us directly at 888-257-1985 to notify us of your pregnancy.

If you have a high-risk pregnancy, you can work directly with our high-risk pregnancy nurses, who support you during your pregnancy. Call us at 888-257-1985 (TTY: 711) for more information. Also see page 36 for more information on the EXTRAS that you can receive during your pregnancy.

EXTRAS

Only current, eligible Members can get the EXTRAS. Note: Some restrictions may apply, and we reserve the right to stop giving an EXTRAS at any time.

EXTRAS are subject to change. Go to tuftshealthplan.com/TogetherExtras for up-to-date information about EXTRAS, including eligibility. You can also download the EXTRAS Form(s). To request EXTRAS, follow the directions on the form and send us the completed form.

Gift card to use to buy children's car seats

We help your kids ride in style. Members who are 28 or more weeks pregnant, and Members who are 8 years old or younger, are eligible to get a $25 gift card to use toward buying a convertible car seat (for kids 5–40 pounds and 19–43 inches tall).

Also, one year later, as long as your child is a Member, you can get a $25 gift card to use toward buying a booster car seat (for kids 30–100 pounds and 43–57 inches tall).

How to get this benefit:

1. Visit tuftshealthplan.com/TogetherExtras or call us at 888-257-1985 (TTY: 711) to get a copy of the EXTRAS Car Seat Reward Form.
2. Fill out the form and make a copy for yourself.
3. Mail the completed form to:

   Tufts Health Plan
   Attn: Claims Department
   P.O. Box 524
   Canton, MA 02021-1166

4. Watch your mail for instructions on how to redeem your gift card online or by mail.

Note: Members can get one gift card to use to buy a car seat every 12 months, and two gift cards in total during their membership. Gift cards are valid only for a convertible or booster car seat. You must be an eligible Member when you order your car seat gift card and when we process your EXTRAS Form.

Rewards for healthy behaviors

To help our young Members get and stay healthy, we reward their healthy actions. We list below how you and your kids can earn a gift card from us.

- Get the recommended childhood immunizations and screenings by age 2, and we'll send you a $25 supermarket gift card.
- Get the recommended adolescent immunizations by age 13, and we'll send you a $10 department store gift card.
- Get an annual wellness visit (ages 3–9), and we'll send you a $25 supermarket gift card.
- Get an annual wellness visit (ages 10–17), and we'll send you a $10 department store gift card
- Get an annual wellness visit (ages 18 and older), and you can receive a $25 supermarket gift card.

Note: The current childhood immunizations and screenings include: four DTaP, four Hib, four PCV, three Hep B, three IPV, three Rota, one Hep A, one MMR, one Varicella, blood lead screening and a yearly flu shot (note that children should receive two annual flu shots before their second birthday). Your child's doctor will talk to you about the best time to get these immunizations. We also send you reminder cards in the mail around the time your child should get these immunizations.

Note: The current recommended immunizations for adolescents include: one meningococcal vaccine, one Tdap, and a complete two-dose or three-dose schedule of the HPV vaccine by their 13th birthday.

How to get these benefits:

1. Visit tuftshealthplan.com/TogetherExtras or call us at 888-257-1985 (TTY:711) to get a copy of the Reward Form.
2. Fill out the form and make a copy for yourself.
3. Mail the completed form to:

   Tufts Health Plan
   Attn: Claims Department
   P.O. Box 524
   Canton, MA 02021-1166
4. Watch your mail for instructions on how to redeem your gift card online or by mail.

Note: You must be a Member at the time of the doctor visit(s) and when we process your Reward Form. Members can get one gift card every 12 months for each eligible healthy behavior.

Fitness reimbursement

We help you stay fit. After you've been a Tufts Health Plan Member for three months and completed one of several types of fitness activities, we'll give you up to $30 back. While this benefit is available to all Members every 12 months, Members age 18 and younger must get a parent's permission to join a gym or participate in a fitness activity.

- Eligible fitness activities include but are not limited to:
- Gym and health club memberships, including YMCAs and Jewish Community Centers (JCCs)
- Yoga, Pilates and fitness classes
- Salsa and other types of dance classes
- Sports leagues, like soccer and basketball
- Martial arts classes, like karate and tai chi

Please discuss any diet or exercise program with your PCP before you begin.

How to get your reimbursement:

1. Visit tuftshealthplan.com/TogetherExtras or call us at 888-257-1985 (TTY: 711) to get a copy of the Reimbursement Form.
2. Fill out the form and make a copy of the form and your itemized receipt for yourself.
3. Mail the completed form and your itemized receipt to:

   Tufts Health Plan
   Attn: Claims Department
   P.O. Box 524
   Canton, MA 02021-1166
4. Watch your mail for your reimbursement of up to $30, which should arrive in six to eight weeks.

Note: You must be a Tufts Health Plan Member when you sign up for your gym membership or fitness activity and when we process your Reimbursement Form. Members can get one $30 reimbursement every 12 months.

Rewards and help for your health care needs

Our clinicians can help you with your health care needs. To speak with a clinician, call us at 888-257-1985 (TTY: 711).

If you are pregnant

We give our pregnant Members help during and after a pregnancy to make sure they have as healthy a pregnancy and baby as possible.

- Get a $25 supermarket gift card after attending childbirth, newborn or breastfeeding classes.
- Get a $25 supermarket gift card after visiting a Women, Infants and Children (WIC) office twice during your pregnancy.

- Get help choosing a doctor for your baby.
- Get a gift card to use to buy a car seat. See page 34 for more information.

Call us at 888-257-1985 (TTY: 711) as soon as you know you are pregnant to find out about these benefits.

How to get the $25 gift cards:

1. Visit tuftshealthplan.com/TogetherExtras or call us at 888-257-1985 (TTY: 711) to get a copy of the Reward Form and New Baby Care Form.
2. After visiting WIC twice during pregnancy, fill out the information on the Reward Form.
3. After attending a new baby care class, fill out the information on the New Baby Care Form. Submit with an itemized receipt and confirmation of attendance or certificate of completion.
4. Make a copy of the form(s) and other documents you send us for yourself.
5. Mail the completed form(s) to:

   Tufts Health Plan
   Attn: Claims Department
   P.O. Box 524
   Canton, MA 02021-1166
6. Watch your mail for instructions on how to redeem your gift card online or by mail.

Note: You must be a Member each time you visit WIC, when you attend the new baby care class, and when we process your Reward Form. Member can get both of the $25 gift cards during each pregnancy.

After having a baby

Get a $25 supermarket gift card if you visit your OB/GYN for a postpartum visit between 7 and 84 days after you have your baby.

How to get the $25 gift card:

1. Visit tuftshealthplan.com/TogetherExtras or call us at 888-257-1985 (TTY: 711) to get a copy of the Reward Form.
2. Fill out the information on the form and make a copy of the form for yourself.
3. Mail the completed form to:

   Tufts Health Plan
   Attn: Claims Department
   P.O. Box 524
   Canton, MA 02021-1166
4. Watch your mail for instructions on how to redeem your gift card online or by mail.

Note: You must be a Member when you have your postpartum visit and when we process your Reward Form. Members can get one $25 gift card after each pregnancy.

If you have asthma

- Get a $25 supermarket gift card for filling out an asthma action plan with your PCP.
- Get information on asthma and a copy of an asthma action plan by calling us at 888-257-1985 (TTY: 711) or by visiting tuftshealthplan.com.

How to get the $25 gift card:

1. Visit tuftshealthplan.com/TogetherExtras or call us at 888-257-1985 (TTY: 711) to get a copy of the Reward Form.
2. Visit your PCP and fill out the asthma action plan together.
3. Make a copy of the asthma action plan and the form for yourself.
4. Mail the completed form and the asthma action plan to:

   Tufts Health Plan
   Attn: Claims Department
   P.O. Box 524
   Canton, MA 02021-1166
5. Watch your mail for instructions on how to redeem your gift card online or by mail.

Note: You must be a Member when you fill out the asthma action plan and when we process your Reward Form. Members can get one $25 gift card every 12 months.

If you have diabetes

- Get a $25 supermarket gift card for getting an eye exam, two blood sugar (HbA1c) tests, a protein test and a blood cholesterol test every 12 months.
- To get information about diabetes, call us at 888-257-1985 (TTY: 711) or visit tuftshealthplan.com.

How to get the $25 gift card:

1. Visit tuftshealthplan.com/TogetherExtras or call us at 888-257-1985 (TTY: 711) to get a copy of the Reward Form.
2. Visit your PCP, complete the tests, and fill out the information on the form.
3. Make a copy of the form for yourself.
4. Mail the completed form to:

   Tufts Health Plan
   Attn: Claims Department
   P.O. Box 524
   Canton, MA 02021-1166
5. Watch your mail for instructions on how to redeem your gift card online or by mail.

Note: You must be a Member when you get the five screenings and when we process your Reward Form. Members can get one $25 gift card every 12 months for completing the five screenings.

Renewing your benefits

Each year MassHealth members must renew their MassHealth benefits. There are two ways to renew:

1. Automatic renewal. When you have had no changes in your Eligibility criteria within the previous year, and MassHealth can confirm it, you are automatically renewed as a MassHealth Member. MassHealth notifies you if your MassHealth membership has automatically renewed.

OR

2. Prepopulated review form. If MassHealth cannot confirm your Eligibility criteria, then you may need to send them more information. MassHealth sends you a “prepopulated review” (or prefilled) form with the information they have on file. You have 45 days to complete, sign and mail this form back to MassHealth. If you don’t return this form, you risk losing your MassHealth and your health plan benefits.

You can return this form by mail, online at MAhealthconnector.org or by calling the MassHealth Enrollment Center at 800-841-2900 (TTY: 711) from 8:45 a.m. to 5 p.m.

If you get Transitional Aid to Families with Dependent Children (TAFDC), you can also renew your MassHealth benefits with your caseworker or your local Department of Transitional Assistance (DTA) office. To find your local DTA office, call 877.382.2363. If you receive both MassHealth and Supplemental Nutrition Assistance Program (SNAP) benefits (formerly food stamps), you will be a part of MassHealth’s Express Lane renewal process. Your MassHealth benefits will be automatically renewed at the time of your annual review.

If you would like to find out whether other members of your household are eligible for MassHealth and our health plan, just add their contact information to the prepopulated review form or update your online account at MAhealthconnector.org.

Effective Coverage Date

The Effective Coverage Date is the date you become a Member of our health plan and are eligible to get Covered Services from In-network Providers. For members of MassHealth Standard/CommonHealth, MassHealth Family Assistance and MassHealth CarePlus, your Effective Coverage Date is one business day after MassHealth tells Tufts Health Plan about your enrollment.

Protecting your benefits

Fraud and abuse

Help reduce health care Fraud and abuse and protect the MassHealth program for everyone. Member and Provider Fraud or abuse includes:

- Your lending your Member ID Card to someone else
- Your getting prescriptions for controlled substances in an improper way
- Your doctors billing us for services you did not get

To report potential Fraud and/or abuse, or if you have questions, please call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, or email us at

fraudandabuse@point32health.org. We don't need your name or Member information. You can also call our confidential hotline anytime at 877.824.7123, or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
1 Wellness Way
Canton, MA 02021-1166

Disenrollment

Voluntary Disenrollment

You are able to change health plans only during your annual 90-day Plan Selection Period. Once your annual Plan Selection Period has ended, you will be in a Fixed Enrollment Period. You are unable to disenroll from health plans until your next Plan Selection Period, except in limited circumstances. To disenroll from our health plan, call the MassHealth Customer Service Center at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m. For members of MassHealth Standard/CommonHealth, MassHealth Family Assistance and MassHealth CarePlus, voluntary Disenrollments are usually effective one business day after we get the request from MassHealth.

After Disenrollment, we provide coverage for:

- Covered Services, through the date of your Disenrollment
- Any custom-ordered equipment we approved prior to your Disenrollment, even if you don't get the equipment until after your Disenrollment

Disenrollment because of loss of Eligibility

If you become ineligible for MassHealth coverage, MassHealth will disenroll you from our health plan. Your coverage ends on the same date as your MassHealth Disenrollment. MassHealth may automatically re-enroll you in our health plan if you become eligible again for MassHealth. Remember to answer all MassHealth requests for information in order to avoid being disenrolled as a MassHealth Member.

Disenrollment for cause

We have the right to submit a written request to MassHealth to disenroll you due to disruptive behavior which impairs our ability to furnish services to you or other Members. We make serious efforts to work with you to resolve the issue. In addition, we send you Advance Notice to describe the behavior, its impact, and to let you know you may be disenrolled as a result of continued disruptive behavior. We do not ask to disenroll you because your health is poor, you use medical services, you missed appointments, you lack mental capacity, or you display negative behavior related to your special needs.

MassHealth decides whether to approve our request for Disenrollment. If MassHealth disenrolls you as a Member, MassHealth will send you a letter letting you know of the Disenrollment and will contact you about your other health plan options.

Your rights

As our Member, you have the right to:

- Be treated with respect and dignity regardless of your race, ethnicity, creed, religious belief, sexual orientation or source of payment for care
- Get Medically Necessary treatment, including Emergency care
- Get information about us and our services, Primary Care Providers (PCPs), Specialists, other Providers, and your rights and responsibilities
- Have a candid, easy-to-understand discussion of appropriate or Medically Necessary treatment options for your condition(s), regardless of cost or benefit coverage
- Work with your PCP, Specialists and other Providers to make decisions about your health care
- Accept or refuse medical or surgical treatment
- Call your PCP and/or Behavioral Health (mental health and/or substance use disorder) Provider's office 24 hours a day, seven days a week
- Expect that your health care records are private, and that we abide by all laws regarding confidentiality of patient records and personal information, in recognition of your right to privacy
- Get a Second Opinion for proposed treatments and care; Tufts Health Plan pays for the second opinion consultation visit
- File a Grievance to express dissatisfaction with us, your Providers, or the quality of care or services you get
- Appeal a denial or Adverse Action we make for your care or services
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Ask for more information or an explanation on anything included in this *Member Handbook*, either orally or in writing
- Ask for a duplicate copy of this *Member Handbook* at any time
- Get written notice of any significant and final changes to our Provider Network, including but not limited to PCP, Specialist, Hospital and facility terminations that affect you
- Ask for and get copies of your medical records, and ask that we amend or correct the records, if necessary
- Get the services in your *Covered Services List*
- Make recommendations about our Member rights and responsibilities policy
- Ask for and get this *Member Handbook* and other health plan information translated into your preferred language or in your preferred format

- Freely exercise your rights without adversely affecting the way we or your Providers treat you

Advance Directives

Advance Directives, also called living wills or durable powers of attorney, are written instructions that communicate your health care decisions if you are not capable of doing so. Advance Directives are recognized under Massachusetts law and relate to getting health care when a person isn't capable of making a decision. If you are no longer able to make decisions about your health care, having an Advance Directive in place can help. These written instructions tell your Providers how to treat you if you aren't able to make your own health care decisions.

In Massachusetts, if you are at least 18 years old and of sound mind, you can make decisions for yourself. You may also choose someone as your health care agent or health care proxy. Your health care agent or proxy can make health care decisions for you in the event that your Providers determine you are unable to make your own decisions.

As a Member, you have certain rights that relate to an Advance Directive. To choose a health care agent or proxy, you must fill out a Health Care Proxy Form, available from your Provider or your health plan. You can also request a Health Care Proxy Form from the Commonwealth of Massachusetts. Write to the address below and send a self-addressed and stamped envelope to:

Commonwealth of Massachusetts
Executive Office of Elder Affairs
1 Ashburton Place, Room 517
Boston, MA 02108

With Advance Directives, you also have the right to:

- Make decisions about your medical care
- Get the same level of care and be free from any form of discrimination, whether or not you have an Advance Directive
- Get written information about your Provider's Advance Directive policies
- Include your Advance Directive in your medical record

Our Providers comply with state law concerning Advance Directives. We also educate staff and people they interact with in the community about Advance Directives.

Your responsibilities

As a Member, you have the responsibility to:

- Treat all Providers with respect and dignity
- Keep appointments, be on time, or call if you'll be late or need to cancel an appointment

- Give us, your Primary Care Provider (PCP), Specialists and other Providers complete and correct information about your medical history, medicine you take and other matters about your health in order to provide care
- Ask for more information from your PCP and other Providers if you don't understand what they tell you
- Participate with your PCP, Specialists and other Providers to understand and help develop mutually agreed upon plans and goals to improve your health
- Follow plans and instructions for care that you have agreed to with your Providers
- Understand that refusing treatment may have serious effects on your health
- Contact your PCP or Behavioral Health (mental health and/or substance use disorder) Provider for follow-up care within 48 hours after you visit the emergency room
- Change your PCP or Behavioral Health Provider if you are not happy with your current care
- Voice your concerns and complaints clearly
- Tell us if you have access to any other insurance
- Tell us if you suspect potential Fraud and/or abuse
- Tell us and the state about any address, phone or PCP changes

Your concerns

Inquiries

An Inquiry is any question or request that you may have about our operations. As a Member, you have the right to make an Inquiry. We do our best to respond to your Inquiry within one business day.

Grievances

A Grievance is an expression of dissatisfaction you or your Designated Representative (someone you have authorized in writing to act on your behalf) makes about any action or inaction by us that is not an Adverse Action. As a Member, you or your Designated Representative, if you identify one, has the right to file a Grievance with us. You may file a Grievance at any time and for any reason, including if:

- You are dissatisfied with the quality of care or services you get
- One of your Providers or one of our employees is rude to you
- You believe one of your Providers or one of our employees did not respect your rights
- You disagree with our decision to extend the time frame for making an Authorization decision or a Standard Internal or Expedited (fast) Appeal decision
- You disagree with our decision not to expedite an Internal Appeal request

Your Designated Representative can file a Grievance for you. You can appoint a Designated Representative by sending us a signed Authorized Representative Form. You can get a form by calling our Member Services

Team at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays. You can also find the form at tuftshealthplan.com.

If we don't get your signed Designated Representative Form within 30 days of someone other than you filing a Grievance on your behalf, we dismiss the Grievance.

How to file a Grievance

You or your Designated Representative may file a Grievance in the following ways:

- **Telephone** — call us at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **TTY/TTD** — people with hearing loss can call our TTY line at 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **Mail** — mail a Grievance to:

  Tufts Health Plan
  Attn: Appeals and Grievances Department
  1 Wellness Way
  Canton, MA 02021-1166
- **Email** — email a Grievance via the "Contact us" section of our website at tuftshealthplan.com
- **Fax** — fax a Grievance to us at 857-304-6342
- **In person** — visit 1 Wellness Way, Canton, MA 02021-1166, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

We will help you fill out forms and follow procedures related to all Grievances, including providing interpreter services.

Once you file a Grievance, we:

- Tell you and your Designated Representative in writing within one business day that we received your Grievance
- Look into the substance of your request, including any aspect of clinical care involved
- Tell you and your Designated Representative in writing of the outcome of your Grievance within 30 days from when we receive your Grievance
- Document the substance of your Grievance Review request and the actions taken
- Provide interpreter services, if necessary

You also have the right to file a Grievance with the Executive Office of Health and Human Services. You can call MassHealth Customer Service at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., to file a Grievance.

