2023

Tufts Health Together
with Atrius Health

Member Handbook

TUFTS Health Plan

a Point32Health company

Atrius Health

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DISCRIMINATION IS AGAINST THE LAW

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 doctors 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 will find definitions for each of these terms in the Glossary starting on page 43.

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 can help 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.

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).

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. Connect with your health plan anywhere 24/7:
  - Check your benefits
  - Choose or change your PCP
  - Confirm referrals and approvals (authorizations)
  - View your member ID card
  - Update your contact information
  - Create a personal private health record to store information about you
  - 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!

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 us 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**, 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**, 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.

Table of Contents

Your ID Cards

Your health plan Member ID Card

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

When you get your health plan Member ID Card, please read it carefully and make sure all of the information is correct. 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.

Your MassHealth ID Card

As a MassHealth member, you will 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 your health plan Member ID Card and MassHealth ID Card 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**, 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 calendar days of your asking for an appointment

- Routine, Non-symptomatic Care: within 45 calendar days of your asking for an appointment

- Specialty care:
  - Non-urgent Symptomatic Care: within 30 calendar days of your asking for an appointment
  - Routine, Non-symptomatic Care: within 60 calendar 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 calendar 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 calendar days of discharge
  - For medication management: within 14 calendar days of discharge
  - For other outpatient services: within seven calendar 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 www.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:

- Violent feelings toward 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 Doctor, Hospital or Pharmacy 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'll 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** 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, Hospital or Pharmacy tool, or call our Member Services Team at **888.257.1985**, 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*, you can find important information like a Provider's address, phone number, 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 professional qualifications, the names of any medical or professional school(s) attended, where a residency or training took place, and for doctors, board certification status. Just give us a call at **888.257.1985**. 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 will be able to help you. If you have problems contacting your PCP, please call us at **888.257.1985**. We're available 24 hours a day, seven days a week, to assist you with any of your questions.

To find a PCP and see where the PCP's office is located, please visit tuftshealthplan.com and use the Find a Doctor, Hospital or Pharmacy 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 checkups 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. You can choose to stay with your PCP and with the plan he or she has selected.

If you don't want to stay with your PCP, you can always choose a different PCP in your PCP's network by calling us at **888.257.1985** or by using our member portal at tuftshealthplan.com/memberlogin. You can choose a PCP outside of your PCP's 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**.

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, Hospital or Pharmacy 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. To find a Specialist, talk to your PCP.

You can also call us at **888.257.1985** or visit tuftshealthplan.com and use the Find a Doctor, Hospital or Pharmacy 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-network. Staying in-network means you receive care within a Network of providers. If you are a provider helping a Member seek care, please ensure that you refer the Member within the appropriate Network for his or her 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 Network 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 10.)

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 Provider

Your PCP must ask us for and get Prior Authorization before you see an Out-of-network Provider. 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**.

You can see an Out-of-network Provider 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

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.

 For MassHealth-related questions, please call MassHealth Customer Service at 800.841.2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

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

Continuity of Care

New Members

If you are a new Member to our Plan, we'll 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**, 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 the Provider is your current pregnancy care provider, you will be able to keep seeing him or her through delivery and your first follow-up checkup.
- If your Provider, including a Primary Care Provider (PCP), is providing outpatient medical, Behavioral Health or substance use disorder care, or your Provider is actively treating a chronic or acute medical condition (with a treatment like dialysis, home health services, chemotherapy or radiation), you will be able to keep seeing him or her for up to 30 calendar days.
- If your current PCP is not a Provider with our health plan, you will be able to keep seeing him or her for up to 30 calendar days. If you are terminally ill or have significant health care needs or a complex medical condition, including serious or persistent mental illness, you may be able to keep seeing your Provider.
- If you are receiving inpatient care (medical or Behavioral Health) 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.
- Members with autism spectrum disorder (ASD) who are actively receiving applied behavioral analysis (ABA) services and have a current Prior Authorization for ABA services in place may get continuity of these services for 90 days after enrollment only if the Provider agrees to our terms related to payment, quality, and other plan policies and procedures.
- If you have an existing prescription, we will provide any prescribed refills of your medication, unless this prescription requires a Prior Authorization. If a Prior Authorization is required, we will provide a 72-hour supply of your medication while your Provider sends us the information that allows us to approve the Prior Authorization.
- If, at the time of your enrollment, you were receiving the following services that were authorized by MassHealth, a MassHealth-contracted Managed Care Organization, or a MassHealth Accountable Care Partnership Plan, you may continue to receive these services for 30 days. 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**.