How to request a Grievance Decision Review

If you are dissatisfied with how we resolve your Grievance, you can call MassHealth Customer Service at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., to file a complaint. You or your Designated Representative may also request a Grievance Decision Review with Tufts Health Plan in the following ways:

- **Telephone** — call us at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **TTY/TTD** — people with hearing loss can call our TTY line at 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **Mail** — request a Grievance Decision Review by mailing your request to:

  Tufts Health Plan
  Attn: Appeals and Grievances Department
  1 Wellness Way
  Canton, MA 02021-1166
- **Email** — request a Grievance Decision Review by email via the "Contact us" section of our website at tuftshealthplan.com
- **Fax** — request a Grievance Decision Review by faxing us at 857-304-6342
- **In person** — visit 1 Wellness Way, Canton, MA 02021-1166, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

Once we get your Grievance Decision Review request, we:

- Tell you and your Designated Representative in writing within one business day that we received your request
- Look into the substance of your request, including any aspect of clinical care involved
- Resolve your Grievance Decision Review within 30 days from when we receive your request, and let you and your Designated Representative know of the outcome in writing
- Document the substance of your Grievance Decision Review request and the actions taken
- Provide interpreter services, if necessary

If at any time you are dissatisfied with the outcome of the Grievance process, you can file a complaint by calling MassHealth Customer Service at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

Appeals

As a Member, you or your Designated Representative (someone you have authorized in writing to act on your behalf) has the right to request an Internal Appeal for us to review an Adverse Action.

Adverse Actions are the following actions or inactions:

- Our decision to deny payments for all or part of a requested service
- One of your Providers' failures to provide Covered Services within the time frames we describe in this *Member Handbook* (see the section "Access to Covered Services" on page 4)
- Our decision to deny or provide limited Authorization for a requested service
- Our decision to reduce, suspend or end a previously authorized service
- Our decision to deny, in whole or in part, payment for a service where coverage of the requested service is at issue
- Our failure to act on a request for Prior Authorization within the time frames we describe in this *Member Handbook* (see the section "Prior Authorization for Services" on page 12)
- Our failure to follow the Internal Appeal time frames as we explain in the following pages
- Our decision to involuntarily transfer you to a different PCP

You or your Designated Representative has specific rights in the Internal Appeals process, including the right to:

- Make an appointment to present information in person or in writing within the Internal Appeal time frames
- Send us written comments, documents or other information about your Internal Appeal
- Review your case file, which includes information such as medical records and other documents and records we consider during the Internal Appeal process
- File a Grievance if we ask for more time to make an Internal Appeal decision, and you or your Designated Representative disagrees
- File a Grievance if we deny your request for an Expedited Appeal, and you or your Designated Representative disagrees with that decision

Your Designated Representative can request an Internal Appeal for you. You can appoint a Designated Representative by sending us a signed Designated Representative Form. You can get a form by calling our Member Services Team at 888-257-1985 (TTY: 711). You can also find the form at tuftshealthplan.com. If a Provider acting as your Designated Representative requests an Appeal, we must have the Designated Representative Form showing us that the Provider has permission to act on your behalf.

If we don't get a completed and signed Designated Representative Form within 30 days of an Appeal request, this person cannot act as your representative. The Designated Representative Form must be signed by you, naming the person you want to represent you for your Internal Appeal, and by your representative. It must then be sent to us by:

- **Fax** — 857-304-6321

OR

- **Mail** —

  Tufts Health Plan
  Attn: Appeals and Grievances Department
  1 Wellness Way
  Canton, MA 02021-1166

If you have any questions, please call 888-257-1985 (TTY: 711).

You have the right to an Internal Appeal for any Adverse Action if you request a Standard or Expedited Internal Appeal. You also have the right to further appeal our decision about your upheld Internal Appeal decision by requesting an External Review (Fair Hearing) through the Board of Hearings (BOH) as outlined on page 49. We will help you fill out forms and follow procedures related to all Appeals, including providing interpreter services.

Requesting an Internal Appeal

You or your Designated Representative can request an Internal Appeal to ask that we review any Adverse Action in the following ways:

- **Telephone** — call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **TTY/TTD** — people with hearing loss can call our TTY line at 711, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
- **Mail** — request an Internal Appeal by mail, with a copy of the notice of Adverse Action for an Internal Appeal to us, at:

  Tufts Health Plan
  Attn: Appeals and Grievances Department
  1 Wellness Way
  Canton, MA 02021-1166
- **Email** — request an Internal Appeal by email via the “Contact us” section of our website at tuftshealthplan.com
- **Fax** — request an Internal Appeal by faxing us at 857-304-6321
- **In person** — visit 1 Wellness Way, Canton, MA 02021-1166, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays

You or your Designated Representative must request your Internal Appeal within 60 days of the notification of Adverse Action, as described in this *Member Handbook* (or, if you don’t get a notice, within 60 days from when you learn of the Adverse Action). You or your Designated Representative may also send us written comments, documents or any additional information about your Internal Appeal. We let you and your Designated Representative know in writing within one business day that we have received your Internal Appeal request.

If we don’t have enough information to make a decision about your Internal Appeal, we ask you for it. If you don’t give us the additional information, we may deny your Internal Appeal.

If we don’t receive your Internal Appeal request within 60 days, we consider the Adverse Action final. We dismiss Internal Appeals you or your Designated Representative request after 60 days. If you or your

Designated Representative believes that you requested your Internal Appeal on time, you or your Designated Representative has the right to request that we reverse the dismissal and continue your Internal Appeal.

Standard Internal Appeal

If a Provider acting as your Designated Representative requests an Appeal on your behalf, we request the Designated Representative Form showing us that the Provider has permission to act on your behalf.

After looking into your Standard Internal Appeal, including any additional information from you, your Designated Representative or your Providers, we send you a copy of your case file. We ask you to review it and provide any additional information prior to making our decision. After sufficient time for your review, we make a decision about your Standard Internal Appeal based on a review by a health care professional or professional with the appropriate clinical expertise. This person will not have been involved in any prior review, nor be a subordinate of someone who did. We make our decision within 30 days from the date we receive your request.

If we need more information, and we expect our review to take longer than 30 days, we let you and/or your Designated Representative know and ask for an extension of 14 days. At that time, we give you and/or your Designated Representative a new date for us to resolve your issue. We may ask for an extension if we need more information to make a decision, if we believe the information would lead to us approving your request, and if we can reasonably expect to get this information in 14 days.

If you disagree with our decision to take an extension, you or your Designated Representative can file a Grievance with us as we described previously. Also, you or your Designated Representative has the right to ask for an extension of 14 days to give us more information.

Unless you indicate to us that you don't want to get Continuing Services, we keep covering previously approved services until we decide your Internal Appeal, as long as we receive your request for an Internal Appeal within 10 days from the notice of Adverse Action (or, if you don't receive any notice, within 10 days from when you learn of the Adverse Action).

If we deny your Internal Appeal, you or your Designated Representative may request an External Review (Fair Hearing) from the Board of Hearings (BOH), following the process described later in the BOH section on page 49.

Expedited (fast) Appeal

When you want an Internal Appeal, and the Appeal is about acute medical and/or Behavioral Health (mental health and/or substance use disorder) services and taking the time for a Standard Internal Appeal could seriously jeopardize your life, health, or ability to attain, maintain or regain maximum function, we have an Expedited Appeal process.

You or your Designated Representative can request an Expedited Appeal in any of the ways we described previously; in addition, you or your Designated Representative may request an Expedited Appeal at night, on weekends or on holidays. You or your Designated Representative must request your Expedited Appeal within 60 days of the notification of Adverse Action (or, if you don't receive a notice, within 60 days from when you learn of the Adverse Action).

Unless you or your Designated Representative tells us that you don't want to receive Continuing Services, we keep covering previously approved services until we make a decision about your Expedited Appeal, as long as

we get the request within 10 days from the notice of Adverse Action (or, if you don't receive a notice, within 10 days from when you learned of the Adverse Action).

If a Provider acting as your Designated Representative requests an Expedited Appeal on your behalf, or if your Provider confirms your request meets the criteria to be expedited, then we approve the request to speed up the Appeal.*

*Although we require having a Designated Representative Form telling us you have someone acting on your behalf, we do not hold up processing your Appeal while we wait to receive the form if the request was submitted by your Provider.

If the request for an Expedited Appeal doesn't have to do with a specific health condition, we may or may not decide to speed up your Appeal. If we deny your Expedited Appeal request, we tell you and your Designated Representative within one business day and treat your request as a Standard Internal Appeal (as we described earlier). You or your Designated Representative may file a Grievance if you disagree with our decision to deny your request for an Expedited Appeal.

If we accept your Expedited Appeal request, we make a decision as quickly as your condition requires, and in no more than 72 hours, and we tell you and your Designated Representative our decision by phone (whenever possible) and in writing. If we need more information, there is a reasonable likelihood that such information would lead to the approval of your request, and we can reasonably expect to get this information in 14 days, we'll let you know and take a 14-day extension. You or your Designated Representative may file a Grievance if you disagree with our need for this extension. You or your Designated Representative also has the right to ask for an extension of up to 14 days to give us more information.

If we deny your Expedited Appeal, you or your Designated Representative may request an External Review (Fair Hearing) directly from the BOH, following the process we describe in the next section.

Requesting an External Review (Fair Hearing) with the EOHHS, Office of Medicaid's Board of Hearings (BOH)

You or your Appeal representative may request an External Review (Fair Hearing) directly from the Board of Hearings (BOH) after we deny an Internal Appeal, or if we don't resolve these Appeals within the appropriate time frames.

We send a notice of our decision and a copy of the "How to Ask for a Fair Hearing" Form and instructions anytime we deny an Internal Appeal. You can also call us at 888-257-1985 (TTY: 711) to get a copy of the form.

You or your Appeal representative must make your request for an External Review (Fair Hearing) within 120 days from the date of our decision on your Internal Appeal.

If your External Review (Fair Hearing) involves a decision by us to reduce, suspend or terminate previously approved services, and you wish to keep receiving the services under dispute during your External Review (Fair Hearing), the BOH must receive your completed form within 10 days of our decision, and you or your Appeal representative must say on the BOH application form that you want to keep receiving these services. If the BOH decision is adverse, you may be required to pay the cost of the services.

At the Hearing, you may represent yourself or be represented by a lawyer or other representative at your own expense. You may contact a local legal service or community agency to get advice or representation at no

cost. To get information about legal services or community agencies, call the MassHealth Customer Service Center at 800-841-2900 (TTY: 711 for people with partial or total hearing loss). We comply with and implement the BOH's decision.

Questions or concerns?

If you have questions or concerns about the Grievance and/or Appeals processes, please call our Member Services Team at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Complaints

To file a complaint against MassHealth or us, call MassHealth Customer Service at 800-841-2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

My Ombudsman

My Ombudsman is an independent program that can help you if you have questions, concerns or problems related to MassHealth. You can contact My Ombudsman to get information or assistance. My Ombudsman's services are free. My Ombudsman's staff:

- Can answer your questions or refer you to the right place to find what you need.
- Can help you address a problem or concern with MassHealth or your MassHealth plan, Tufts Health Together. My Ombudsman's staff listens, investigates the issue and discusses options with you to help solve the problem.
- Help with Appeals. An Appeal is a formal way of asking your MassHealth plan, MassHealth or Medicare to review a decision about your services. My Ombudsman's staff can talk with you about how to make an Appeal and what to expect during the Appeal process.

You can call or email My Ombudsman.

- **Call**: 855-781-9898 (TTY: 711)
- **Email:** info@myombudsman.org
- **Address:** 25 Kingston Street, 4th Floor, Boston, MA 02111

You can also visit My Ombudsman's office by appointment or during walk-in hours. Walk-in hours are:

- Tuesdays from 10 a.m. to 3 p.m. and
- Thursdays from 10 a.m. to 3 p.m.

When you have additional insurance

You must tell us if you have any other health insurance coverage in addition to MassHealth. You must also let us know when there are any changes in your additional insurance coverage. The types of additional insurance you might have include:

- Coverage from an employer's group health insurance for employees or retirees that covers you and/or any dependents in your household, including your spouse

- Coverage under Workers' Compensation because of a job-related illness or injury
- Coverage from Medicare or other public insurance
- Coverage for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through veterans' benefits
- "Continuation coverage" that you have through COBRA. (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions.)

We are the payer of last resort for medical services involving Coordination of Benefits and third-party liability or Subrogation. Please see the following sections for more information.

Coordination of Benefits

When you have other health insurance coverage, we work with your other insurance to coordinate your benefits. This process is called Coordination of Benefits. The way we work with other companies or state agencies depends on your situation. Through this Coordination of Benefits, you often get your health insurance coverage as usual through us. If you have other health insurance, our coverage is always secondary when the other plan provides you with health care coverage, unless the law states something different. In other situations, such as for care we don't cover, an insurer or agency other than us may be able to cover you. If you have additional health insurance, please call us at 888-257-1985 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, to find out how payment is handled.

If you have comprehensive health insurance with another health plan, including Medicare, you cannot get MassHealth benefits from us. If you fit this category, MassHealth will disenroll you from our health plan. MassHealth will notify you about this.

Subrogation

If another person's action or omission injures you, your benefits will be subrogated. Subrogation means that we may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If another person or party is, or may be, liable to pay for services related to your illness or injury that we may have paid for or provided, we subrogate and succeed to all your rights to recover against such person or party 100 percent of the value of services we pay for or provide.

Your Provider should submit all Claims incurred as a result of any Subrogation case before any settlement. We may deny Claims for services rendered before a settlement when your Provider does not submit Claims before that settlement is reached.

In the event another party reimburses any medical expense we pay for, we are entitled to recover from you 100 percent of the amount you got from us for such services. Attorney's fees and/or expenses you incur do not reduce the amount you must pay back to us.

To enforce our Subrogation rights under this *Member Handbook*, we have the right to take legal action, with or without your consent, against any party to recover the value of services we provide or cover for which that party is, or may be, liable. Nothing in this *Member Handbook* may be interpreted to limit our right to use any means provided by law to enforce our rights to Subrogation under this plan.

We require you to follow all Prior Authorization requirements even when third-party liability exists. Authorization is not a guarantee of payment.

Motor vehicle accidents and/or work-related injury/illness

If you are in a motor vehicle accident, you must use all of your auto insurance carrier's medical coverage (including Personal Injury Protection and/or medical payment coverage) before we consider paying for any of your expenses. You must send us any explanation of payment or denial letters from an auto insurance carrier for us to consider paying a Claim that your Provider sends to us.

In the case of a work-related injury or illness, the Workers' Compensation carrier is responsible for those expenses first.

Member cooperation

As a Member, you agree to cooperate with us in exercising our Subrogation and Coordination of Benefits rights. This means you must complete and sign all necessary documents to help us exercise our rights, and you must notify us before settling any Claim arising out of injuries you sustained by any liable party for which we have provided coverage. You must not do anything that might limit our right to full reimbursement. These Subrogation and recovery provisions apply even if you are a minor.

We ask that you:

- Give us all information and documents we ask for
- Sign any documents we think are necessary to protect our rights
- Promptly assign us any money you receive for services that we've provided or paid for
- Promptly notify us of any potential Subrogation or Coordination of Benefits
- You also must agree to do nothing to prejudice or interfere with our rights to Subrogation or Coordination of Benefits. Nothing in this *Member Handbook* may be interpreted to limit our right to use any means provided by law to enforce our rights to Subrogation or Coordination of Benefits under this plan.

Our responsibilities

We are required by law to maintain the privacy of your individually identifiable health information, known as Protected Health Information (PHI), across our organization, including oral, written and electronic PHI. We ensure the privacy of your PHI in a number of ways. For example, employees don't discuss your PHI in public areas. We monitor breaches of security. We keep any paper PHI in secure spaces. We must follow the terms of this notice (or any revised notice) when using or disclosing your PHI. We may revise this notice at any time. If we do, changes will apply to any of your PHI that we maintain, and we make a copy of the revised notice available at tuftshealthplan.com or upon request.

Tufts Health Plan[1] Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Tufts Health Plan values your privacy rights and is committed to safeguarding your demographic, medical, and financial information we may receive or collect when providing services to you. The information we collect includes protected health information ("PHI") and personal information ("PI"). PHI is information that relates to your physical or behavioral health condition, your health care, or the payment for your health care. PI includes information like your name and Social Security number. PHI and PI are referred to as "information" elsewhere in this notice.

We may obtain your information from a number of sources, such as through your enrollment in a plan or from doctors and hospitals who submit Claim forms containing your information so that we may pay them for services they provided to you.

HOW WE PROTECT YOUR INFORMATION

We are required by law to maintain the privacy of all forms of your information including electronic, written, and verbal information. To support this, Tufts Health Plan has documented privacy and security policies and procedures which include physical and technical safeguards for protecting, using and disclosing information in compliance with applicable state and federal laws. Tufts Health Plan protects electronic information through private networks, passwords, authentication requirements and ongoing monitoring of security threats. Access to your information is limited to employees who require it to do their job. In addition, all employees must complete annual privacy and security training. Tufts Health Plan also requires its business partners who assist with administering your health care coverage to protect your information in accordance with applicable laws.

Tufts Health Plan is required by the Health Insurance Portability and Accountability Act (known as the "HIPAA" statute) to provide you with notice of our legal duties and privacy practices with respect to your information, and to follow the duties and practices described in the notice currently in effect. We may change the terms of this notice at any time and apply the new notice to any information we already maintain. If we make an important change to our notice, we will publish the updated notice on our website at **www.tuftshealthplan.com**.

HOW WE USE AND DISCLOSE YOUR INFORMATION

In order to administer your health care coverage, including paying for your health care services, we need to use and disclose your information in a number of ways. Tufts Health Plan's policies require that we only use or disclose the minimum amount of information necessary for the intended purpose. In certain circumstances, Tufts Health Plan is permitted or required by law (including the HIPAA statute) to use or disclose your information without your written authorization.

The following are examples of the types of uses and disclosures we are permitted or required by federal law to make without your written authorization). Where state or other federal laws, including 42 C.F.R. Part 2 ("Part 2"), offer you greater privacy protections, we will follow the more stringent requirements.

[1] Tufts Health Plan includes Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., Tufts Insurance Company, TAHP Brokerage Corporation, Point32Health Services, Inc. Group Health Plan, and self-funded plans administered by these entities.

For Payment

Tufts Health Plan may use or disclose your information for payment purposes to administer your health benefits, which may involve obtaining premiums, determination of eligibility, claims payment, and coordination of benefits. Examples include:

- Paying claims that were submitted to us by physicians and hospitals
- Providing information to a third party to administer an employee- or employer-funded account, such as a Flexible Spending Account ("FSA") or Health Reimbursement Account ("HRA"), or another benefit plan, such as a dental benefits plan
- Performing medical necessity reviews
- Sharing information with third parties for Insurance Liability Recovery ("ILR") or subrogation purposes

For Health Care Operations

Tufts Health Plan may use or disclose your information for operational purposes, such as care management, customer service, coordination of care, or quality improvement. Examples include:

- Assessing and improving the quality of service, care and outcomes for our members
- Learning how to improve our services through internal and external surveys
- Reviewing the qualifications and performance of physicians
- Evaluating the performance of our staff, such as reviewing our customer service representatives' phone conversations with you
- Seeking accreditation by independent organizations, such as the National Committee for Quality Assurance
- Engaging in wellness programs, preventive health, early detection, disease management, health risk assessment participation initiatives, case management, and coordination of care programs, including sending preventive health service reminders
- Providing you with information about a health-related product or service included in your plan of benefits
- Using information for underwriting, establishing premium rates and determining cost sharing amounts, as well as administration of reinsurance policies. (Tufts Health Plan will not use or disclose any genetic information it might otherwise receive for underwriting purposes)
- Facilitating transition of care from and to other insurers, health plans or third-party administrators
- Communicating with you about your eligibility for public programs, such as Medicare
- Other general administrative activities, including data and information systems management, risk management, auditing, business planning, and detection of fraud and other unlawful conduct

For Treatment

Tufts Health Plan may use and disclose your information for health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers) to treat you. Examples include:

- Our care managers providing your information to a home health care agency to make sure you get the services you need after discharge from a hospital
- Quality improvement programs, safety initiatives, and clinical reminders sent to your primary care provider
- Disclosing a list of medications you've received using your Tufts Health Plan coverage to alert your treating providers about any medications prescribed to you by other providers and help minimize potential adverse drug interactions
- Receiving your test results from labs you use, from your providers, or directly from you, using the results to develop tools to improve your overall health, and sharing the results with providers involved in your care

For other Permitted or Required Purposes

The following are examples of the additional types of uses and disclosures Tufts Health Plan is permitted or required by law to make without your written authorization:

- To **you, your family, and others involved in your care** when you are unavailable to communicate (such as during an emergency), when you are present prior to the disclosure and agree to it, or when the information is clearly relevant to their involvement in your health care or payment for health care
- Sharing eligibility information and copayment, coinsurance, and deductible information for dependents with the **subscriber of the health plan** in order to facilitate management of health costs and Internal Revenue Service verification
- To your **Personal Representative** (including parents or guardians of a minor, so long as that information is not further restricted by applicable state or federal laws) or to an individual you have previously indicated is your Designated Representative or is authorized to receive your information. Information related to any care a minor may receive without parental consent remains confidential unless the minor authorizes disclosure
- To our **business partners and affiliates**. Tufts Health Plan may contract with other organizations to provide services on our behalf. In these cases, Tufts Health Plan will enter into an agreement with the organization explicitly outlining the requirements associated with the protection, use and disclosure of your information. The following corporate affiliates of Tufts Health Plan designate themselves as a single affiliated covered entity and may share your information among them: Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., and Point32Health Services, Inc. Group Health Plan
- To your **plan sponsor**, when sharing information used for enrollment, plan renewal, or plan administration purposes. This is your employer or the employer of your subscriber if you are enrolled through an employer. When sharing detailed information, your plan sponsor must certify that they will

protect the privacy and security of your information and that the information will not be used for employment decisions

- To **government entities**, such as the Centers for Medicare & Medicaid Services, the Health Connector, HealthSourceRI, or MassHealth, if you are enrolled in a government-funded plan
- To provide information for **health research** to improve the health of our members and the community in certain circumstances, such as when an Institutional Review Board or Privacy Board approves a research proposal with protocols to protect your privacy, or for purposes preparatory to research
- To **comply with laws** and regulations, such as those related to **workers' compensation** programs
- For **public health activities**, such as assisting public health authorities with disease prevention or control and pandemic response efforts
- To report suspected cases of **abuse, neglect, or domestic violence**
- For **health oversight activities**, such as audits, inspections, and licensure or disciplinary actions. For example, Tufts Health Plan may submit information to government agencies such as the U.S. Department of Health and Human Services or a state insurance department to demonstrate its compliance with state and federal laws
- For **judicial and administrative proceedings**, such as responses to court orders, subpoenas, or discovery requests
- For **law enforcement purposes**, such as to help identify or locate a victim, suspect, or missing person
- Disclosures to **coroners, medical examiners, and funeral directors** about decedents. Tufts Health Plan may also disclose information about a **decedent** to a person who was involved in their care or payment for care, or to the person with legal authority to act on behalf of the decedent's estate
- To **organ procurement** organizations for cadaveric organ, eye, or tissue donation purposes, only after your prior authorization
- To **prevent a serious threat** to your health or safety, or that of another person
- For **specialized government functions**, such as national security and intelligence activities
- Disclosures by employees for **whistleblower** purposes

Other than the permitted or required uses and disclosures described above, Tufts Health Plan will only use and disclose your information, including medical records with your written authorization. For example, we require your authorization if we intend to sell your information, use or disclose your information for marketing or fundraising purposes, or, in most cases, use or disclose your psychotherapy notes. We will also require your authorization or a court order before disclosing your substance use disorder ("SUD") data from a SUD treatment program that meets the definition of a Part 2 facility under federal regulations in a civil, criminal, administrative, or legislative proceeding against you.

You may give us written authorization to use or disclose your information to any individual or organization for any purpose by submitting a completed authorization form. The form can be found at **www.tuftshealthplan.com**, or you may obtain a copy by calling Member Services at the phone number listed on your Tufts Health Plan ID card.

You may revoke such an authorization at any time in writing, except to the extent we have already made a use or disclosure based on a previously executed authorization. You may elect not to receive any fundraising communications before Tufts Health Plan uses your information related to a SUD for fundraising purposes for their own benefit.

Please be aware that when your information is disclosed in accordance with the HIPAA statute, it may be subject to redisclosure by the recipient and no longer protected by the HIPAA statute.

REPRODUCTIVE HEALTH CARE INFORMATION

Tufts Health Plan is prohibited from using or disclosing your reproductive health care information for any of the following purposes:

- To assist in a criminal, civil, or administrative investigation into or proceeding against you for seeking or obtaining lawful reproductive health care services. For example, if law enforcement officials from a state that criminalizes reproductive health services request information related to reproductive health services you obtained in a state where such services are legal, Tufts Health Plan will not provide that information

- To assist in an investigation into or proceeding against your health care provider for providing or facilitating lawful reproductive health care services. For example, Tufts Health Plan will not provide law enforcement and/or other law officials with information pertaining to provider that provides reproductive health services in a state where such services are legal

If Tufts Health Plan receives a request for your reproductive health care information, the requestor will be required to sign an attestation in certain scenarios to confirm they will not use your information for a non-permitted purpose. For example, we will require the requestor to sign an attestation if the request is related to health oversight activities or law enforcement purposes.

YOUR RIGHTS WITH RESPECT TO YOUR INFORMATION

The following are examples of your rights under federal law with respect to your information. You may also be entitled to additional rights under state law.

Request a Restriction

You have the right to request we restrict the way we use and disclose your information for treatment, payment, or health care operations, to individuals involved in your care, or for notification purposes, including asking that we not share your information for health research purposes. We are not, however, required by law to agree to your request.

Request Confidential Communications

You have the right to request we send communications to you at an address of your choice or that we communicate with you by alternative means. For example, you may ask us to mail your information to an address that is different than your subscriber's address. We accommodate reasonable requests.

Access Your Information and Receive a Copy

You have the right to access, inspect, and obtain a copy of your information maintained by Tufts Health Plan (with certain exceptions). We have the right to charge a reasonable fee for the cost of producing and mailing copies of your information.

Amend Your Information

You have the right to request we amend your information if you believe it is incorrect or incomplete. We may deny your request in certain circumstances, such as when we did not create the information. For example, if a Provider submits medical information to Tufts Health Plan that you believe is incorrect, the Provider needs to amend that information.

Receive an Accounting of Disclosures

You have the right to request an accounting of those instances in which we disclosed your information, except for disclosures made for treatment, payment, or health care operations, or for other permitted or required purposes. Your request must be limited to disclosures in the six years prior to the request. If you request an accounting more than once in a 12-month period, we may charge you a reasonable fee.

Receive a Copy of this Notice of Privacy Practices

You have the right to receive a paper copy of this notice from us at any time upon request.

Be Notified of a Breach

You have the right to be notified if there is a breach of your unsecured information by us or our business partners. We provide you written notice via mail unless we do not have up-to-date contact information for you. In these cases, we notify you by a substitute method, such as posting the notice on our public website.

You may exercise any of your privacy rights described above by contacting Member Services at the phone number listed on your Tufts Health Plan ID card. In some cases, we may require you to submit a written request. Tufts Health Plan does not require you to waive your rights as a condition of the provision of treatment, payment, enrollment in a health plan, or Eligibility for benefits.

WHOM TO CONTACT WITH QUESTIONS OR COMPLAINTS

If you believe your privacy rights have been violated or you would like more information, you may send a question or complaint to:

Privacy Officer
Point32Health
1 Wellness Way
Canton, MA 02021

Or you may call our Compliance Hotline at 877-824-7123 or Member Services at the phone number listed on your Tufts Health Plan ID card.

You also have the right to submit a complaint to the Secretary of the Department of Health and Human Services. You can find more information at www.hhs.gov/ocr.

Tufts Health Plan does not take retaliatory action against you for filing a complaint.

THIS NOTICE IS EFFECTIVE JUNE 30, 2025, AND REPLACES THE VERSION DATED SEPTEMBER 1, 2022.

Mental Health Parity

Federal and state laws require that all Managed Care Organizations, including our health plan, provide Behavioral Health services (mental health and/or substance use disorder) to MassHealth members in the same way they provide physical health services. This is what is referred to as “parity.” In general, this means that:

- We must provide the same level of benefits for any mental health and substance use disorder issues you may have as for physical problems you may have
- We must have similar Prior Authorization requirements and treatment limitations for mental health and substance use disorder services as we do for physical health services
- We must provide you or your Provider with the Medical Necessity criteria used by us for Prior Authorization upon your or your Provider’s request
- We must also provide you, within a reasonable time frame, the reason for any denial of Authorization for mental health or substance use disorder services

If you think that we are not providing parity as explained above, you have the right to file a Grievance with us. For more information about Grievances and how to file them, please see the Grievances section of this *Member Handbook*.

You may also file a Grievance with MassHealth. You can do this by calling the MassHealth Customer Service Center at 800-841-2900 (TTY: 711), Monday through Friday, 8 a.m. to 5 p.m.

Compliance with state and federal laws

We comply with all applicable federal and state laws, including:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act (3/29/2021)

Glossary

To help you understand what you need to know about your health plan, we have capitalized important words and terms throughout this *Member Handbook*. Here you can find definitions for each of these terms.

An **Accountable Care Organization (ACO)** is a team of doctors and health care providers led by your Primary Care Provider (PCP). The team’s mission is to help you meet your health goals while making it easier for you to get high-quality care.

An **Advance Directive** is a legal document, sometimes called a living will, durable power of attorney for health care or health care proxy, with written instructions that you create to manage your care if you are no longer capable of making decisions about your own health care. A living will gives instructions for treatment in the

case of lifesaving or life-sustaining situations. A health care proxy or a durable power of attorney for health care lets you choose someone specifically to make decisions for you if you become ill or incapacitated.

Adverse Actions are the following actions or inactions:

- If we deny payments for all or part of a requested service
- If one of our Providers fails to provide Covered Services within the time frames we describe in this *Member Handbook* (see the “Access to Covered Services” section on page 4)
- If we deny or provide limited Authorization for a requested service
- If we reduce, suspend or end a service we previously authorized
- If we don’t act on a Prior Authorization request within the time frames we describe in this *Member Handbook*
- If we don’t follow the Internal Appeal time frames we describe in this *Member Handbook*
- If we involuntarily transfer you to a different PCP

Ancillary Services are tests, procedures, imaging and support services (such as laboratory tests and radiology services) you get in a health care setting that help your Provider diagnose and/or treat your condition.

Appeal — see Internal Appeals.

Authorization — see Prior Authorization.

Behavioral Health (mental health and/or substance use disorder) services include an annual wellness exam, visits, consultations, counseling, screenings, and assessments for mental health and/or substance use disorder, as well as Inpatient, outpatient, detoxification and diversionary services.

A **Benefit Year** is the annual cycle in which your health plan operates.

The **Board of Hearings (BOH)** is an office within the Executive Office of Health and Human Services (EOHHS), Office of Medicaid.

Care Management (and Integrated Care Management) is how we regularly evaluate, coordinate and help you with your medical, Behavioral Health (mental health and/or substance use disorder) and/or social care health needs. Through Care Management, we do our best to make sure you can get high-quality, cost-effective and appropriate care; get information about disease prevention and wellness; and get and stay healthy.

The **Child and Adolescent Needs and Strengths (CANS) Tool** gives Behavioral Health Providers a standardized way of organizing information during Behavioral Health clinical assessments for Members under the age of 21 and the discharge-planning process from inpatient psychiatric hospitalizations and community-based acute treatment services.

The **Children’s Behavioral Health Initiative (CBHI)** makes sure you and your children with any significant behavioral, emotional and mental health needs get necessary services to do well at home, in school and in your community.

A **Children's Behavioral Health Initiative (CBHI) network** offers a variety of wraparound services for certain children under 21 years old. These include Intensive Care Coordination (ICC) and family support and training services to MassHealth-eligible youth with serious emotional disturbance (SED) and their families/caregivers offered through Community Service Agencies (CSAs; see definition below). Other CBHI services include In-Home Therapy, In-Home Behavioral Services, Family-based Intensive Treatment (FIT) and Youth Mobile Crisis Intervention (YMCI). For more information about CBHI services or to find a CSA or other CBHI service Provider, you can talk to your Primary Care Provider, or call our Member Services Team at 888-257-1985 (TTY: 711). You can also find this information at tuftshealthplan.com and in our *Provider Directory*. Call us if you'd like a copy of the *Provider Directory*.

A **Claim** is a bill your Provider sends us to ask us to pay for services you get.

A **Community Behavioral Health Center (CBHC)** offers treatment for mental health conditions and substance use disorders, including routine appointments, urgent visits, and 24/7 community-based crisis intervention and stabilization services as an alternative to hospital emergency departments.

A **Community Service Agency (CSA)** offers Intensive Care Coordination (ICC), family support and training services, and Family-based Intensive Treatment (FIT) to MassHealth-eligible youth with serious emotional disturbance (SED) and their families/caregivers. There are 32 CSAs across the state. For more information about CSA services or to find a CSA, you can talk to your Primary Care Provider or call our Member Services Team at 888-257-1985 (TTY: 711). You can also find this information at tuftshealthplan.com and in our *Provider Directory*. Call us if you'd like a copy of the *Provider Directory*.

Continuing Services include any service or services you get while waiting for a decision on an Internal Appeal and/or a Board of Hearings (BOH) External Review (Fair Hearing). This includes when the Appeal was filed within 10 days and involves the reduction, suspension or termination of a previously authorized course of treatment; the original period covered by the original Authorization has not expired; and you have requested an extension of benefits. Unless you clearly say that you don't want to get these services, you will continue to get these services until you withdraw the Internal Appeal or BOH External Review (Fair Hearing) or the BOH issues a decision to uphold the original Internal Appeal decision. If the BOH upholds our original decision, you may have to pay back to MassHealth the cost of the requested services you received.

Continuity of Care is how we make sure you keep getting the care you need when your doctor is no longer in our Network or when you first become a Member and you are getting care from another doctor who is not in our Network.

Coordination of Benefits is how we get money from other people to pay for your health care needs when you have coverage from more than one insurer.

Covered Services are the services and supplies our health plan and MassHealth cover. The *Covered Services List* in Appendix A of this *Member Handbook* has all of your Covered Services and supplies. You can call Member Services at 888-257-1985 (TTY: 711) or visit tuftshealthplan.com for copies of your *Covered Services List* or *Member Handbook*.

A **Designated Representative** is someone you are designating in writing to make decisions related to your benefit plan and receive information related to your healthcare.

A **Designated Representative Form** is a form to designate a representative to act your behalf and authorize Tufts Health Plan to disclose your protected health information to that representative.

Disenrollment is the process by which a Member's coverage ends.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are Preventive Care and treatment services, such as physicals and child wellness visits and developmental screenings, which MassHealth Standard and CommonHealth Members under the age of 21 can get from a Primary Care Provider (PCP) at certain identified ages. These include a complete assessment (e.g., physical, mental, and developmental health screens), service coordination, crisis intervention and in-home services.

Effective Coverage Date (or Effective Date) is the date when you become a Member of our health plan and eligible for Covered Services. Generally, for Members of MassHealth Standard/CommonHealth and Family Assistance, your Effective Coverage Date is one business day after MassHealth tells us about your enrollment. For MassHealth CarePlus Members, your Effective Coverage Date is the first day of the month following your enrollment. So, if you joined MassHealth CarePlus on July 3, your Effective Coverage Date would be Aug. 1.

Eligibility is whether or not you qualify for MassHealth benefits.

An **Emergency** is a medical or Behavioral Health (mental health and/or substance use disorder) condition with such serious symptoms, including such severe pain, that a person with an average knowledge of health and medicine could realistically expect that not getting medical attention right away would result in the health of the Member (or in the case of a pregnant woman, the health of the woman and/or unborn child) being put in serious danger. This danger could include serious damage to bodily function or a serious problem with any body organ or part; or, in the case of a pregnant woman who is having contractions, if there isn't enough time to safely transfer to another Hospital before delivery, or if that transfer could be harmful to the health of the woman or unborn child.

An **Expedited (fast) Appeal** is an oral or written request for a fast review of an Adverse Action when your life, health or ability to attain, maintain or regain maximum function will be at risk if we follow our standard time frames when reviewing your request.

An **External Review (Fair Hearing)** is a written request to the Executive Office of Health and Human Services (EOHHS), Office of Medicaid's Board of Hearings (BOH) to review Tufts Health Plan's decisions on Appeals. EOHHS refers to an External Review as a "Fair Hearing."

Fair Hearing is another term for a Board of Hearings (BOH) External Review.

Family-planning Services are services you can get from any contracted MassHealth Provider and your Primary Care Provider (PCP) without a Referral. Family-planning Services include birth control methods, exams, counseling, pregnancy testing and some lab tests.

Fraud is when someone dishonestly gets services or payment for services but doesn't have a right to them under MassHealth or Tufts Health Plan rules. An example of Fraud is Members lending their health plan Member ID Cards to other people so they can get health care or pharmacy services.

A **Grievance** is any expression of dissatisfaction by you or your Designated Representative about any action or inaction by our health plan that is not an Adverse Action. Reasons to file Grievances may include but are not limited to the quality of care or services provided, rudeness on the part of a Provider or employee of our health plan, failure to respect your rights, a disagreement you may have with our decision not to approve a request to speed up an Internal Appeal, and a disagreement with our requests to extend the time frames for resolving an Authorization decision or an Internal Appeal.

Grievance Decision Review is a second review of a Grievance decision by our health plan.

Hospice Services are services designed to meet the needs of Members who are certified with a terminal illness and have a life expectancy of six months or less if the illness runs its normal course. Hospice Services include routine Hospice care, continuous home care, Inpatient respite care and general Inpatient care.