We will 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'll make every effort to tell you at least 30 calendar 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** and tell us that you want to keep seeing this Provider.

- If the Provider is your current pregnancy care Provider, you will be able to keep seeing him or her through delivery and your first follow-up checkup.
- If your Provider, including a PCP, is actively treating 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 be able to keep seeing him or her through the current period of active treatment or for up to 90 calendar days (whichever period is less) after we tell you he or she is no longer part of our Network.
- If the Provider is your PCP, you may be able to keep seeing him or her for up to 31 calendar days after the PCP is disenrolled.
- If you are terminally ill or have significant health care needs or a complex medical condition, including serious or persistent mental illness, you may be able to keep seeing your Provider for at least 30 days.

We will 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) will work with your other Providers to make sure you get the care you need. For some services, your PCP or other Provider will need to ask us for Prior Authorization (permission) before sending you to get those services. Please see the *Covered Services List*, enclosed with your *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'll 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'll 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 Doctor, Hospital or Pharmacy tool.

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

 For MassHealth-related questions, please call MassHealth Customer Service at 800.841.2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

- 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'll 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 9.

Standard service authorizations

We make standard service authorization decisions as fast as your health condition requires, but no more than 14 calendar 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 calendar 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 calendar days, and we believe the information would lead to approving the request.

If we decide to extend the 14-calendar-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. You, your Designated Representative, your Provider or we can extend this time frame by an additional 14 calendar 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 calendar 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 31.

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 that will state 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 will 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. 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 31.

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 the enclosed *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**, 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 the enclosed *Covered Services List* for details on services that may need Prior Authorization for MassHealth Standard/CommonHealth, Family Assistance or CarePlus plan Members. We'll make a decision based on whether you need the services and whether you're getting the services in the right place.

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 Intensive Early Intervention, 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**, or you can call the MassHealth Customer Service Center at 800.841.2900 (TTY: 711).

Please see the enclosed *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 nonemergency transportation to go to health care visits. Note: Nonemergency 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 nonemergency 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 nonemergency transportation services you may be eligible for, call us at **888.257.1985**. 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:

- Checkups: every one to three years

- 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): 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 checkups so they can stay healthy. Children who are under age 21 should see their PCP for checkups at least once every year, even if they are well. As part of a well-child checkup, your child's PCP will check your child's development, health, vision, dental health, hearing, behavioral health and need for immunizations.

We pay your child's PCP for well-child checkups, so make sure to schedule them. At these checkups, 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 checkup.

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 will help 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**. We can give you information and help.

Preventive Pediatric Health Care Screening and Diagnosis (PPHSD) services

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Diagnostic services are tests and procedures a doctor does or sends you to have (like X-rays and lab tests) to learn why you are sick or hurting.

If you or your child is under age 21 and enrolled in MassHealth Family Assistance, we'll pay for all Medically Necessary Covered Services. This means that when a PCP or any other Provider finds a health condition, we'll pay for any Medically Necessary covered treatment.

Children under age 21 are eligible for preventive behavioral health services. To receive these services a member must have a positive behavioral health screen. An infant must have a positive parental post-partum depression screening.

To assess the member's needs, a provider must conduct and document the results of an age-appropriate behavioral health screen using a tool from a list of MassHealth approved screeners. These

are listed online at www.mass.gov/info-details/learn-about-the-approved-masshealth-screening-tools.

If a screening is positive, the member does not need to meet criteria for a behavioral health diagnosis. Managed care plans may not require a diagnostic assessment or the Child and Adolescent Strengths and Needs (CANS) before preventive behavioral health services start.

If a member is determined to need behavioral health treatment during or after the course of preventive services, they should be referred to appropriate clinical services.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services

EPSDT services include health care, 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 enrolled in MassHealth Standard or CommonHealth and a PCP discovers a 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.

You can find the services we cover on your *Covered Services List*. If we don't cover the services you need, or if the *Covered Services List* doesn't include the services, the Provider providing the services can ask us for Prior Authorization. We'll pay for the 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 31. Talk to your child's PCP, Behavioral Health Provider or other Specialist for help getting these services.

Behavioral Health services for children

Your child's Behavioral Health Provider will do 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 will use the CANS Tool during an initial assessment — and at least every 90 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 will also complete 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**. You can also find this information in our *Provider Directory* and by using the Find a Doctor, Hospital or Pharmacy 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)

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**.

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 will get some services at a Hospital but still live at home
- Inpatient care

For more information, please call us at **888.257.1985** 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 will do a dental exam at each well-child checkup 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 will be provided. Make sure that your child gets:

- A dental checkup 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

We also cover Medically Necessary fluoride varnish for Members under age 21.

Fluoride varnish is recommended every six months from when the first tooth comes in (usually at six months) to a child's third birthday. Children up to age 21 can get fluoride varnish when Medically Necessary. Doctors, physician assistants, nurse practitioners, registered nurses and certified 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.

Other services for children

Children under age 21 are entitled to certain additional services under federal law. Some children need extra help for healthy growth and development. Children with growth or development problems can get services from early intervention specialists, such as:

- Social workers
- Nurses
- Physical, occupational and speech therapists

All of these Providers work with children under age 3 and their families to make sure a child gets any necessary extra help. Children age 3 and older may usually receive these services through the school department. Children younger than age 3 receive services through an early intervention program from our health plan. Your child may get

some of these services at home or at an early intervention center.

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.

Children under the age of 21 who have been diagnosed with autism spectrum disorder (ASD) and have MassHealth Standard or CommonHealth are covered for applied behavioral analysis (ABA). Children under the age of 19 who have been diagnosed with ASD and have MassHealth Family Assistance are also covered for 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 calendar days and a full medical examination within 30 calendar 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 31.

If you get a bill for a Covered Service

Your Provider should not bill you for any Covered Service. If you have any questions about whether Tufts Health Plan or MassHealth covers a specific service, or if you get a bill that you believe is in error, call us at **888.257.1985**. We can help.

Covered medications, pharmacy programs and prior authorizations

For information on co-payments please refer to the *Covered Services List.* You can find co-payment information directly following the prior authorization and referral requirements grids.

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 (https://www.mass.gov/doc/masshealth-non-drug-product-list/download).

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'll cover one of these drugs or medical devices. Please see the section "Prior Authorization for drugs and medical devices" immediately following.

Your covered medications may be subject to co-payments, but a pharmacy cannot refuse to dispense that medication if you are unable to

afford that co-payment. 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'll cover the drug. One of our clinicians will review this request. We'll 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 Preferred Drug List (PDL) 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 31 for Grievance and Appeal information. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at **888.257.1985**.

Preferred Drug List (PDL)

We use a PDL as our list of covered drugs and medical devices.

We update the PDL every month. The PDL applies only to drugs and medical devices you get at retail and specialty pharmacies. The PDL doesn't apply to drugs and medical devices you get if you are in the Hospital. For the most current PDL, please visit tuftshealthplan.com or call us at **888.257.1985**.

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 and get Prior Authorization before we'll cover the drug or medical device. One of our clinicians will review 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 31 for Grievance and Appeal information. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at **888.257.1985**.