A **Hospital** is any licensed facility that provides medical and surgical care for patients who have acute illnesses or injuries and that the American Hospital Association lists as a Hospital or The Joint Commission accredits.

In-network Provider is a Provider our health plan contracts with to provide Covered Services to Members.

Inpatient Services are services that need at least one overnight stay in a hospital setting. This generally applies to services you get in licensed facilities, such as Hospitals and skilled-nursing facilities.

An **Inquiry** is any question or request you have.

Intensive Care Coordination (ICC) is a program certain Members with hard-to-manage, unstable, and/or long-lasting medical and Behavioral Health (mental health and/or substance use disorder) conditions can get if working with a team of dedicated clinicians and professionals will help.

Integrated Care Management (ICM) is a Care Management program we offer Members. ICM may include community support programs and services, in-home therapy, crisis-prevention planning and follow-up support.

Internal Appeals are oral or written requests for our health plan to review an Adverse Action. The Contractor may only have one level of Internal Appeal for Enrollees consistent with 42 CFR 438.402(b).

MassHealth is the medical assistance or benefits programs (also known as Medicaid) that the Executive Office of Health and Human Services (EOHHS) manages. Tufts Health Plan covers MassHealth Members under the Standard, CommonHealth, Family Assistance and CarePlus plans.

MassHealth CarePlus offers health benefits for adults ages 21 to 64 who are not eligible for MassHealth Standard.

MassHealth CommonHealth offers similar health benefits as MassHealth Standard to disabled adults and disabled children or young adults who cannot get MassHealth Standard because their income is too high.

MassHealth Family Assistance offers health benefits to children, young adults, certain immigrants, and HIV-positive men and women who cannot get MassHealth Standard, CommonHealth or CarePlus.

MassHealth Standard offers a full range of health care benefits. It is available to individuals who are under age 21, pregnant women, parents or caregiver relatives living with a child under the age of 19, disabled individuals (as determined by standards set by federal and state law — individuals must have a mental or physical condition that limits their ability to work for at least 12 months), HIV-positive individuals, former foster care individuals up to age 26, individuals who are getting services or are on a waiting list to get services from the Department of Mental Health, individuals with breast or cervical cancer, and Medically Frail individuals who are otherwise eligible for CarePlus. Income Eligibility levels vary for these different groups.

A **Medically Frail** individual has special health care needs. For example, an individual who has a medical, mental health or substance use disorder condition that limits the ability to work or go to school; needs help with daily activities, like bathing or dressing; regularly gets medical care, personal care or health services at home or in another community setting, like adult day care; or is terminally ill.

Medically Necessary or Medical Necessity are services that are, within reason, intended to prevent, diagnose, stop the worsening of, improve, correct or cure conditions that endanger your life, cause suffering or pain, cause physical deformity or malfunction, may cause or worsen a disability, or that could result in making you very sick and for which there is no other medical service or site of service that could give you the same result, that is available and suitable for you, and that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care and must be validated by records including evidence of such Medical Necessity and quality.

A **Member** is anyone enrolled in our health plan by choice or assignment by the Executive Office of Health and Human Services (EOHHS), or its designees.

Your ***Member Handbook*** is this document that describes the Covered Services you get with our health plan. It is our agreement with you and includes any riders, amendments or other documents that add to the details of Covered Services.

A health plan **Member Identification Card (Member ID Card)** is the card that identifies you as a Member of our health plan. Your Member ID Card includes your name and your Member ID number. You must show it and your MassHealth ID Card to Providers and pharmacists before you get services. If you lose your Member ID Card, or if someone steals your Member ID Card, call us to get another one.

Member Services Team is the team at our health plan that handles all of your questions about policies, procedures, requests and concerns. You can reach our Member Services Team at 888-257-1985 (TTY: 711). We are available Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Network or Provider Network is the collective group of Providers who have contracted with Tufts Health Public Plans, Inc., to provide Covered Services.

Non-Symptomatic Care is care not associated with any visible health signs. Examples include well visits and physical examinations. See also Preventive Care.

Non-urgent Symptomatic Care is care associated with visible health signs and symptoms but not requiring immediate health attention. Examples include visits for recurrent headaches or fatigue.

Our **Notice of Privacy Practices** tells you about how we may use and disclose your Protected Health Information (PHI). To read our Notice of Privacy Practices, go to tuftshealthplan.com or call 888-257-1985 (TTY: 711) to have a copy mailed to you.

Our **NurseLine** is our help line for health questions, 24 hours a day, seven days a week. When you call our 24/7 NurseLine at 888-MY-RN-LINE (888-697-6546) (TTY: 711), you can talk with a caring and supportive health care professional at any hour and at no cost. Our 24/7 NurseLine staff can give you information and support on health care issues like symptoms, diagnosis and test results, as well as treatments, tests and procedures your Provider has ordered. The NurseLine doesn't replace your Provider.

An **Out-of-network Provider** is a Provider we don't contract with to provide Covered Services to Members.

Post-stabilization Care Services are Covered Services that help you get better and stay healthy after an Emergency health condition. You can get Post-stabilization Care Services at Hospitals and all health care centers that provide Emergency services.

Preventive Care includes a variety of services for adults and children, such as annual physicals, blood pressure screenings, immunizations, behavioral assessments for children and many other services to help keep you healthy.

Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services are Preventive Care and treatment services that MassHealth Family Assistance Members under the age of 21 can get from a Primary Care Provider (PCP) on a periodic schedule.

Primary Care is comprehensive, coordinated medical care you get during a first visit and at any following visit. Primary Care involves an initial medical history intake, medical diagnosis and treatment, Behavioral Health (mental health and/or substance use disorder) screenings, communication of information about illness prevention, health maintenance and Prior Authorizations.

A **Primary Care Provider (PCP)** is the individual Provider or team you pick, or to whom we assign you, to take care of all of your health care needs. PCPs who are doctors must practice one of the following specialties: family practice, internal medicine, general practice, adolescent and pediatric medicine, or obstetrics/gynecology (for women only). PCPs must be board-certified or eligible for board certification in their area of specialty. You may also choose a nurse practitioner or a licensed physician's assistant as a PCP if the nurse practitioner or a licensed physician's assistant is a participating Provider in our Network. PCPs for people with disabilities, including people with HIV/AIDS, may include practitioners in other specialties.

Prior Authorization is approval Tufts Health Plan gives for you to get a specific health care service. We must authorize certain types of services and Providers before you can get the service or see the Provider. We take into account the benefit, any benefit limits and the Provider's Network status as we make our decision.

Protected Health Information (PHI) is any information (oral, written or electronic) about your past, present or future physical or mental health or condition, or about your health care or payment for your health care. PHI includes any health information that a person could use to identify you.

A **Provider** is an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity that has an agreement with Tufts Health Plan, or its subcontractor, to deliver the Covered Services under this contract.

The ***Provider Directory*** is a publication that lists contracted health care facilities and professionals, including Primary Care Providers (PCPs), Specialists listed by specialty, Hospitals, emergency rooms and Community Behavioral Health Centers (CBHCs), pharmacies, Ancillary Services, Behavioral Health (mental health and/or substance use disorder) services and school-based health centers. You can call us at 888-257-1985 (TTY: 711) to get a *Provider Directory*.

A **Referral** is notification from your PCP to us that you can get care from a different Provider.

A **Region** is the area where you live and where you should pick your Primary Care Provider (PCP).

A **Second Opinion** is a consultation you can get on a medical procedure from an In-network Provider. Your Primary Care Provider (PCP) will refer you to a contracted In-network Provider for a Second Opinion. We must give Prior Authorization when your Provider wants you to get a Second Opinion from a Provider who is not part of the Provider Network. Tufts Health Plan pays for any costs related to your getting a Second Opinion from a contracted In-network Provider or, with Prior Authorization, from a Provider who is not part of the Provider Network.

Service Area is the geographic area in which our health plan has developed a Network of Providers to provide adequate access to Covered Services for Members.

A **Specialist** is a Provider who is trained to provide specialty medical services, such as cardiologists (heart doctors), obstetricians (doctors who take care of pregnant women) and dermatologists (skin doctors).

Subrogation is the procedure under which our health plan can recover the full or partial cost of benefits paid from a third person or entity, such as an insurer.

Urgent Care includes services that are not Emergency or routine.

Utilization Management is our constant process of reviewing and evaluating the care you get to make sure that it is appropriate and what you need.

Utilization Review is our process of looking at information from doctors and other clinicians to help us decide what services you need to get better or stay healthy. Our formal review methods help us monitor the use of — or evaluate the clinical necessity, appropriateness or efficiency of — Covered Services, procedures or settings. The review methods may include but are not limited to ambulatory review, prospective review, Second Opinion, certification, concurrent review, Care Management, discharge planning or retrospective review.

Workers' Compensation is insurance coverage employers maintain under state and federal law to cover employees' injuries and illnesses under certain conditions.

2026

Tufts Health Together with CHA

Covered Services List

TUFTS Health Plan

a Point32Health company

CHA Cambridge Health Alliance

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COVERED SERVICES LISTS

MassHealth Standard & CommonHealth, MassHealth CarePlus, and MassHealth Family Assistance

Please refer to the following pages for exact details and/or limitations, including prior authorization requirements.
Each coverage type may have different covered services and benefits available to our members.

MassHealth Standard & MassHealth CommonHealth Coverage 68

MassHealth CarePlus Coverage 95

MassHealth Family Assistance Coverage 115

Covered Services List for Tufts Health Together Members with MassHealth Standard & MassHealth CommonHealth Coverage

Overview

The following table is an overview of the covered services and benefits for MassHealth Family Assistance members enrolled in our health plan. We will coordinate all covered services listed below. It is your responsibility to always carry your health plan and your MassHealth identification cards and show them to your providers at all appointments.

The table also shows whether each service requires

- a referral (approval from your primary care provider [PCP]);
- prior authorization (permission from us or one of our vendors); or
- both a referral and prior authorization to receive the service.

There is more information about prior authorizations and referrals in your member handbook. Before you receive some services, providers may ask about your health care needs to decide if the service is appropriate and to register you for the service with your health plan (if required). Also, please note that as of April 1, 2024, there are no copays for any MassHealth-covered service.

You can call our member services team for more information about services and benefits or to ask questions. Please see the telephone number and hours of operation for member services at the bottom of every page of this document.

- For questions about medical or behavioral health services, please call (888) 257-1985, TDD/TTY: 711.
- For more information about pharmacy services, please call (888) 257-1985, TDD/TTY: 711 or go to the MassHealth Drug List at www.mass.gov/druglist.
- For questions about dental services, please call (800) 207-5019, TDD/TTY: 711 or visit www.masshealth-dental.net.

Please keep in mind that MassHealth-covered services and benefits change from time to time and flexibilities may be available because of COVID-19. This Covered Services list is for your general information only and should not be the only thing you rely on to see if you have MassHealth coverage for the service you need. (For example, there may be limits to what is covered for a service.) The best way to find out if the service you need is covered is to call our member services team. Please see the telephone number and hours of operation for member services at the bottom of every page of this document

Also, MassHealth regulations control the covered services and benefits available to you. To look at MassHealth regulations, visit www.mass.gov/masshealth-and-eohhs-regulations.

MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Emergency Services		
Emergency Inpatient and Outpatient Services	No	No
Medical Services		
Abortion Services	No	No
Acupuncture Treatment – For use for pain relief or anesthesia.	No	Yes
Acute Inpatient Hospital Services – Includes all inpatient services in an acute hospital, such as daily physician intervention, surgery, obstetrics, behavioral health, radiology, laboratory, and other diagnostic and treatment procedures. This also includes administratively necessary days. May require prescreening.	Yes	No
Acute Outpatient Hospital Services – Services in a hospital's outpatient department or satellite clinic. They are generally provided, directed, or ordered by a physician. Services include specialty care, observation services, day surgery, diagnostic services, and rehabilitation services.	Yes	Yes
Adult Day Health Services – Center-based services, offered by Department of Public Health-licensed adult day health providers, have the general goal of meeting activities of daily living (ADLs) and/or skilled nursing and therapeutic needs, and may include • Nursing services and health oversight • Nutritional or dietary services • Care management and social service advocacy and support • Counseling activities • Transportation	*	No

*These services are covered directly by MassHealth and may require prior authorization and/or referrals. We will assist in the coordination of these services.
**These services do not require prior authorization to begin services.

MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Adult Foster Care (AFC) Services – Community-based services provided to members 16 years of age and older by a live-in caregiver that meet member's need for assistance with • Activities of daily living (ADLs); and • Instrumental activities of daily living (IADLs). The AFC provider handles nursing oversight and care management for services delivered to the member.	*	No
Ambulatory Surgery Services – Surgical, diagnostic, and medical services that provide diagnosis or treatment through operative procedures, including oral surgery, requiring general, local, or regional anesthesia to patients who do not require hospitalization or overnight services upon completion of the procedure, but who require constant medical supervision for a limited amount of time following the conclusion of the procedure.	Yes	Yes
Audiologist (Hearing) Services – Services include, but are not limited to, testing related to the determination of hearing loss, evaluation for hearing aids, prescription for hearing-aid devices, and aural rehabilitation.	No	Yes
Chiropractic Services – Chiropractic manipulative treatment, office visits, and some radiology services (e.g., X-rays).	No	Yes
Chronic Disease and Rehabilitation Hospital (CDRH) Services – Services in a CDRH for up to 100 days per admission. After 100 days in a CDRH, members will be transferred from their plan to MassHealth fee-for-service to keep receiving CDRH services. (Note: Members who also receive Nursing Facility services will be transferred after 100 days of combined CDRH and Nursing Facility services.)	Yes	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Community Health Center Services - Examples include • Specialty office visits • OB/GYN services • Pediatric services, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services • Medical social services • Nutrition services, including diabetes self-management training and medical nutrition therapy • Vaccines/immunizations • Health education	No	Yes
Day Habilitation Services – Center-based services for members with intellectual or developmental disabilities offered by a day habilitation provider may include • Nursing services and health care supervision • Developmental skills training • Individualized activities or therapies • Assistance with activities of daily living (ADLs)	*	No
Diabetes Self-Management Training – Diabetes self-management training and education services provided to a member with pre-diabetes or diabetes by a physician or certain accredited qualified health care professionals (e.g., registered nurses, physician assistants, nurse practitioners, and licensed dieticians).	No	Yes
Dialysis Services – Medically necessary renal dialysis that includes all services, supplies, and routine laboratory tests; also includes training for home dialysis.	No	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Durable Medical Equipment (DME) – Including but not limited to the purchase or rental of medical equipment, replacement parts, and repair for such items. Covered DME includes, but is not limited to, • absorbent products • breast pumps • enteral and parenteral nutrition • glucose monitors and diabetic supplies • mobility equipment and seating systems • hospital beds and accessories • augmentative and alternative communication devices, including speech generating devices (SGD) (See also Tablets for use as speech-generating devices [SGD], below.)	Yes	No
Early Intervention Services	No	Yes
Family Planning Services	No	No
Fluoride Varnish – Fluoride varnish applied to the teeth by pediatricians and other qualified health care professionals (physician assistants, nurse practitioners, registered nurses, and licensed practical nurses) to members younger than 21 years of age during a pediatric preventive care visit.	No	No
Group Adult Foster Care (GAFC) – Community-based services, provided to members 22 years of age or older by a GAFC direct care aide that meet member's need for assistance with • Activities of daily living (ADLs); and • Instrumental activities of daily living (IADLs). The GAFC provider handles nursing oversight and care management for services provided to the member.	*	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Hearing Aid Services	Yes	Yes
Home Health Services – Skilled and supportive care services provided in the member's home to meet skilled care needs and associated activities of daily living to allow the member to safely stay in their home. Available services include skilled nursing, medication administration, home health aide, and occupational, physical, and speech/language therapy.	Yes	No
Hospice Services – Members should discuss their options for hospice services with MassHealth or their health plan.	Yes	No
Infertility Services – Diagnosis of infertility and treatment of underlying medical condition.	Yes	Yes
Isolation and Recovery Site Services – Services that a member receives at an isolation and recovery site. This is a location such as a hotel or motel that contracts with EOHHS to provide safe, isolated lodging for members with a COVID-19 diagnosis.	*	No
Laboratory Services – All services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of health.	Yes	No
MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids – A service that provides targeted case management services for high-risk members younger than 21 years of age with medical complexity. MassHealth CARES for Kids provides comprehensive, high-touch care coordination for youth and their families. This service is provided in certain primary care or specialized settings where medically complex members younger than 21 years of age receive medical care. MassHealth CARES for Kids providers will serve as lead entities to coordinate prompt and individualized care across the health, educational, state agency, and social service systems.	No	No
Medical Nutritional Therapy – Nutritional, diagnostic, therapy and counseling services for the purpose of a medical condition that are provided by a physician, licensed dietician, licensed dietician/nutritionist, or other accredited qualified health care professionals (e.g., registered nurses, physician assistants, and nurse practitioners).	No	Yes

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Medical Respite Services – Short-term recuperative care in a community-based setting for eligible homeless members after hospital discharge or before certain medical procedures (such as colonoscopy preparation).	*	No
Nursing Facility Services – Services in a nursing facility. After 100 days in a nursing facility, members will be transferred from their plan to MassHealth fee-for-service to keep receiving Nursing Facility services. [Note: Members who also receive Chronic Disease Rehabilitation Hospital (CDRH) services will be transferred after 100 days of combined CDRH and Nursing Facility services.]	Yes	No
Orthotic Services – Nondental braces and other mechanical or molded devices to support or correct any defect of form or function of the human body.	Yes	Yes
Oxygen and Respiratory Therapy Equipment	Yes	No
Personal Care Attendant – Services to assist members with activities of daily living and instrumental activities of daily living. For example, • Bathing • Dressing • Mobility/Transfers • Passive range of motion • Toileting • Eating • Medication management	*	No
Podiatrist Services – Services for footcare.	No	Yes

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Primary Care (provided by member's PCC or PCP) – Examples include: • Annual wellness visit and office visits for primary care • Annual gynecological exams • Prenatal care • Diabetes self-management training • Tobacco cessation services • Fluoride varnish to prevent tooth decay in members younger than 21 years of age	No	No
Private Duty Nursing/Continuous Skilled Nursing – A nursing visit of more than two continuous hours of nursing services. This service can be provided by a home health agency, continuous skilled nursing agency, or an independent nurse.	*	No
Prosthetic Services – Nondental devices meant to replace either a lower or upper external body part lost due to amputation or congenital deformities and meant to serve as a limb or total joint replacement.	Yes	Yes
Radiology and Diagnostic Services – Examples include • X-rays • Magnetic resonance imaging (MRI) and other imaging studies • Radiation oncology services performed at radiation oncology centers (ROCs) that are independent of an acute outpatient hospital or physician service	Yes	Yes