We don't cover:

- Any drug products used for cosmetic purposes**
- Any drugs that are not approved by the U.S. Food and Drug Administration**
- Weight loss medications**
- Infertility medications**
- Medications used for male or female sexual** dysfunction**
- Contraceptive implants*
- Experimental and/or investigational drugs (exceptions may apply)**
- Digital therapeutics and prescription digital therapeutics (PDTs), unless indicated otherwise
- Medical supplies*

* May be covered as a non-pharmacy benefit

** In accordance with guidelines found in 130 CMR 406.413(B), we do not cover drugs used for cosmetic purposes, weight loss, infertility, sexual dysfunction, or drugs that are experimental and/or investigational. Additionally, in according with 130 CMR 406.412(A), we do not cover drugs that are not approved by the United States Food and Drug Administration.

Generic drugs

Generic drugs have the same active ingredients as brand-name drugs. When generic drugs are available, we 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 will then review the request. Please see the section "Prior Authorization for drugs and medical devices" on page 18 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 31 for Grievance and Appeal information. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at **888.257.1985**.

New-to-market drugs

We review new drugs and medical devices for safety and effectiveness before we add them to our PDL. 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 will review this request. If we approve the request, we'll 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 31 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 will review the request. We'll 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'll 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 31 for Grievance and Appeal information. For more information, visit tuftshealthplan.com or call us at **888.257.1985**.

Voluntary 90-Day supply pharmacy program

Tufts Health Together has a voluntary 90-day supply pharmacy program. The program allows for select generic maintenance medications used to treat common chronic conditions to be filled at a retail pharmacy for a 90-day supply. Please refer to the Tufts Health Together Preferred Drug List (PDL) to see whether a medication can be filled for a 90-day supply.

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'll 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 will review the request. We'll cover the drug according to our clinical guidelines. Please see the section "Prior Authorization for drugs and medical devices" on page 20.

Pharmacy (drug and medical device) authorizations

We will 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

Once we authorize the drug or medical device, we'll notify you by phone and send you or your Designated Representative and your Provider an authorization letter.

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 will 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 31.

 For MassHealth-related questions, please call MassHealth Customer Service at 800.841.2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

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 will:

- 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 and refer to your plan's PDL to identify any specialty drugs you may be taking. You can't get these drugs at a retail pharmacy.

Utilization Review — 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.

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**, 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 will 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.

Evaluating experimental and/or investigational drugs 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 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 in order 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 four main types: 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**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

Community Partners (CP) program

The Community Partners (CP) program was developed by MassHealth to coordinate care and resources for those services that will promote independence for MassHealth members. These programs bring together community resources, health insurers and PCPs to work together to ensure that members are receiving the right community services. The Community Partners serve both members with medical (Long-term Supports and Services CP) and those with Behavioral Health (Behavioral Health CP) needs. Examples of services provided include furnishing of items to perform daily tasks such as hearing and vision items and durable medical equipment, personal care assistance, and services provided by home health aides.

Community Partners will also address social needs such as food stamps, fuel assistance and Meals on Wheels. CP may also assist with access to day programs such as Adult Day Health and Adult Foster Care and will also help the pediatric population access community resources.

Members can self-refer to be considered for either of the CP programs by calling the Member Services Team at **888.257.1985**.

Health and wellness support

Along with health coaching, we also offer wellness services. These services may include but are not limited to:

- Providing you with general health information
- Nutrition counseling
- Helping you identify some of the signs and symptoms of common diseases (e.g., stroke, diabetes and depression)
- Covering children and adolescents under age 21 for Early Periodic Screening, Diagnosis and Treatment (EPSDT) services

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

 For MassHealth-related questions, please call MassHealth Customer Service at 800.841.2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

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).

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 24.

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 1.800.QUITNOW.

24/7 NurseLine

We have a 24-hour NurseLine 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 will 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 will 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 nonmedical 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 will help you with a transition plan (the care you need to help you keep getting better at home). We'll 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 by calling us at **888.257.1985** or by visiting tuftshealthplan.com.

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

We have different levels of Behavioral Health services, based on your need, what type of and how many services you need, and/or any medical condition you may have. You can find a complete list of these 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. You can find a list of Providers who can help you get these services at tuftshealthplan.com.