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Remote Patient Monitoring (RPM) – Home monitoring of Enrollees for chronic disease management and e-consult services. • RPM – As of August 1, 2024, as further specified by EOHHS, certain services, provided by a physician, community health center, or hospital, to facilitate close, in-home monitoring of Enrollees who are pregnant, postpartum, have congestive heart failure, chronic obstructive pulmonary disease, or other conditions specified by EOHHS. • COVID-19 RPM - bundled services to facilitate home monitoring of Enrollees with confirmed or suspected COVID-19 who do not require emergency department or hospital level of care but require continued close monitoring. The COVID-19 RPM bundle includes all medically necessary clinical services required to facilitate seven days of close, in-home, monitoring of members with confirmed or suspected COVID-19.	No	No
School Based Health Center Services – All covered services delivered in School Based Health Centers (SBHCs).	No	No
Specialists – Examples include • Office visits for specialty care • OB/GYN (No referral needed for prenatal care and annual gynecological exam) • Medical nutritional therapy	No	Yes
Tablets (for use as speech-generating devices (SGD) – State law provides limited coverage of tablets used as SGD for certain members younger than 21 years of age, who have a diagnosis of an Autism Spectrum Disorder and a severe expressive communication disorder and for whom an SGD is medically necessary, and a tablet is the most appropriate device. If a medical device covered as Durable Medical Equipment (DME) (made solely for a medical purpose) is more appropriate, the member may receive a medically necessary speech-generating medical device. [See description of Durable Medical Equipment (DME) above.]	*	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Therapy Services – Therapy services include diagnostic evaluation, therapeutic intervention, and Caregiver training that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of functional capabilities and/or disease, injury, or congenital disorder. Examples include: • Occupational therapy • Physical therapy • Speech/language therapy	Yes	Yes
Tobacco Cessation Services – Face-to-face individual and group tobacco cessation counseling and tobacco cessation drugs, including nicotine replacement therapy (NRT).	No	No
Urgent Care Clinic Services	No	No
Vaccine Counseling Services	No	No
Wigs – As prescribed by a physician and related to a medical condition.	No	No
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for members younger than 21 years of age		
Screening Services – Members should go to their Primary Care Provider (PCP) for preventive wellness visits even when they are well. As part of these visits, PCPs can perform screenings that can identify health problems or risks. These screenings include physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems. Wellness visits with a dental provider are also covered for members younger than 21 years of age.	No	No
Diagnosis and Treatment Services – Diagnostic testing is performed to follow up when a risk is identified. Treatment is used to control, correct, or reduce health problems.	Yes	Yes

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Dental Services		
Adult Dentures – Full and partial dentures, and adjustments and repairs to those dentures, for members 21 years of age and older.	*	No
Diagnostic, Preventive, Restorative, and Major Dental Services – Used for the prevention, control, and treatment of dental diseases and the maintenance of oral health for children and adults.	*	No
Emergency-Related Dental Care	No	No
Oral Surgery – To treat a medical condition, performed in any place of service, including but not limited to an outpatient setting, such as an ambulatory surgery/outpatient hospital or a clinic or office.	Yes	Yes
Doula Services		
Doula Services – Non-medical emotional, informational, and physical support to pregnant, birthing, and postpartum members.	*	No
Transportation Services		
Transportation Services: Emergency – Ambulance (air and land) transport that generally is not scheduled but is needed on an emergency basis. These include specialty care transport (that is, an ambulance transport of a critically injured or ill member from one facility to another, requiring care beyond the scope of a paramedic).	No	No
Transportation Services: Non-Emergency – Transportation by land ambulance, chair car, taxi, and common carriers to transport a member to and from a covered service.	*	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Vision Services		
Vision Care: Medical – Includes: • Comprehensive eye exams once every year for members younger than 21 years of age and once every 24 months for members 21 years of age and older, and whenever medically necessary • Vision training • Ocular prosthesis • Contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus • Bandage lenses	Yes	Yes
Vision Care: Non-Medical – Includes: • Prescription and dispensing of ophthalmic materials, including eyeglasses and other visual aids, excluding contacts	*	*
Pharmacy Services		
The items in this section are covered as listed on the MassHealth Drug List. Delivery of medications from pharmacy providers to a personal residence, including homeless shelters, may be available.		
Compounded Drugs	Yes	No
Non-Drug Pharmacy Products	Yes	No
Over-the-Counter Medicines	Yes	No
Prescription Drugs	Yes	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Behavioral Health Services		
Diversionary Services – Mental health and substance use disorder services that are provided as clinically appropriate alternatives to behavioral health inpatient services to support a member returning to the community after a 24-hour acute placement, and to provide intensive support to maintain functioning in the community. There are two categories of diversionary services: those provided in a 24-hour facility and those provided in a non-24-hour setting or facility.		
Non 24-Hour Diversionary Services		
Community Support Program (CSP) and Specialized CSP Programs – Behavioral health services provided through community-based, mobile paraprofessional staff to members. **Community Support Program for Homeless Individuals (CSP-HI)** – A specialized CSP service to address the health-related social needs of members who • are experiencing homelessness and are frequent users of acute health MassHealth services; or • are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development. **Community Support Program for Individuals with Justice Involvement (CSP-JI)** – A specialized CSP service to address the health-related social needs of members with justice involvement who have a barrier to accessing or consistently using medical and behavioral health services. **Community Support Program Tenancy Preservation Program (CSP-TPP)** – A specialized CSP service to address the health-related social needs of members who are at risk of homelessness and facing eviction as a result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation.	**	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Intensive Outpatient Program (IOP) – A clinically intensive service that follows a discharge from an inpatient stay and helps members avoid readmission to an inpatient service and helps them move back to the community. The service provides coordinated treatment using a range of specialists.	No	No
Partial Hospitalization (PHP) – These services offer short-term day mental health programming available seven days a week, as an alternative to inpatient hospital services. These services include daily psychiatric management.	**	No
Program of Assertive Community Treatment (PACT) – A treatment team approach to providing acute, active, and long-term community-based mental health treatment, outreach, rehabilitation, and support. This service helps members maximize their recovery, set goals, and be in the community. Services are provided in the community and are available 24 hours a day, seven days a week, 365 days a year, as needed.	No	No
Psychiatric Day Treatment – Mental health services for members who do not need an inpatient hospital stay, but who need more treatment than a weekly visit. Psychiatric day treatment includes diagnostic, treatment, and rehabilitative services.	No	No
Recovery Coaching – A nonclinical service provided by peers who have lived experience with substance use disorder and who have been certified as recovery coaches. Members are connected with recovery coaches who help them start treatment. Recovery coaches also serve as a guide to help members maintain recovery and stay in the community.	**	No
Recovery Support Navigators (RSN) – Specialized care coordination services for members who have substance use disorder. This service helps members to access and receive treatment, including withdrawal management and step-down services, and to stay motivated for treatment and recovery.	**	No

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**These services do not require prior authorization to begin services.

MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Structured Outpatient Addiction Program (SOAP) – Substance use disorder services that are clinically intensive and offered in a structured setting in the day or evening. These programs can be used to help a member transition from an inpatient substance use disorder program. It can also be used by members who need more structured outpatient services for a substance use disorder. These programs may include specialized services for pregnant members, adolescents, and adults who need 24-hour monitoring.	No	No
24-Hour Diversionary Services		
Mental health and substance use disorder services used instead of inpatient hospital services. These services support a member returning to the community after an inpatient hospital stay, or help a member maintain functioning in the community.		
Acute Treatment Services (ATS) for Substance Use Disorders – Services used to treat substance use disorders on a 24-hour, seven days a week basis. Services may include assessment, use of approved medications for addictions, individual and group counseling, educational groups, and discharge planning. Pregnant members receive specialized services. Members receive additional services to treat other mental health conditions.	**	No
Clinical Support Services for Substance Use Disorders – 24-hour treatment services that can be used by themselves or after acute treatment services for substance use disorders. Services include education and counseling, outreach to families and significant others, medications for treating substance use disorders, referrals to primary care and community supports, and planning for recovery. Members with other mental health disorders receive coordination of transportation and referrals to mental health providers. Pregnant members receive coordination with their obstetrical care.	**	No
Community-Based Acute Treatment for Children and Adolescents (CBAT) – Intensive mental health services in a secure setting on a 24-hour basis, with clinical staffing to ensure the safety of the child or adolescent. Treatment may include checking medications; psychiatric assessment; nursing; one-to-one treatments to maintain the member's safety (specialing); individual, group, and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing. This service may be used as an alternative to or transition from inpatient hospital services.	**	No

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**These services do not require prior authorization to begin services.

MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Community Crisis Stabilization (CCS) – Services provided instead of inpatient hospital services. These services provide 24-hour observation and supervision for members.	**	No
Transitional Care Unit (TCU) – A community-based treatment program with high levels of supervision, structure, and support within an unlocked setting. This service serves children and adolescents younger than 19 years of age who are in the custody of the Department of Children and Families (DCF) who need group care or foster care, but who no longer require an acute level of care. This comprehensive service includes a therapeutic setting, psychiatry, case management, and treatments with a range of specialists.	**	No
Transitional Support Services (TSS) for Substance Use Disorders – A 24-hour, short-term intensive case management and psychoeducational residential program with nursing available for members with substance use disorders who have recently been detoxified or stabilized and require additional transitional stabilization before they are placed in a residential or community-based program. Members with co-occurring physical health, mental health, and substance use disorders are eligible for coordination of transportation and referrals to providers to ensure treatment for these conditions. Pregnant members are eligible for coordination of their obstetric care.	*	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Residential Rehabilitation Services for Substance Use Disorders		
Adult Residential Rehabilitation Services for Substance Use Disorders – Services for substance use disorder offered in a 24-hour residential setting. Services include at least five hours of individual or group therapy each week, case management, education, and rehabilitation based in the residence. Some residential programs serve pregnant and postpartum members, and provide assessment and management of gynecological, obstetric, and other prenatal needs, and offer parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups. Members receive coordination of transportation and referrals to mental health providers to ensure treatment for any other mental health conditions.	**	No
Co-occurring Enhanced Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour, safe, structured setting in the community. These services support the member's recovery from substance use disorders and moderate to severe mental health conditions. The services support a move back into the community and a return to social, work, and educational roles. Services are provided to support recovery. Clinical services, additional outpatient levels of care, and access to prescribers for medications are available.	**	No
Family Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for families in which a parent has a substance use disorder. Rehabilitative services that support parents and children are provided along with ongoing support for developing and maintaining interpersonal and parenting skills and support family reunification and stability. Members receive therapy, case management, education, and rehabilitation based in the residence.	**	No
Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for youth 16 to 21 years of age or young adults 18 to 25 years of age who are recovering from alcohol or other drug problems. Services include individual or group therapy, case management, education, and rehabilitation based in the residence. Members also receive coordination of transportation and referrals to mental health providers for any co-occurring mental health conditions.	**	No

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**These services do not require prior authorization to begin services.

MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Youth Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for youth 13 to 17 years of age who are recovering from alcohol or other drug problems. Services include individual or group therapy case management education and rehabilitation based in the residence. Members also receive coordination of transportation and referrals to mental health providers for any co-occurring mental health conditions.	**	No
Inpatient Services		
24-hour hospital services that provide mental health or substance use disorder treatment, diagnoses, or both.		
Administratively Necessary Day (AND) Services – Day(s) of inpatient hospital services for members who are ready for discharge, but the right setting is not available. Services include appropriate continuing clinical services.	Yes	No
Inpatient Mental Health Services – Inpatient hospital services to evaluate and treat acute psychiatric conditions. Such services may include • specialized inpatient psychiatric services provided to children or adolescents with neurodevelopmental disorders who have severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and co-occurring mental health conditions; and • specialized inpatient psychiatric services provided to members with an eating disorder diagnosis and severe associated psychiatric and medical needs in specialized eating disorder psychiatric settings.	**	No
Inpatient Substance Use Disorder Services – Inpatient hospital services that provide medically directed care and treatment to members with complex withdrawal needs, as well as co-occurring medical and behavioral health conditions.	**	No
Observation/Holding Beds – Hospital services that are used to assess, stabilize, and identify resources for members for up to 24 hours.	**	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Outpatient Behavioral Health Services – Mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may also be provided at a member's home or school. Some providers of these services offer extended hours at night or during weekends through behavioral health urgent care centers. They can offer new client assessments on the same or next day, appointments for existing clients with an urgent behavioral health need on the same or next day, medication appointments within 72 hours of an initial assessment, and follow-up appointments within 14 calendar days. These services may also be provided at a community behavioral health center (CBHC). CBHCs offer crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, screening, and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. A CBHC must provide services to adults and youths, including infants and young children, and their families. See also "crisis services."		
Standard Outpatient Services – Outpatient services most often provided in an ambulatory setting.		
Acupuncture Treatment – The insertion of metal needles through the skin at certain points on the body as an aid to members who are withdrawing from, or in recovery from, dependence on substances.	No	No
Ambulatory Withdrawal Management – Outpatient services for members who are experiencing a serious episode of excessive substance use or complications from withdrawal when neither life nor significant bodily functions are threatened.	No	No
Applied Behavioral Analysis for members under 21 years of age (ABA Services) – A service for a member younger than 21 years of age with an Autism Spectrum Disorder diagnosis (ASD) or Down Syndrome. It is used to treat challenging behaviors that interfere with a youth's ability to function successfully. This service includes behavioral assessments, interpretation of behaviors, development of a treatment plan, supervision and coordination of treatments, and parent training to address specific goals.	Yes	No
Assessment for Safe and Appropriate Placement (ASAP) – An assessment for certain sexually abusive youth or arsonists who are in the care and custody of the Department of Children and Families (DCF), and who are being discharged from an inpatient or certain diversionary settings to a family home care setting. Services are provided through a DCF-designated ASAP provider.	Yes	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Case Consultation – A meeting between the treating provider and other behavioral health clinicians, or the member's primary care physician, concerning a member. The meeting is used to identify and plan for additional services, coordinate or revise a treatment plan, and review the member's progress.	No	No
Collateral Contact – A communication between a provider and individuals who are involved in the care or treatment of a member younger than 21 years old. Providers may include school and day care personnel, state agency staff, and human services agency staff.	No	No
Couples/Family Treatment – Therapy and counseling to treat a member and their partner or family in the same session.	No	No
Diagnostic Evaluation – An assessment of a member's functioning, used to diagnose and to design a treatment plan.	No	No
Dialectical Behavioral Therapy (DBT) – Outpatient treatment involving strategies from behavioral, cognitive, and supportive psychotherapies for members with certain disorders, including members with borderline personality disorder.	No	No
Early Intensive Behavioral Intervention (EIBI) Services – Provided to eligible children younger than three years of age who have a diagnosis of Autism Spectrum Disorder or Down Syndrome.	No	No
Family Consultation – A meeting with family members or others who are important to the member and to a member's treatment. The meeting is used to identify and plan for additional services, coordinate or revise a treatment plan, and review the member's progress.	No	No
Group Treatment – Therapy and counseling to treat unrelated individuals in a group setting.	No	No
Individual Treatment – Therapy or counseling to treat an individual on a one-to-one basis.	No	No
Inpatient-Outpatient Bridge Visit – A single-session consultation led by an outpatient provider while a member is still in an inpatient psychiatric unit. This visit includes the member and the inpatient provider.	No	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Medication Visit – A visit to evaluate the appropriateness of the member's prescriptions for drugs used for behavioral health needs, as well as any need for monitoring by a psychiatrist or registered nurse clinical specialist for whether such drugs are useful and any side effects.	No	No
Opioid Treatment Services – Supervised assessment and treatment of a member, using medications approved by the Food and Drug Administration, along with a range of medical and rehabilitative services to relieve the effects of opiate addiction. Includes detoxification and maintenance treatment.	No	No
Preventive Behavioral Health Services – Short-term interventions in supportive group, individual, or family settings to cultivate coping skills and strategies for symptoms of depression, anxiety, and other social/emotional concerns, which may prevent the development of behavioral health conditions for members who are younger than 21 years old and have a positive behavioral health screen (or, in the case of an infant, a caregiver with a positive postpartum depression screening), even if the member does not meet criteria for a behavioral health diagnosis.	No	No
Psychiatric Consultation on an Inpatient Medical Unit – A meeting between a psychiatrist or advanced practice registered nurse clinical specialist and a member, at the request of the medical unit. It is used to assess the member's mental status and to consult on a behavioral health plan, including proper medications, with the medical staff.	No	No
Psychological Testing – Standardized tests used to assess a member's cognitive, emotional, neuropsychological, and verbal functioning.	Yes	No
Special Education Psychological Testing – Testing used toward the development of, or to determine the need for, an Individualized Educational Program (IEP) for children.	Yes	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Intensive Home and Community-Based Services for Youth		
Intensive behavioral health services provided to members in a community-based setting.		
Family Support and Training – A service provided to the parent or caregiver of a youth younger than 21 years of age where the youth lives. The purpose of this service is to help with the youth's emotional and behavioral needs by improving the capacity of the parent or caregiver to parent the youth. Services may include education, help in identifying and navigating available resources, fostering empowerment, links to peer/parent support and self-help groups, and coaching and training for the parent or caregiver. (Referral required by Outpatient Therapy, In-Home Therapy, or Intensive Care Coordination.)	No	No
Family-based Intensive Treatment (FIT) - This service is delivered by a team consisting of a clinician, paraprofessional, and Family Partner (FIT Team) offering a combination of medically necessary intensive family therapy, intensive care, and Family Partner engagement for youth younger than 21 years of age with serious emotional disturbance (SED). Services may be provided in any setting where the youth is naturally located, including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, childcare centers, respite settings, and other community settings.	Yes	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
In-Home Behavioral Services – This service usually includes a combination of behavior management therapy and behavior management monitoring, as follows: • **Behavior Management Monitoring** – This service includes putting the behavior plan into effect, monitoring the child's behavior, reinforcement of the plan by parents or other caregivers, and reporting to the behavior management therapist on progress toward goals in the behavior plan. • **Behavior Management Therapy** – This service includes assessment, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral goals or performance. This service addresses behaviors that interfere with the child's successful functioning. The therapist develops and monitors objectives and interventions, including a crisis-response strategy, that are written into the child's treatment plan. The therapist may also provide short-term counseling and assistance.	Yes	No
In-Home Therapy Services – This service for children that often is delivered in a teamed approach includes a therapeutic clinical intervention and training and therapeutic support paraprofessional, as follows: • **Therapeutic Clinical Intervention** – A therapeutic relationship between a Master's level clinician and the child and family. The aim is to treat the child's mental health needs by improving the family's ability to support the healthy functioning of the child within the family. The clinician develops a treatment plan and works with the family to improve problem-solving, limit-setting, communication, and emotional support or other functions. The qualified clinician may often work with a Therapeutic Training and Support paraprofessional. • **Therapeutic Training and Support** – A service provided by paraprofessional working under the direction of the Master's level clinician to support implementation of a licensed clinician's treatment plan to achieve the goals of the treatment plan. This trained individual works with a Master's level clinician to support a treatment plan that addresses the child's mental health and emotional challenges.	Yes	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Intensive Care Coordination – A service that provides targeted case management services to members younger than 21 years of age with a serious emotional disturbance (SED). This service includes assessment, development of an individualized care plan, referral, and related activities to put the care plan into effect and to monitor the care plan.	Yes	No
Therapeutic Mentoring Services – This service provides a structured, one-to-one relationship between a therapeutic mentor and a child or adolescent younger than 21 years of age. Its goal is to address daily living, social, and communication needs. Goals are written into a treatment plan that is developed by the child or adolescent and their treatment team. The service includes supporting, coaching, and training the child or adolescent in age-appropriate behaviors, communication, problem-solving, conflict resolution, and relating to others in a healthy way. The therapeutic mentor works in settings such as home, school, or community.	No	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Crisis Services – Available seven days a week, 24 hours a day to provide treatment for any member who is experiencing a mental health crisis. CBHCs can provide crisis services.		
Adult Mobile Crisis Intervention (AMCI) – Provides adult community-based behavioral health crisis assessment, intervention, stabilization, and follow-up for up to three days. AMCI services are available 24 hours a day, seven days a week, 365 days a year and are co-located at the CBHC site. Services are provided as mobile responses to the member (including in private residences) and provided via telehealth to members 21 years of age and older at the request of the member, or at the direction of the Behavioral Health Help Line when clinically appropriate. AMCIs operate adult community crisis stabilization programs with a preference for co-location of services.	No	No
Behavioral Health Crisis Evaluation Services in Acute Medical Setting – Crisis evaluations provided in medical and surgical inpatient and emergency department (ED) settings for members arriving at the ED in a behavioral health crisis. Elements of crisis evaluations include • Comprehensive Behavioral Health Crisis Assessment • Crisis Interventions • Discharge Planning and Care Coordination • Reporting and Community Collaboration	No	No
Behavioral Health Crisis Management Services in Acute Medical Settings – Crisis management services provided to members in medical and surgical inpatient and emergency department settings. Elements of crisis management include • Crisis Interventions • Discharge Planning and Care Coordination • Ongoing Required Reporting and Community Collaboration	No	No

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Youth Mobile Crisis Intervention (YMCI) – A short-term service that is a mobile, on-site, face-to-face therapeutic response to youth younger than 21 years of age experiencing a behavioral health crisis and that includes follow-up for up to seven days. YMCIs are available 24 hours a day, seven days a week, 365 days a year and are co-located at the CBHC site. Services are provided as mobile responses to the member (including in private residences) and via telehealth when that is requested by the family and is clinically appropriate. YMCIs will have access to youth community crisis stabilization (YCCS) services. YMCIs must have the capacity to accept youths voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.	No	No
Other Behavioral Health Services		
Electro-Convulsive Therapy (ECT) – A treatment that is used to treat depression that has not responded to medications and psychotherapy. This treatment initiates a seizure with an electric impulse while the member is under anesthesia.	No	No
Repetitive Transcranial Magnetic Stimulation (rTMS) – A treatment that is used to treat depression that has not responded to medications and psychotherapy. In this treatment, rapidly changing magnetic fields are applied to the brain through a wire attached to the scalp.	Yes	No
Specialing – Treatment services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the member's safety.	No	No
Health Related Social Needs (HRSN) Supplemental Nutrition Services		
Medically Tailored Home Delivered Meals – These are prepared meals for people with specific health needs. Meals are made to best support a person's specific health needs and are delivered to that person.	Yes	Yes
Nutritionally Appropriate Food Prescriptions and Vouchers – These are gift cards for buying healthy groceries.	Yes	Yes

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MassHealth Standard and CommonHealth Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Health Related Social Needs (HRSN) Supplemental Housing Services		
Housing Navigation – This service can help a person who is having housing problems to talk to their landlord, get legal help, or find a new place to live.	Yes	Yes
Healthy Homes – This service can help a person buy things and fix problems in a person's home to make it healthier for them. This service is for things that are not the landlord's job.	Yes	Yes

Excluded Services

The following services or supplies are not covered under MassHealth, unless they are medically necessary, or as noted.

- Cosmetic surgery. There are exceptions if MassHealth agrees it is necessary for
    - Treating damage following injury or illness;
    - Breast reconstruction following a mastectomy; or
    - Other procedures that MassHealth determines are medically necessary.
- Treatment for infertility. This includes in-vitro fertilization (IVF) and gamete intrafallopian tube (GIFT) procedures
- Experimental treatment
- A service or supply that is not provided by, or at the direction of, your provider or MassHealth. There are exceptions for:
    - Emergency services
    - Family planning services
- Noncovered laboratory services
- Personal comfort items such as air conditioners, radios, telephones, and televisions
- Services not otherwise covered by MassHealth, except as determined by the contractor to be medically necessary for MassHealth Standard or MassHealth CommonHealth members younger than 21 years of age. Such services are considered a Covered Service under the contract per Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

Contact MassHealth

If you have questions, please call the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711, Monday through Friday from 8:00 a.m. to 5:00 p.m.

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Covered Services List for Tufts Health Together Members with MassHealth CarePlus Coverage

Overview

The following table is an overview of the covered services and benefits for MassHealth CarePlus members enrolled in our health plan. We will coordinate all covered services listed below. It is your responsibility to always carry your health plan and your MassHealth identification cards and show them to your providers at all appointments.

The table also shows whether each service requires

- a referral (approval from your primary care provider [PCP]);
- prior authorization (permission from us or one of our vendors); or
- both a referral and prior authorization to receive the service.

There is more information about prior authorizations and referrals in your member handbook. Before you receive some services, providers may ask about your health care needs to decide if the service is appropriate and to register you for the service with your health plan (if required). Also, please note that as of April 1, 2024, there are no copays for any MassHealth-covered service.

You can call our member services team for more information about services and benefits or to ask questions. Please see the telephone number and hours of operation for member services at the bottom of every page of this document.

- For questions about medical or behavioral health services, please call (888) 257-1985 (TDD/TTY: 711).
- For more information about pharmacy services, please call (888) 257-1985 (TDD/TTY: 711 or go to the MassHealth Drug List at www.mass.gov/druglist.
- For questions about dental services, please call (800) 207-5019 (TDD/TTY: 711) or visit www.masshealth-dental.net.

Please keep in mind that MassHealth covered services and benefits change from time to time and flexibilities may be available because of COVID-19. This Covered Services list is for your general information only and should not be the only thing you rely on to see if you have MassHealth coverage for the service you need. (For example, there may be limits to what is covered for a service.) The best way to find out if the service you need is covered is to call our member services team. Please see the telephone number and hours of operation for member services at the bottom of every page of this document.

Also, MassHealth regulations control the covered services and benefits available to you. To look at MassHealth regulations, visit www.mass.gov/masshealth-and-eohhs-regulations.

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**These services do not require prior authorization to begin services.

MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Emergency Services		
Emergency Inpatient and Outpatient Services	No	No
Medical Services		
Abortion Services	No	No
Acupuncture Treatment – For use for pain relief or anesthesia.	No	Yes
Acute Inpatient Hospital Services – Includes all inpatient services in an acute hospital, such as daily physician intervention, surgery, obstetrics, behavioral health, radiology, laboratory, and other diagnostic and treatment procedures. This also includes administratively necessary days. May require prescreening.	Yes	No
Acute Outpatient Hospital Services – Services in a hospital's outpatient department or satellite clinic. They are generally provided, directed, or ordered by a physician. Services include specialty care, observation services, day surgery, diagnostic services, and rehabilitation services.	Yes	Yes
Ambulatory Surgery Services – Surgical, diagnostic, and medical services that provide diagnosis or treatment through operative procedures, including oral surgery, requiring general, local, or regional anesthesia to patients who do not require hospitalization or overnight services upon completion of the procedure, but who require constant medical supervision for a limited amount of time following the conclusion of the procedure.	Yes	Yes
Audiologist (Hearing) Services – Services include, but are not limited to, testing related to the determination of hearing loss, evaluation for hearing aids, prescription for hearing-aid devices, and aural rehabilitation.	No	Yes
Chiropractic Services – Chiropractic manipulative treatment, office visits, and some radiology services (e.g., X-rays).	No	Yes

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Chronic Disease and Rehabilitation Hospital (CDRH) Services – Services in a CDRH for up to 100 days. If the member becomes eligible for another MassHealth coverage type (e.g., MassHealth Standard or CommonHealth), this coverage may be extended beyond 100 days. (Note: Admission in a CDRH and a Nursing Facility will be treated as one admission. In those cases, 100 days of combined CDRH and Nursing Facility services are covered.)	Yes	No
Community Health Center Services – Examples include • Specialty office visits • OB/GYN services • Medical social services • Nutrition services, including diabetes self-management training and medical nutrition therapy • Vaccines/immunizations • Health education	No	Yes
Diabetes Self-Management Training – Diabetes self-management training and education services provided to a member with pre-diabetes or diabetes by a physician or certain accredited qualified health care professionals (e.g., registered nurses, physician assistants, nurse practitioners, and licensed dieticians).	No	Yes
Dialysis Services – Medically necessary renal dialysis that includes all services, supplies, and routine laboratory tests; also includes training for home dialysis.	No	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Durable Medical Equipment (DME) – Including but not limited to the purchase or rental of medical equipment, replacement parts, and repair for such items. Covered DME includes, but is not limited to, • absorbent products • breast pumps • enteral and parenteral nutrition • glucose monitors and diabetic supplies • mobility equipment and seating systems • hospital beds and accessories	Yes	No
Family Planning Services	No	No
Hearing Aid Services	Yes	Yes
Home Health Services – Skilled and supportive care services provided in the member's home to meet skilled care needs and associated activities of daily living to allow the member to safely stay in their home. Available services include skilled nursing, medication administration, home health aide, and occupational, physical, and speech/language therapy.	Yes	No
Hospice Services – Members should discuss their options for hospice services with MassHealth or their health plan.	Yes	No
Infertility Services – Diagnosis of infertility and treatment of underlying medical condition.	Yes	Yes
Isolation and Recovery Site Services – Services that a member receives at an isolation and recovery site. This is a location such as a hotel or motel that contracts with EOHHS to provide safe, isolated lodging for individuals with a COVID-19 diagnosis.	*	No
Laboratory Services – All services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of health.	Yes	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Medical Nutritional Therapy – Nutritional, diagnostic, therapy and counseling services for the purpose of a medical condition that are provided by a physician, licensed dietician, licensed dietician/nutritionist, or other accredited qualified health care professionals (e.g., registered nurses, physician assistants, and nurse practitioners).	No	Yes
Medical Respite Services – Short-term recuperative care in a community-based setting for eligible homeless members after hospital discharge or before certain medical procedures (such as colonoscopy preparation).	*	No
Nursing Facility Services – Services in a nursing facility for up to 100 days. If the member becomes eligible for another MassHealth coverage type (e.g., MassHealth Standard or CommonHealth), this coverage may be extended beyond 100 days. (Note: Admission in a Nursing Facility and a Chronic Disease Rehabilitation Hospital [CDRH] will be treated as one admission. In those cases, 100 days of combined Nursing Facility and CDRH services are covered.)	Yes	No
Orthotic Services – Nondental braces and other mechanical or molded devices to support or correct any defect of form or function of the human body.	Yes	Yes
Oxygen and Respiratory Therapy Equipment	Yes	No
Podiatrist Services – Services for footcare.	No	Yes
Primary Care (provided by member's PCC or PCP) – Examples include • Annual wellness visit and office visits for primary care • Annual gynecological exams • Prenatal care • Diabetes self-management training • Tobacco cessation services • Fluoride varnish to prevent tooth decay in members younger than 21 years of age	No	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Prosthetic Services – Nondental devices meant to replace either a lower or upper external body part lost due to amputation or congenital deformities and meant to serve as a limb or total joint replacement.	Yes	Yes
Radiology and Diagnostic Services – Examples include • X-rays • Magnetic resonance imaging (MRI) and other imaging studies • Radiation oncology services performed at radiation oncology centers (ROCs) that are independent of an acute outpatient hospital or physician service	Yes	Yes
Remote Patient Monitoring (RPM) – Home monitoring of Enrollees for chronic disease management and e-consult services. • RPM – As of August 1, 2024, as further specified by EOHHS, certain services, provided by a physician, community health center, or hospital, to facilitate close, in-home monitoring of Enrollees who are pregnant, postpartum, have congestive heart failure, chronic obstructive pulmonary disease, or other conditions specified by EOHHS. • COVID-19 RPM - bundled services to facilitate home monitoring of Enrollees with confirmed or suspected COVID-19 who do not require emergency department or hospital level of care but require continued close monitoring. The COVID-19 RPM bundle includes all medically necessary clinical services required to facilitate seven days of close, in-home, monitoring of members with confirmed or suspected COVID-19.	No	No
Specialists – Examples include • Office visits for specialty care • OB/GYN (No referral needed for prenatal care and annual gynecological exam) • Medical nutritional therapy	No	Yes

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Therapy Services – Therapy services include diagnostic evaluation, therapeutic intervention, and Caregiver training that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of functional capabilities and/or disease, injury, or congenital disorder. Examples include: • Occupational therapy • Physical therapy • Speech/language therapy	Yes	Yes
Tobacco Cessation Services – Face-to-face individual and group tobacco cessation counseling and tobacco cessation drugs, including nicotine replacement therapy (NRT).	No	No
Urgent Care Clinic Services	No	No
Vaccine Counseling Services	No	No
Wigs – As prescribed by a physician and related to a medical condition	No	No
Dental Services		
Adult Dentures – Full and partial dentures, and adjustments and repairs to those dentures, for members 21 years of age and older.	*	No
Diagnostic, Preventive, Restorative, and Major Dental Services – Used for the prevention, control, and treatment of dental diseases and the maintenance of oral health for children and adults.	*	No
Emergency-Related Dental Care	No	No
Oral Surgery – To treat a medical condition, performed in any place of service, including but not limited to an outpatient setting, such as an ambulatory surgery/outpatient hospital or a clinic or office.	Yes	Yes

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Doula Services		
Doula Services – Nonmedical emotional, informational, and physical support to pregnant, birthing, and postpartum members.	*	No
Transportation Services		
Transportation Services: Emergency – Ambulance (air and land) transport that generally is not scheduled but is needed on an emergency basis. These include specialty care transport (that is, an ambulance transport of a critically injured or ill member from one facility to another, requiring care beyond the scope of a paramedic).	No	No
Transportation Services: Non-Emergency – Transportation by land ambulance, chair car, taxi, and common carriers to transport a member to and from a covered service.	*	No
Vision Services		
Vision Care: Medical – Includes • Comprehensive eye exams once every year for members younger than 21 years of age and once every 24 months for members 21 years of age and older, and whenever medically necessary • Vision training • Ocular prosthesis • Contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus • Bandage lenses	Yes	Yes
Vision Care: Non-Medical – Includes: Prescription and dispensing of ophthalmic materials, including eyeglasses and other visual aids, excluding contacts	*	*

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Pharmacy Services		
The items in this section are covered as listed on the MassHealth Drug List. Delivery of medications from pharmacy providers to a personal residence, including homeless shelters, may be available.		
Compounded Drugs	Yes	No
Non-Drug Pharmacy Products	Yes	No
Over-the-Counter Medicines	Yes	No
Prescription Drugs	Yes	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Behavioral Health Services		
Diversionary Services – Mental health and substance use disorder services that are provided as clinically appropriate alternatives to behavioral health inpatient services to support a member returning to the community after a 24-hour acute placement, and to provide intensive support to maintain functioning in the community. There are two categories of diversionary services: those provided in a 24-hour facility and those provided in a non-24-hour setting or facility.		
Non 24-Hour Diversionary Services		
Community Support Program (CSP) and Specialized CSP Programs – Behavioral health services provided through community-based, mobile paraprofessional staff to members. **Community Support Program for Homeless Individuals (CSP-HI)** – A specialized CSP service to address the health-related social needs of members who • are experiencing homelessness and are frequent users of acute health MassHealth services; or • are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development. **Community Support Program for Individuals with Justice Involvement (CSP-JI)** – A specialized CSP service to address the health-related social needs of members with justice involvement who have a barrier to accessing or consistently using medical and behavioral health services. **Community Support Program Tenancy Preservation Program (CSP-TPP)** – A specialized CSP service to address the health-related social needs of members who are at risk of homelessness and facing eviction as a result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation.	**	No

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**These services do not require prior authorization to begin services.

MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Intensive Outpatient Program (IOP) – A clinically intensive service that follows a discharge from an inpatient stay and helps members avoid readmission to an inpatient service and helps them move back to the community. The service provides coordinated treatment using a range of specialists.	No	No
Partial Hospitalization (PHP) – These services offer short-term day mental health programming available seven days a week, as an alternative to inpatient hospital services. These services include daily psychiatric management.	**	No
Program of Assertive Community Treatment (PACT) – A treatment team approach to providing acute, active, and long-term community-based mental health treatment, outreach, rehabilitation, and support. This service helps members maximize their recovery, set goals, and be in the community. Services are provided in the community and are available 24 hours a day, seven days a week, 365 days a year, as needed.	No	No
Psychiatric Day Treatment – Mental health services for members who do not need an inpatient hospital stay, but who needs more treatment than a weekly visit. Psychiatric day treatment includes diagnostic, treatment, and rehabilitative services.	No	No
Recovery Coaching – A nonclinical service provided by peers who have lived experience with substance use disorder and who have been certified as recovery coaches. Members are connected with recovery coaches who help them start treatment. Recovery coaches also serve as a guide to help members maintain recovery and stay in the community.	**	No
Recovery Support Navigators (RSN) – Specialized care coordination services for members who have substance use disorder. This service helps members to access and receive treatment, including withdrawal management and step-down services, and to stay motivated for treatment and recovery.	**	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Structured Outpatient Addiction Program (SOAP) – Substance use disorder services that are clinically intensive and offered in a structured setting in the day or evening. These programs can be used to help a member transition from an inpatient substance use disorder program. It can also be used by members who need more structured outpatient services for a substance use disorder. These programs may include specialized services for pregnant members, adolescents, and adults who need 24-hour monitoring.	No	No
24-Hour Diversionary Services		
Mental health and substance use disorder services used instead of inpatient hospital services. These services support a member returning to the community after an inpatient hospital stay, or help a member maintain functioning in the community.		
Acute Treatment Services (ATS) for Substance Use Disorders – Services used to treat substance use disorders on a 24-hour, seven days a week basis. Services may include assessment, use of approved medications for addictions, individual and group counseling, educational groups, and discharge planning. Pregnant members receive specialized services. Members receive additional services to treat other mental health conditions.	**	No
Clinical Support Services for Substance Use Disorders – 24-hour treatment services that can be used by themselves or after acute treatment services for substance use disorders. Services include education and counseling, outreach to families and significant others, medications for treating substance use disorders, referrals to primary care and community supports, and planning for recovery. Members with other mental health disorders receive coordination of transportation and referrals to mental health providers. Pregnant members receive coordination with their obstetrical care.	**	No
Community Crisis Stabilization (CCS) – Services provided instead of inpatient hospital services. These services provide 24-hour observation and supervision for members.	**	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Transitional Support Services (TSS) for Substance Use Disorders – A 24-hour, short-term intensive case management and psychoeducational residential program with nursing available for members with substance use disorders who have recently been detoxified or stabilized and require additional transitional stabilization before they are placed in a residential or community-based program. Members with cooccurring physical health, mental health, and substance use disorders are eligible for coordination of transportation and referrals to providers to ensure treatment for these conditions. Pregnant members are eligible for coordination of their obstetric care.	*	No
Residential Rehabilitation Services for Substance Use Disorders		
Adult Residential Rehabilitation Services for Substance Use Disorders – Services for substance use disorder offered in a 24-hour residential setting. Services include at least five hours of individual or group therapy each week, case management, education, and rehabilitation based in the residence. Some residential programs serve pregnant and postpartum members, and provide assessment and management of gynecological, obstetric, and other prenatal needs, and offer parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups. Members receive coordination of transportation and referrals to mental health providers to ensure treatment for any other mental health conditions.	**	No
Cooccurring Enhanced Residential Rehabilitation Services for Substance Use Disorders Services provided in a 24-hour, safe, structured setting in the community. These services support the member's recovery from substance use disorders and moderate to severe mental health conditions. The services support a move back into the community and a return to social, work, and educational roles. Services are provided to support recovery. Clinical services, additional outpatient levels of care, and access to prescribers for medications are available.	**	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Family Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for families in which a parent has a substance use disorder. Rehabilitative services that support parents and children are provided along with ongoing support for developing and maintaining interpersonal and parenting skills and support family reunification and stability. Members receive therapy, case management, education, and rehabilitation based in the residence.	**	No
Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for youth 16 to 21 years of age or young adults 18 to 25 years of age who are recovering from alcohol or other drug problems. Services include individual or group therapy, case management, education, and rehabilitation based in the residence. Members also receive coordination of transportation and referrals to mental health providers for any cooccurring mental health conditions.	*	No
Inpatient Services		
24-hour hospital services that provide mental health or substance use disorder treatment, diagnoses, or both.		
Administratively Necessary Day (AND) Services – Day(s) of inpatient hospital services for members who are ready for discharge, but the right setting is not available. Services include appropriate continuing clinical services.	Yes	No
Inpatient Mental Health Services – Inpatient hospital services to evaluate and treat acute psychiatric conditions. Such services may include • specialized inpatient psychiatric services provided to children or adolescents with neurodevelopmental disorders who have severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and cooccurring mental health conditions; and • specialized inpatient psychiatric services provided to members with an eating disorder diagnosis and severe associated psychiatric and medical needs in specialized eating disorder psychiatric settings.	**	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Inpatient Substance Use Disorder Services – Inpatient hospital services that provide medically directed care and treatment to members with complex withdrawal needs, as well as co-occurring medical and behavioral health conditions.	**	No
Observation/Holding Beds – Hospital services that are used to assess, stabilize, and identify resources for members for up to 24 hours.	**	No
Outpatient Behavioral Health Services – Mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may also be provided at a member's home or school. Some providers of these services offer extended hours at night or during weekends through behavioral health urgent care centers. They can offer new client assessments on the same or next day, appointments for existing clients with an urgent behavioral health need on the same or next day, medication appointments within 72 hours of an initial assessment, and follow-up appointments within 14 calendar days. These services may also be provided at a community behavioral health center (CBHC). CBHCs offer crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, screening, and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. A CBHC must provide services to adults and youths, including infants and young children, and their families. See also "crisis services."		
Standard Outpatient Services – Outpatient services most often provided in an ambulatory setting.		
Acupuncture Treatment – The insertion of metal needles through the skin at certain points on the body as an aid to members who are withdrawing from, or in recovery from, dependence on substances.	No	No
Ambulatory Withdrawal Management – Outpatient services for members who are experiencing a serious episode of excessive substance use or complications from withdrawal when neither life nor significant bodily functions are threatened.	No	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Case Consultation – A meeting between the treating provider and other behavioral health clinicians, or the member's primary care physician, concerning a member. The meeting is used to identify and plan for additional services, coordinate or revise a treatment plan, and review the member's progress.	No	No
Couples/Family Treatment – Therapy and counseling to treat a member and their partner or family in the same session.	No	No
Diagnostic Evaluation – An assessment of a member's functioning, used to diagnose and to design a treatment plan.	No	No
Dialectical Behavioral Therapy (DBT) – Outpatient treatment involving strategies from behavioral, cognitive, and supportive psychotherapies for members with certain disorders, including members with borderline personality disorder.	No	No
Family Consultation – A meeting with family members or others who are important to the member and to a member's treatment. The meeting is used to identify and plan for additional services, coordinate or revise a treatment plan, and review the individual's progress.	No	No
Group Treatment – Therapy and counseling to treat unrelated individuals in a group setting.	No	No
Individual Treatment – Therapy or counseling to treat an individual on a one-to-one basis.	No	No
Inpatient-Outpatient Bridge Visit – A single-session consultation led by an outpatient provider while a member is still in an inpatient psychiatric unit. This visit includes the member and the inpatient provider.	No	No
Medication Visit – A visit to evaluate the appropriateness of the member's prescriptions for drugs used for behavioral health needs, as well as any need for monitoring by a psychiatrist or registered nurse clinical specialist for whether such drugs are useful and any side effects.	No	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Opioid Treatment Services – Supervised assessment and treatment of a member, using medications approved by the Food and Drug Administration, along with a range of medical and rehabilitative services to relieve the effects of opiate addiction. Includes detoxification and maintenance treatment.	No	No
Psychiatric Consultation on an Inpatient Medical Unit – A meeting between a psychiatrist or advanced practice registered nurse clinical specialist and a member at the request of the medical unit. It is used to assess the member's mental status and to consult on a behavioral health plan, including proper medications, with the medical staff.	No	No
Psychological Testing – Standardized tests used to assess a member's cognitive, emotional, neuropsychological, and verbal functioning.	Yes	No
Crisis Services – Available seven days a week, 24 hours per day to provide treatment for any member who is experiencing a mental health crisis. CBHCs can provide crisis services.		
Adult Mobile Crisis Intervention (AMCI) – Provides adult community-based behavioral health crisis assessment, intervention, stabilization, and follow-up for up to three days. AMCI services are available 24 hours a day, seven days a week, 365 days a year and are co-located at the CBHC site. Services are provided as mobile responses to the member (including in private residences) and provided via telehealth to members 21 years of age and older at the request of the member, or at the direction of the Behavioral Health Help Line when clinically appropriate. AMCIs operate adult community crisis stabilization programs with a preference for colocation of services.	No	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Behavioral Health Crisis Evaluation Services in Acute Medical Settings – Crisis evaluations provided in medical and surgical inpatient and emergency department (ED) settings. Elements of crisis evaluations include • Comprehensive Behavioral Health Crisis Assessment • Crisis Interventions • Discharge Planning and Care Coordination • Reporting and Community Collaboration	No	No
Behavioral Health Crisis Management Services in Acute Medical Settings – Crisis management services provided to members in medical and surgical inpatient and emergency department settings. Elements of crisis management include • Crisis Interventions • Discharge Planning and Care Coordination • Ongoing Required Reporting and Community Collaboration	No	No
Other Behavioral Health Services		
Electro-Convulsive Therapy (ECT) – A treatment that is used to treat depression that has not responded to medications and psychotherapy. This treatment initiates a seizure with an electric impulse while the member is under anesthesia.	No	No
Repetitive Transcranial Magnetic Stimulation (rTMS) – A treatment that is used to treat depression that has not responded to medications and psychotherapy. In this treatment, rapidly changing magnetic fields are applied to the brain through a wire attached to the scalp.	Yes	No
Specialing – Treatment services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the member's safety.	No	No

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MassHealth CarePlus Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Health Related Social Needs (HRSN) Supplemental Nutrition Services		
Medically Tailored Home Delivered Meals – These are prepared meals for people with specific health needs. Meals are made to best support a person's specific health needs and are delivered to that person.	Yes	Yes
Nutritionally Appropriate Food Prescriptions and Vouchers – These are gift cards for buying healthy groceries.	Yes	Yes
Health Related Social Needs (HRSN) Supplemental Housing Services		
Housing Navigation – This service can help a person who is having housing problems to talk to their landlord, get legal help, or find a new place to live.	Yes	Yes
Healthy Homes – This service can help a person buy things and fix problems in a person's home to make it healthier for them. This service is for things that are not the landlord's job.	Yes	Yes

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Excluded Services

The following services or supplies are not covered under MassHealth, unless they are medically necessary, or as noted.

- Cosmetic surgery. There are exceptions if MassHealth agrees it is necessary for
  - Treating damage following injury or illness;
  - Breast reconstruction following a mastectomy; or
  - Other procedures that MassHealth determines are medically necessary.
- Treatment for infertility. This includes in-vitro fertilization (IVF) and gamete intrafallopian tube (GIFT) procedures
- Experimental treatment
- A service or supply that is not provided by, or at the direction of, your provider or MassHealth. There are exceptions for
  - Emergency services
  - Family planning services
- Noncovered laboratory services
- Personal comfort items such as air conditioners, radios, telephones, and televisions
- Services not otherwise covered by MassHealth, except as determined by the contractor to be medically necessary for MassHealth Standard or MassHealth CommonHealth members younger than 21 years of age. Such services constitute a Covered Service under the Contract in accordance with Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

Contact MassHealth

If you have questions, please call the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Covered Services List for Tufts Health Together Members with MassHealth Family Assistance Coverage

Overview

The following table is an overview of the covered services and benefits for MassHealth Family Assistance members enrolled in our health plan. We will coordinate all covered services listed below. It is your responsibility to always carry your health plan and your MassHealth identification cards and show them to your providers at all appointments.

The table also shows whether each service requires

- a referral (approval from your primary care provider [PCP]);
- prior authorization (permission from us or one of our vendors); or
- both a referral and prior authorization to receive the service.

There is more information about prior authorizations and referrals in your member handbook. Before you receive some services, providers may ask about your health care needs to decide if the service is appropriate and to register you for the service with your health plan (if required). Also, please note that as of April 1, 2024, there are no copays for any MassHealth-covered service.

You can call our member services team for more information about services and benefits or to ask questions. Please see the telephone number and hours of operation for member services at the bottom of every page of this document.

- For questions about medical or behavioral health services, please call (888) 257-1985, TDD/TTY: 711.
- For more information about pharmacy services, please call (888) 257-1985, TDD/TTY: 711 or go to the MassHealth Drug List at www.mass.gov/druglist.
- For questions about dental services, please call (800) 207-5019, TDD/TTY: 711 or visit www.masshealth-dental.net.

Please keep in mind that MassHealth-covered services and benefits change from time to time and flexibilities may be available because of COVID-19. This Covered Services list is for your general information only and should not be the only thing you rely on to see if you have MassHealth coverage for the service you need. (For example, there may be limits to what is covered for a service.) The best way to find out if the service you need is covered is to call our member services team. Please see the telephone number and hours of operation for member services at the bottom of every page of this document.

Also, MassHealth regulations control the covered services and benefits available to you. To look at MassHealth regulations, visit www.mass.gov/masshealth-and-eohhs-regulations.

MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Emergency Services		
Emergency Inpatient and Outpatient Services	No	No
Medical Services		
Abortion Services	No	No
Acupuncture Treatment – For use for pain relief or anesthesia.	No	Yes
Acute Inpatient Hospital Services – Includes all inpatient services in an acute hospital, such as daily physician intervention, surgery, obstetrics, behavioral health, radiology, laboratory, and other diagnostic and treatment procedures. This also includes administratively necessary days. May require prescreening.	Yes	No
Acute Outpatient Hospital Services – Services in a hospital's outpatient department or satellite clinic. They are generally provided, directed, or ordered by a physician. Services include specialty care, observation services, day surgery, diagnostic services, and rehabilitation services.	Yes	Yes
Ambulatory Surgery Services – Surgical, diagnostic, and medical services that provide diagnosis or treatment through operative procedures, including oral surgery, requiring general, local, or regional anesthesia to patients who do not require hospitalization or overnight services upon completion of the procedure, but who require constant medical supervision for a limited amount of time following the conclusion of the procedure.	Yes	Yes
Audiologist (Hearing) Services – Services include, but are not limited to, testing related to the determination of hearing loss, evaluation for hearing aids, prescription for hearing-aid devices, and aural rehabilitation.	No	Yes
Chiropractic Services – Chiropractic manipulative treatment, office visits, and some radiology services (e.g., X-rays).	No	Yes

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Chronic Disease and Rehabilitation Hospital (CDRH) Services – Services in a CDRH for up to 100 days per admission. After 100 days, the member may be transferred from their plan to MassHealth fee-for-service to keep receiving CDRH services. Note: Members who also receive Nursing Facility services will be transferred after 100 days of combined CDRH and Nursing Facility services. Coverage is limited to six months, per MassHealth policy.	Yes	No
Community Health Center Services – Examples include • Specialty office visits • OB/GYN services • Medical social services • Nutrition services, including diabetes self-management training and medical nutrition therapy • Vaccines/immunizations • Health education	No	Yes
Diabetes Self-Management Training – Diabetes self-management training and education services provided to a member with pre-diabetes or diabetes by a physician or certain accredited qualified health care professionals (e.g., registered nurses, physician assistants, nurse practitioners, and licensed dieticians).	No	Yes
Dialysis Services – Medically necessary renal dialysis that includes all services, supplies, and routine laboratory tests; also includes training for home dialysis.	No	No

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Durable Medical Equipment (DME) – Including but not limited to the purchase or rental of medical equipment, replacement parts, and repair for such items. Covered DME includes, but is not limited to, • absorbent products • breast pumps • enteral and parenteral nutrition • glucose monitors and diabetic supplies • mobility equipment and seating systems • hospital beds and accessories • augmentative and alternative communication devices, including speech generating devices (SGD) (See also Tablets for use as speech generating devices [SGD], below.)	Yes	No
Early Intervention Services	No	Yes
Family Planning Services	No	No
Fluoride Varnish – Fluoride varnish applied to the teeth by pediatricians and other qualified health care professionals (physician assistants, nurse practitioners, registered nurses, and licensed practical nurses) to members younger than 21 years of age during a pediatric preventive care visit.	No	No
Hearing Aid Services	Yes	Yes
Home Health Services – Skilled and supportive care services provided in the member's home to meet skilled care needs and associated activities of daily living to allow the member to safely stay in their home. Available services include skilled nursing, medication administration, home health aide, and occupational, physical, and speech/language therapy.	Yes	No
Hospice Services – Members should discuss their options for hospice services with MassHealth or their health plan.	Yes	No

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Infertility Services – Diagnosis of infertility and treatment of underlying medical condition.	Yes	Yes
Isolation and Recovery Site Services – Services that a member receives at an isolation and recovery site. This is a location such as a hotel or motel that contracts with EOHHS to provide safe, isolated lodging for individuals with a COVID-19 diagnosis.	*	No
Laboratory Services – All services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of health.	Yes	No
Medical Nutritional Therapy – Nutritional, diagnostic, therapy and counseling services for the purpose of a medical condition that are provided by a physician, licensed dietician, licensed dietician/nutritionist, or other accredited qualified health care professionals (e.g., registered nurses, physician assistants, and nurse practitioners).	No	Yes
Medical Respite Services – Short-term recuperative care in a community-based setting for eligible homeless members after hospital discharge or before certain medical procedures (such as colonoscopy preparation).	*	No
Nursing Facility Services – Services in a nursing facility for up to 100 days per admission. After 100 days, members may be transferred from their plan to MassHealth fee-for-service to keep receiving Nursing Facility services. [Note: Members who also receive Chronic Disease Rehabilitation Hospital (CDRH) services will be transferred after 100 days of combined CDRH and Nursing Facility services.] Coverage is limited to six months, per MassHealth policy.	Yes	No
Orthotic Services – Nondental braces and other mechanical or molded devices to support or correct any defect of form or function of the human body.	Yes	Yes
Oxygen and Respiratory Therapy Equipment	Yes	No
Podiatrist Services – Services for footcare.	No	Yes

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Primary Care (provided by member's PCC or PCP) – Examples include • Annual wellness visit and office visits for primary care • Annual gynecological exams • Prenatal care • Diabetes self-management training • Tobacco cessation services • Fluoride varnish to prevent tooth decay in members younger than 21 years of age	No	No
Prosthetic Services – Nondental devices meant to replace either a lower or upper external body part lost due to amputation or congenital deformities and meant to serve as a limb or total joint replacement.	Yes	Yes
Radiology and Diagnostic Services – Examples include • X-rays • Magnetic resonance imaging (MRI) and other imaging studies • Radiation oncology services performed at radiation oncology centers (ROCs) that are independent of an acute outpatient hospital or physician service	Yes	Yes
Remote Patient Monitoring (RPM) – Home monitoring of Enrollees for chronic disease management and e-consult services. • RPM – As of August 1, 2024, as further specified by EOHHS, certain services, provided by a physician, community health center, or hospital, to facilitate close, in-home monitoring of Enrollees who are pregnant, postpartum, have congestive heart failure, chronic obstructive pulmonary disease, or other conditions specified by EOHHS. COVID-19 RPM - bundled services to facilitate home monitoring of Enrollees with confirmed or suspected COVID-19 who do not require emergency department or hospital level of care but require continued close monitoring. The COVID-19 RPM bundle includes all medically necessary clinical services required to facilitate seven days of close, in-home, monitoring of members with confirmed or suspected COVID-19.	No	No

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
School Based Health Center Services – All covered services delivered in School Based Health Centers (SBHCs).	No	No
Specialists – Examples include • Office visits for specialty care • OB/GYN (No referral needed for prenatal care and annual gynecological exam) • Medical nutritional therapy	No	Yes
Tablets (for use as speech generating devices [SGD]) – State law provides limited coverage of tablets used as SGD for certain members younger than 21 years of age, who have a diagnosis of an Autism Spectrum Disorder and a severe expressive communication disorder and for whom an SGD is medically necessary, and a tablet is the most appropriate device. If a medical device covered as Durable Medical Equipment (DME) (made solely for a medical purpose) is more appropriate, the member may receive a medically necessary speech-generating medical device. [See description of Durable Medical Equipment (DME) above.]	*	No
Therapy Services – Therapy services include diagnostic evaluation, therapeutic intervention, and Caregiver training that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of functional capabilities and/or disease, injury, or congenital disorder. Examples include: • Occupational therapy • Physical therapy • Speech/language therapy	Yes	Yes
Tobacco Cessation Services – Face-to-face individual and group tobacco cessation counseling and tobacco cessation drugs, including nicotine replacement therapy (NRT).	No	No
Urgent Care Clinic Services	**No**	**No**
Vaccine Counseling Services	**No**	**No**
Wigs – As prescribed by a physician and related to a medical condition.	No	No

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Preventive Pediatric Health-Care Screening & Diagnosis Services (PPHSD)		
Screening Services – Children should go to their Primary Care Provider (PCP) for preventive wellness visits even when they are well. As part of these visits, PCPs can perform screenings that can identify health problems or risks. These screenings include physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems. Routine visits with a dental provider are also covered for children younger than 21 years of age.	No	No
Diagnostic Services – Diagnostic testing is performed to follow up when a risk is identified.	Yes	Yes
Dental Services		
Adult Dentures – Full and partial dentures, and adjustments and repairs to those dentures, for members 21 years of age and older.	*	**No**
Diagnostic, Preventive, Restorative, and Major Dental Services – Used for the prevention, control, and treatment of dental diseases and the maintenance of oral health for children and adults.	*	**No**
Emergency-Related Dental Care	No	No
Oral Surgery – To treat a medical condition, performed in any place of service, including but not limited to an outpatient setting, such as an ambulatory surgery/outpatient hospital or a clinic or office.	Yes	Yes
Doula Services		
Doula Services – Nonmedical emotional, informational, and physical support to pregnant, birthing, and postpartum members.	*	No