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

Together, we can help make sure you get the best care. We'll 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

If you need help finding a Behavioral Health Provider, please call us at **888.257.1985**.

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** 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 will include clinical follow up.

Integrated Care Management

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 Clinical Community Outreach Specialists 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

Our team of dedicated health care professionals includes nurses, Behavioral Health Providers, Clinical Community Outreach Specialists and health advocates. This team understands how to work with you if you have special health care needs and will help 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 will work 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 four types of Care Management services:

- Medical care management (includes complex care management and pregnancy care management)
- Behavioral Health Intensive Clinical Management (ICM)
- Social care management
- Community Care Outreach (CCO)

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 will get help from a team of dedicated health professionals, community organizations and state agencies. They will help Members receive appropriate care to get better and to stay healthy, and will 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, diabetes, 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 personalized support, coaching and education, while also identifying the services that will 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** to talk to a care manager.

Behavioral Health Intensive Clinical Management (ICM)

We can offer you Behavioral Health ICM if you:

- Have severe Behavioral Health issues
- Are a child or adolescent
- Have three or more Behavioral Health inpatient hospital admissions during a 12-month period
- Have not accessed or cannot access community-based services
- Experience a catastrophic event
- Have a history of multiple hospitalizations
- Are newly diagnosed with a major mental illness
- Have substance use disorder
- Have special needs or cultural issues that require multiple agencies to coordinate service delivery

Call us at **888.257.1985** if you want information or have questions about Behavioral Health ICM and how we determine the care we authorize.

Disease Management

We offer coaching and education for Members with asthma, diabetes, and chronic obstructive pulmonary disease. Our Care Managers are licensed health care professionals, with a great deal of knowledge and expertise in helping Members learn about, and learn how to manage, their diseases. Our Care Management Team is also able to connect you with many community resources. We will coordinate with your PCP, as needed, and assist with education, discuss ways to manage your symptoms, and answer any questions you may have about your medications.

We will work with you to set goals, measure progress and focus on your specific needs. We also offer app-based programs to help you lose weight and improve your health through nutrition.

We use evidence-based practice guidelines (clinical guidelines based on the best research) as a basis for disease management. These guidelines will help you live as healthily as possible and feel your best. Disease Management is available to all current Members, including pediatric Members.

If you have a history of diabetes, asthma, or COPD, you may be identified as a candidate for disease management.

Asthma

A Care Management Team member can make in-home visits and 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. The one-on-one telephonic coaching teaches you about the disease, identifying triggers and medications.

We'll 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 will answer your questions about diabetes. Care Managers will also provide information that will increase your knowledge of your disease and help you focus on areas of diabetes you feel you need a better understanding of. 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 will 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.

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.**

Social care management

Our Clinical Community Outreach (CCO) team can help you with more than health care issues. CCOs are here to support you with anything in your life that could affect your health, including addressing barriers you may have getting health care. CCOs can help you:

- Find a doctor
- Find community services
- Apply for food stamps
- Apply for benefits like Supplemental Security Income (SSI) and Social Security and Disability Insurance (SSDI)
- Coordinate services with the Department of Transitional Assistance (DTA) and/or the Social Security Office
- Locate emergency shelter
- Get community services in addition to services we provide
- Get information about programs that help pay for utilities (electricity or heat)
- Find disability support groups
- Coordinate transportation to Medically Necessary appointments, when appropriate and applicable
- Get counseling
- Make sure you know which benefits and EXTRAS you can get

We'll look at your situation, and with your consent, move you to another Care Management or Community Partner program if we think it is necessary.

To get social care management services or for more information, call us at **888.257.1985**.

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 will assist 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.

Our trained staff will call you to perform further screening to see what level of support you will need. Pregnant Members can receive the following services through this program:

- Congratulations and introductory educational materials
- Pregnancy calendar with information related to prenatal care, nutrition and exercise during pregnancy, labor and birth, postpartum care, and breastfeeding and newborn care
- Information regarding your health plan EXTRAS
- Information and links to Healthy Baby Essentials, our preferred breast pump provider

If you have a high-risk pregnancy, you can work directly with our high-risk pregnancy nurses, who will support you during your pregnancy.

Call us at **888.257.1985** for more information. Also see page 26 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 EXTRA 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 cards 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** 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

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 a yearly checkup (ages 3–9), and we'll send you a $25 supermarket gift card.
- Get a yearly checkup (ages 10–17), and we'll send you a $10 movie theater gift card
- Get a yearly checkup (ages 18 and older), and you can receive a fitness band or supermarket gift card. Note: Adults 18 and older can get one fitness band during their membership. They can earn a $25 supermarket gift card for having a yearly checkup all other years.
- 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 movie theater 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 your child should receive two annual flu shots before his or her second birthday). Your child's doctor will talk to you about the best time to get these immunizations. We'll 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** to get a copy of the Reward Form.
2. Fill out the information on the form and make a copy of the form to keep for yourself.
3. Mail the completed form to:

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

Watch your mail for your 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** 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

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**.

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 calendar with information about your baby's development during and after your pregnancy and reminders for making appointments with your child's PCP.
- Get a gift card to use to buy a car seat. See page 27 for more information.

Call us at **888.257.1985** as soon as you know you are pregnant to find out about these benefits.

How to get the $25 gift card:

1. Visit http://www.tuftshealthplan.com/TogetherExtras or call us at **888.257.1985** to get a copy of the Reward Form.
2. After visiting WIC twice during pregnancy, fill out the information on the form.
3. After attending a new baby care class, fill out the information on the form and submit with an itemized receipt, confirmation of attendance or certificate of completion.
4. Make a copy of the form for yourself.
5. Mail the completed form to:

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

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 and when we process your Reward Form. Members can get one $25 gift card during each pregnancy.

How to get the calendar:

Call us at **888.257.1985** to tell us you are pregnant. You should get your calendar in six to eight weeks.

After having a baby

- Get a $25 supermarket gift card if you visit your OB/GYN for a postpartum visit between 21 and 56 days after you have your baby.
- Get a calendar to help you keep track of your child's development and remind you to make appointments with your child's PCP. See the section "If you are pregnant" on page 26.

Call us at **888.257.1985** as soon as you have your baby to get these benefits.

How to get the $25 gift card:

1. Visit tuftshealthplan.com/TogetherExtras or call us at **888.257.1985** 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

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** or by visiting tuftshealthplan.com.

How to get the $25 gift card:

1. Visit tuftshealthplan.com/TogetherExtras or call us at **888.257.1985** 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

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** or visit tuftshealthplan.com.

How to get the $25 gift card:

1. Visit tuftshealthplan.com/TogetherExtras or call us at **888.257.1985** 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

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 will automatically be renewed as a MassHealth member. MassHealth will notify 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 will send 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**, 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

Effective March 1, 2018, you will be 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 will be 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'll 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 will end 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 will make serious efforts to work with you to resolve the issue. In addition, we will 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 will 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 will decide 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 will pay 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 will 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 will 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

- 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 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 will 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**, 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 calendar days of someone other than you filing a Grievance on your behalf, we will 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'll:

- 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 calendar 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'll:

- 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 calendar 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' failure 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 10)
- Our failure to follow the Internal Appeal time frames as we explain in the following pages

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**. 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 calendar 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**.

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 35. 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**, 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

Note: If you request an Internal Appeal by telephone or in person, we may ask that you or your

Designated Representative follow up with a written Internal Appeal request, unless you request an Expedited Appeal. If you don't send us this written documentation, we may deny your Internal Appeal.

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

You or your Designated Representative must request your Internal Appeal within 60 calendar days of the notification of Adverse Action, as described in this *Member Handbook* (or, if you don't get a notice, within 60 calendar 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 will let you and your Designated Representative know in writing within one business day that we received your Internal Appeal request.