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Transportation Services		
Transportation Services: Emergency – Ambulance (air and land) transport that generally is not scheduled but is needed on an emergency basis. These include specialty care transport (that is, an ambulance transport of a critically injured or ill member from one facility to another, requiring care beyond the scope of a paramedic).	No	No
Vision Services		
Vision Care: Medical – Includes • Comprehensive eye exams once every year for members younger than 21 years of age and once every 24 months for members 21 years of age and older, and whenever medically necessary • Vision training • Ocular prosthesis • Contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus • Bandage lenses	Yes	Yes
Vision Care: Non-Medical – Includes: • Prescription and dispensing of ophthalmic materials, including eyeglasses and other visual aids, excluding contacts	*	*

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MassHealth Family Assistance Covered Services	Prior authorization required for some or all of the services?	Referral required for some or all of the services?
Pharmacy Services		
The items in this section are covered as listed on the MassHealth Drug List. Delivery of medications from pharmacy providers to a personal residence, including homeless shelters, may be available.		
Compounded Drugs	Yes	No
Non-Drug Pharmacy Products	Yes	No
Over-the-Counter Medicines	Yes	No
Prescription Drugs	Yes	No

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Behavioral Health Services		
Diversionary Services – Mental health and substance use disorder services that are provided as clinically appropriate alternatives to behavioral health inpatient services, to support a member returning to the community after a 24-hour acute placement, and to provide intensive support to maintain functioning in the community. There are two categories of diversionary services: those provided in a 24-hour facility and those provided in a non-24-hour setting or facility.		
Non 24-Hour Diversionary Services		
Community Support Program (CSP) and Specialized CSP Programs – Behavioral health services provided through community-based, mobile paraprofessional staff to members. Community Support Program for Homeless Individuals (CSP-HI) – A specialized CSP service to address the health-related social needs of members who • are experiencing homelessness and are frequent users of acute health MassHealth services; or • are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development. **Community Support Program for Individuals with Justice Involvement (CSP-JI) –** A specialized CSP service to address the health-related social needs of members with justice involvement who have a barrier to accessing or consistently using medical and behavioral health services. **Community Support Program Tenancy Preservation Program (CSP-TPP) –** A specialized CSP service to address the health-related social needs of members who are at risk of homelessness and facing eviction as a result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation.	**	No

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Intensive Outpatient Program (IOP) – A clinically intensive service that follows a discharge from an inpatient stay and helps members avoid readmission to an inpatient service and helps them move back to the community. The service provides coordinated treatment using a range of specialists.	No	No
Partial Hospitalization (PHP) – These services offer short-term day mental health programming available seven days a week, as an alternative to inpatient hospital services. These services include daily psychiatric management.	**	No
Program of Assertive Community Treatment (PACT) – A treatment team approach to providing acute, active, and long-term community-based mental health treatment, outreach, rehabilitation, and support. This service helps members to maximize their recovery, set goals, and be in the community. Services are provided in the community and are available 24 hours a day, seven days a week, 365 days a year, as needed.	No	No
Psychiatric Day Treatment – Mental health services for members who do not need an inpatient hospital stay, but who needs more treatment than a weekly visit. Psychiatric day treatment includes diagnostic, treatment, and rehabilitative services.	No	No
Recovery Coaching – A nonclinical service provided by peers who have lived experience with substance use disorder and who have been certified as recovery coaches. Members are connected with recovery coaches who help them start treatment. Recovery coaches also serve as a guide to help members maintain recovery and stay in the community.	**	No
Recovery Support Navigators (RSN) – Specialized care coordination services for members who have substance use disorder. This service helps members to access and receive treatment, including withdrawal management and step-down services, and to stay motivated for treatment and recovery.	**	No

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Structured Outpatient Addiction Program – Substance use disorder services that are clinically intensive and offered in a structured setting in the day or evening. These programs can be used to help a member transition from an inpatient substance use disorder program. It can also be used by members who need more structured outpatient services for a substance use disorder. These programs may include specialized services for pregnant members, adolescents, and adults who need 24-hour monitoring.	No	No
24-Hour Diversionary Services		
Mental health and substance use disorder services used instead of inpatient hospital services. These services support a member returning to the community after an inpatient hospital stay, or help a member maintain functioning in the community.		
Acute Treatment Services (ATS) for Substance Use Disorders – Services used to treat substance use disorders on a 24-hour, seven days a week basis. Services may include assessment, use of approved medications for addictions, individual and group counseling, educational groups, and discharge planning. Pregnant members receive specialized services. Members receive additional services to treat other mental health conditions.	**	No
Clinical Support Services for Substance Use Disorders – 24-hour treatment services that can be used by themselves or after acute treatment services for substance use disorders. Services include education and counseling; outreach to families and significant others, medications for treating substance use disorders, referrals to primary care and community supports, and planning for recovery. Members with other mental health disorders receive coordination of transportation and referrals to mental health providers. Pregnant members receive coordination with their obstetrical care.	**	No

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Community-Based Acute Treatment for Children and Adolescents (CBAT) – Intensive mental health services in a secure setting on a 24-hour basis, with clinical staffing to ensure the safety of the child or adolescent. Treatment may include checking medications; psychiatric assessment; nursing; one-to-one treatments to maintain the member's safety (specialing); individual, group, and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing. This service may be used as an alternative to or transition from inpatient hospital services.	**	No
Community Crisis Stabilization (CCS) – Services provided instead of inpatient hospital services. These services provide 24-hour observation and supervision for members.	**	No
Transitional Care Unit (TCU) – A community-based treatment program with high levels of supervision, structure, and support within an unlocked setting. This service serves children and adolescents younger than 19 years of age who are in the custody of the Department of Children and Families (DCF) who need group care or foster care, but who no longer require an acute level of care. This comprehensive service includes a therapeutic setting, psychiatry, case management, and treatments with a range of specialists.	**	No
Transitional Support Services (TSS) for Substance Use Disorders – A 24-hour, short-term intensive case management and psychoeducational residential program with nursing available for members with substance use disorders who have recently been detoxified or stabilized and require additional transitional stabilization before they are placed in a residential or community-based program. Members with co-occurring physical health, mental health, and substance use disorders are eligible for coordination of transportation and referrals to providers to ensure treatment for these conditions. Pregnant members are eligible for coordination of their obstetric care.	*	No

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Residential Rehabilitation Services for Substance Use Disorders		
Adult Residential Rehabilitation Services for Substance Use Disorders – Services for substance use disorder offered in a 24-hour residential setting. Services include at least five hours of individual or group therapy each week, case management, education, and rehabilitation based in the residence. Some residential programs serve pregnant and postpartum members, and provide assessment and management of gynecological, obstetric, and other prenatal needs, and offer parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups. Members receive coordination of transportation and referrals to mental health providers to ensure treatment for any other mental health conditions.	**	No
Co-occurring Enhanced Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour, safe, structured setting in the community. These services support the member's recovery from substance use disorders and moderate to severe mental health conditions. The services support a move back into the community and a return to social, work, and educational roles. Services are provided to support recovery. Clinical services, additional outpatient levels of care, and access to prescribers for medications are available.	**	No
Family Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for families in which a parent has a substance use disorder. Rehabilitative services that support parents and children are provided along with ongoing support for developing and maintaining interpersonal and parenting skills and support family reunification and stability. Members receive therapy, case management, education, and rehabilitation based in the residence.	**	No

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Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for youth 16 to 21 years of age or young adults ages 18 to 25 years of age who are recovering from alcohol or other drug problems. Services include individual or group therapy, case management, education, and rehabilitation based in the residence. Members also receive coordination of transportation and referrals to mental health providers for any co-occurring mental health conditions.	**	No
Youth Residential Rehabilitation Services for Substance Use Disorders – Services provided in a 24-hour residential setting for youth 13 to 17 years of age who are recovering from alcohol or other drug problems. Services include individual or group therapy, case management, education, and rehabilitation based in the residence. Members also receive coordination of transportation and referrals to mental health providers for any co-occurring mental health conditions.	**	No
Inpatient Services		
24-hour hospital services that provide mental health or substance use disorder treatment, diagnoses, or both.		
Administratively Necessary Day (AND) Services – Day(s) of inpatient hospital services for members who are ready for discharge, but the right setting is not available. Services include appropriate continuing clinical services.	Yes	No
Inpatient Mental Health Services – Inpatient hospital services to evaluate and treat acute psychiatric conditions. Such services may include • specialized inpatient psychiatric services provided to children or adolescents with neurodevelopmental disorders who have severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and co-occurring mental health conditions; and • specialized inpatient psychiatric services provided to members with an eating disorder diagnosis and severe associated psychiatric and medical needs in specialized eating disorder psychiatric settings.	**	No

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Inpatient Substance Use Disorder Services – Inpatient hospital services that provide medically directed care and treatment to members with complex withdrawal needs, as well as co-occurring medical and behavioral health conditions.	**	No
Observation/Holding Beds – Hospital services that are used to assess, stabilize, and identify resources for members for up to 24 hours.	**	No

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Outpatient Behavioral Health Services – Mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may also be provided at a member's home or school. Some providers of these services offer extended hours at night or during weekends through behavioral health urgent care centers. They can offer new client assessments on the same or next day, appointments for existing clients with an urgent behavioral health need on the same or next day, medication appointments within 72 hours of an initial assessment, and follow-up appointments within 14 calendar days. These services may also be provided at a community behavioral health center (CBHC). CBHCs offer crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, screening, and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. A CBHC must provide services to adults and youths, including infants and young children, and their families. See also "crisis services."		
Standard Outpatient Services – Outpatient services most often provided in an ambulatory setting.		
Acupuncture Treatment – The insertion of metal needles through the skin at certain points on the body as an aid to members who are withdrawing from, or in recovery from, dependence on substances.	No	No
Ambulatory Withdrawal Management – Outpatient services for members who are experiencing a serious episode of excessive substance use or complications from withdrawal when neither life nor significant bodily functions are threatened.	No	No
Applied Behavioral Analysis for members under 21 years of age (ABA Services) – A service for a member younger than 21 years of age with Autism Spectrum Disorder (ASD) or Down Syndrome diagnosis. It is used to treat challenging behaviors that interfere with a youth's ability to function successfully. This service includes behavioral assessments, interpretation of behaviors, development of a treatment plan, supervision and coordination of treatments, and parent training to address specific goals.	Yes	No

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Assessment for Safe and Appropriate Placement (ASAP) – An assessment for certain sexually abusive youth or arsonists who are in the care and custody of the Department of Children and Families (DCF), and who are being discharged from an inpatient or certain diversionary settings to a family home care setting. Services are provided through a DCF designated ASAP provider.	Yes	No
Case Consultation – A meeting between the treating provider and other behavioral health clinicians, or the member's primary care physician, concerning a member. The meeting is used to identify and plan for additional services, coordinate or revise a treatment plan, and review the individual's progress.	No	No
Collateral Contact – A communication between a provider and individuals who are involved in the care or treatment of a member younger than 21 years of age. Providers may include school and day care personnel, state agency staff, and human services agency staff.	No	No
Couples/Family Treatment – Therapy and counseling to treat a member and their partner or family in the same session.	No	No
Diagnostic Evaluation – An assessment of a member's functioning, used to diagnose and to design a treatment plan.	No	No
Dialectical Behavioral Therapy (DBT) – Outpatient treatment involving strategies from behavioral, cognitive, and supportive psychotherapies for members with certain disorders, including members with borderline personality disorder.	No	No
Early Intensive Behavioral Intervention (EIBI) Services – Provided to eligible children younger than three years of age who have a diagnosis of Autism Spectrum Disorder or Down Syndrome.	No	No
Family Consultation – A meeting with family members or others who are important to the member and to a member's treatment. The meeting is used to identify and plan for additional services, coordinate or revise a treatment plan, and review the member's progress.	No	No
Group Treatment – Therapy and counseling to treat unrelated individuals in a group setting.	No	No
Individual Treatment – Therapy or counseling to treat an individual on a one-to-one basis.	No	No

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Inpatient-Outpatient Bridge Visit – A single-session consultation led by an outpatient provider while a member is still in an inpatient psychiatric unit. This visit includes the member and the inpatient provider.	No	No
Medication Visit – A visit to evaluate the appropriateness of the member's prescriptions for drugs used for behavioral health needs, as well as any need for monitoring by a psychiatrist or registered nurse clinical specialist for whether such drugs are useful and any side effects.	No	No
Opioid Treatment Services – Supervised assessment and treatment of a member, using medications approved by the Food and Drug Administration, along with a range of medical and rehabilitative services to relieve the effects of opiate addiction. Includes detoxification and maintenance treatment.	No	No
Preventive Behavioral Health Services – Short-term interventions in supportive group, individual, or family settings to cultivate coping skills and strategies for symptoms of depression, anxiety, and other social/emotional concerns, which may prevent the development of behavioral health conditions for members who are younger than 21 years old and have a positive behavioral health screen (or, in the case of an infant, a caregiver with a positive postpartum depression screening), even if the member does not meet criteria for a behavioral health diagnosis.	No	No
Psychiatric Consultation on an Inpatient Medical Unit – A meeting between a psychiatrist or advanced practice registered nurse clinical specialist and a member at the request of the medical unit. It is used to assess the member's mental status and to consult on a behavioral health plan, including proper medications, with the medical staff.	No	No
Psychological Testing – Standardized tests used to assess a member's cognitive, emotional, neuropsychological, and verbal functioning.	Yes	No
Special Education Psychological Testing – Testing used toward the development of, or to determine the need for, an Individualized Educational Program (IEP) for children.	Yes	No

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Intensive Home and Community-Based Services for Youth		
Intensive behavioral health services provided to members in a community-based setting.		
In-Home Therapy Services – This service for children that often is delivered in a teamed approach includes a therapeutic clinical intervention and training and therapeutic support paraprofessional, as follows: • **Therapeutic Clinical Intervention** – A therapeutic relationship between a Master's level clinician and the child and family. The aim is to treat the child's mental health needs by improving the family's ability to support the healthy functioning of the child within the family. The clinician develops a treatment plan and works with the family to improve problem-solving, limit-setting, communication, and emotional support or other functions. The qualified clinician may often work with a Therapeutic Training and Support paraprofessional. • **Therapeutic Training and Support** – A service provided by paraprofessional working under the direction of the Master's level clinician to support implementation of a licensed clinician's treatment plan to achieve the goals of the treatment plan. This trained individual works with a Master's level clinician to support a treatment plan that addresses the child's mental health and emotional challenges.	Yes	No

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Crisis Services – Available seven days per week, 24 hours a day to provide treatment for any member who is experiencing a mental health crisis. CBHCs can provide crisis services.		
Adult Mobile Crisis Intervention (AMCI) – Provides adult community-based behavioral health crisis assessment, intervention, stabilization, and follow-up for up to three days. AMCI services are available 24 hours a day, seven days a week, 365 days a year and are co-located at the CBHC site. Services are provided as mobile responses to the member (including in private residences) and provided via telehealth to members 21 years of age and older at the request of the member, or at the direction of the Behavioral Health Help Line when clinically appropriate. AMCIs operate adult community crisis stabilization programs with a preference for co-location of services.	No	No
Behavioral Health Crisis Evaluation Services in Acute Medical Settings – Crisis evaluations provided in medical and surgical inpatient and emergency department (ED) settings for members presenting to the ED in a behavioral health crisis. Elements of crisis evaluations include • Comprehensive Behavioral Health Crisis Assessment • Crisis Interventions • Discharge Planning and Care Coordination • Reporting and Community Collaboration	No	No
Behavioral Health Crisis Management Services in Acute Medical Settings – Crisis management services provided to members in medical and surgical inpatient and emergency department settings. Elements of crisis management include • Crisis Interventions • Discharge Planning and Care Coordination • Ongoing Required Reporting and Community Collaboration	No	No

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Youth Mobile Crisis Intervention (YMCI) – A short-term service that is a mobile, on-site, face-to-face therapeutic response to youths younger than 21 years of age experiencing a behavioral health crisis and that includes follow-up for up to seven days. YMCIs are available 24 hours a day, seven days a week, 365 days a year and are co-located at the CBHC site. Services are provided as mobile responses to the member (including in private residences) and via telehealth when that is requested by the family and is clinically appropriate. YMCIs will have access to youth community crisis stabilization (YCCS) services. YMCIs must have the capacity to accept youths voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.	No	No
Other Behavioral Health Services		
Electro-Convulsive Therapy (ECT) – A treatment that is used to treat depression that has not responded to medications and psychotherapy. This treatment initiates a seizure with an electric impulse while the member is under anesthesia.	No	No
Repetitive Transcranial Magnetic Stimulation (rTMS) – A treatment that is used to treat depression that has not responded to medications and psychotherapy. In this treatment, rapidly changing magnetic fields are applied to the brain through a wire attached to the scalp.	Yes	No
Specialing – Treatment services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the member's safety.	No	No
Health Related Social Needs (HRSN) Supplemental Nutrition Services		
Medically Tailored Home Delivered Meals – These are prepared meals for people with specific health needs. Meals are made to best support a person's specific health needs and are delivered to that person.	Yes	Yes
Nutritionally Appropriate Food Prescriptions and Vouchers – These are gift cards for buying healthy groceries.	Yes	Yes
Health Related Social Needs (HRSN) Supplemental Housing Services		

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Housing Navigation – This service can help a person who is having housing problems to talk to their landlord, get legal help, or find a new place to live.	Yes	Yes
Healthy Homes – This service can help a person buy things and fix problems in a person's home to make it healthier for them. This service is for things that are not the landlord's job.	Yes	Yes

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Excluded Services

The following services or supplies are not covered under MassHealth, unless they are medically necessary, or as noted.

- Cosmetic surgery. There are exceptions if MassHealth agrees it is necessary for
  - Treating damage following injury or illness;
  - Breast reconstruction following a mastectomy; or
  - Other procedures that MassHealth determines are medically necessary.
- Treatment for infertility. This includes in-vitro fertilization (IVF) and gamete intrafallopian tube (GIFT) procedures
- Experimental treatment
- A service or supply that is not provided by, or at the direction of, your provider or MassHealth. There are exceptions for:
  - Emergency services
  - Family planning services
- Noncovered laboratory services
- Personal comfort items such as air conditioners, radios, telephones, and televisions
- Services not otherwise covered by MassHealth, except as determined by the contractor to be medically necessary for MassHealth Standard or MassHealth CommonHealth members younger than 21 years of age. Such services are considered a Covered Service under the contract per Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

Contact MassHealth

If you have questions, please call the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711, Monday through Friday from 8:00 a.m. to 5:00 p.m.