If we don't receive your Internal Appeal request within 60 calendar days, we'll consider the Adverse Action final. We will 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 will 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'll send you a copy of your case file. We will ask you to review it and provide any additional information prior to making our decision. After sufficient time for your review, we will 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 will make our decision within 30 calendar days from the date we receive your request.

If we need more information, and we expect our review to take longer than 30 calendar days, we'll let you and/or your Designated Representative know and ask for an extension of 14 calendar days. At that time, we'll 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 calendar 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 calendar days to give us more information.

Unless you indicate to us that you don't want to get Continuing Services, we'll keep covering previously approved services until we decide your Internal Appeal, as long as we receive your request for an Internal Appeal within 10 calendar days from the notice of Adverse Action (or, if you don't receive any notice, within 10 calendar 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 BOH, following the process described later in the BOH section on page 35.

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 calendar days of the notification of Adverse Action (or, if you don't receive a notice, within 60 calendar 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'll keep covering previously approved services until we make a decision about your Expedited Appeal, as long as we get the request within 10 calendar days from the notice of Adverse Action (or, if you don't receive a notice, within 10 calendar 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'll 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 will 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'll 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'll make a decision as quickly as your condition requires, and in no more than 72 hours, and we'll 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 calendar days, we'll let you know and take a 14-calendar-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 calendar 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 will 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** to get a copy of the form.

You or your Appeal representative must make your request for an External Review (Fair Hearing) within 120 calendar 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 calendar 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 will 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 will listen, investigate the issue and discuss options with you to help solve the problem.
- Help with Appeals. An Appeal is a formal way of asking your 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 write My Ombudsman.

- Call: 1.855.781.9898 (TTY: 711)
- Write: My Ombudsman, 25 Kingston St, 4th floor, Boston, MA 02111

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

- Mondays from 1 p.m. to 4 p.m. and
- Thursdays from 9 a.m. to 12 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 the other companies or state agencies depends on your situation. Through this Coordination of Benefits, you will often get your health insurance coverage as usual through us. If you have other health insurance, our coverage will always be 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**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, to find out how payment will be 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'll 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 will not reduce the amount you must pay back to us.

To enforce our Subrogation rights under this *Member Handbook*, we'll 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'll 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 will be 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'll 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. We are required by law to maintain the privacy of your information. To support this, Tufts Health Plan has privacy and security policies for safeguarding, using, and disclosing information in compliance with applicable state and federal laws. All employees must complete annual privacy and security training, and access to your information is limited to employees who require it to do their job. Tufts Health Plan also requires its business partners who assist with administering health care coverage to you on our behalf to protect your information in accordance with applicable laws.

Tufts Health Plan is required 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 maintains and enforces company policies governing the use and disclosure of information, including only using or disclosing the minimum amount of information necessary for the intended purpose. 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 offer you greater privacy protections, we will follow the more stringent requirements.

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:

[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 MassHealth-related questions, please call MassHealth Customer Service at 800.841.2900 (TTY: 711), Monday through Friday, from 8 a.m. to 5 p.m.

- 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, HealthSource RI, 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 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.

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 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.

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 will 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 will need 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 will provide you written notice via mail unless we do not have up-to-date contact information for you. In these cases, we will 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 will 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 will not take retaliatory action against you for filing a complaint.

THIS NOTICE IS EFFECTIVE 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 will find definitions for each of these terms.

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*

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 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 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**. 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) and family support and training services 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**. 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 calendar 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.

A **copay** is a small amount that a member pays when they get health services. The only time that a member may have a copay is when they get certain prescription drugs.

A **Co-payment Cap** is the limit on the Co-payments a pharmacist can charge you each calendar year (January 1–December 31).

Covered Services are the services and supplies our health plan and MassHealth cover. The *Covered Services List* we give you with this *Member Handbook* has all of your Covered Services and supplies. You can call Member Services at **888.257.1985** or visit tuftshealthplan.com for copies of the *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 well-child checkups 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 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 her 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 her 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.

Intensive Clinical 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.

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 his or her 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**. 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.

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** 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** 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 will 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 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.