

***Network Health Together***<sup>®</sup>  
**Member  
Handbook**



**NETWORK HEALTH**



## If you move or change your phone number, don't forget to update your contact information!

When you move, you must call both MassHealth and us to update your address and phone number. If MassHealth doesn't have your current contact information on file, you may lose your health benefits. You should also put the last names of all **Network Health Together** Members of your household on your mailbox. The post office may not deliver mail from MassHealth or us to someone whose name is not listed on the mailbox.

- Call MassHealth Customer Service at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m., and Network Health at **888-257-1985** (TTY: 888-391-5535), Monday through Friday, from 8 a.m. to 5 p.m., to update your contact information.

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

You can learn about all of MassHealth's health plan options, including Network Health, by calling MassHealth Customer Service at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m.

## Other household Members may be eligible for MassHealth!

If other people in your home may be eligible for MassHealth, we can help! Call us at **888-257-1985**. They can also call MassHealth Customer Service at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m.

## Changing your Primary Care Provider (PCP)

You can switch your PCP for any reason by calling us at **888-257-1985** or by visiting us online at [www.network-health.org](http://www.network-health.org).

## Contact us:

**888-257-1985**

TTY: 888-391-5535

(for people with partial or total hearing loss)

Web: [www.network-health.org](http://www.network-health.org)

Mail: 101 Station Landing, Fourth Floor, Medford, MA 02155

Translation services are available in 170 languages.

## Customer Service hours:

If you want to talk to a customer service representative who can help you with any questions you may have, call us at **888-257-1985** during our office hours, Monday through Friday, from 8 a.m. to 5 p.m. We're also available 24 hours a day, seven days a week for Behavioral Health (mental health and/or substance abuse) issues and questions.

## NurseLine:

888-MY-RN-LINE (888-697-6546), 24 hours a day, seven days a week

TTY: 800-942-1859

## In an Emergency:

If you believe that you are in an Emergency situation, take immediate action.

- Call 911 or go to the nearest Emergency room right away. For Behavioral Health (mental health and/or substance abuse) emergencies, call 911, your local Emergency Services Program (ESP) Provider, or go to the nearest

Emergency room right away. You can find a complete listing of Emergency rooms and Emergency Services Program (ESP) Providers in Massachusetts on our Web site, [www.network-health.org](http://www.network-health.org), and in your Network Health *Provider Directory*. If you want a Network Health *Provider Directory*, please call us at **888-257-1985**, and we will send you one.

- Bring your **Network Health Together** ID Card and your MassHealth ID Card with you.
- Tell your Primary Care Provider (PCP) and, if applicable, your Behavioral Health (mental health and/or substance abuse) Provider within 48 hours of an Emergency to get any necessary follow-up care.

You will not need Prior Authorization for any Emergency care, including ambulance transportation and Post-stabilization Care Services. For complete details about Prior Authorizations, please see the "Getting the care you need" section of this *Member Handbook*.

## In an Urgent Care situation:

In an Urgent Care situation, 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 Behavioral Health (mental health and/or substance abuse) Provider can usually address these health problems.

- Call your PCP or Behavioral Health Provider. You can contact any of your health care Providers' offices 24 hours a day, seven days a week.
- Make an appointment if your health care Provider asks you to come in. Your health care Provider must see you within 48 hours of your request for an Urgent Care appointment.

## Visit us on the Web!

Visit us online at [www.network-health.org](http://www.network-health.org) to:

- Find a PCP, Specialist, or health center near you.
- Find a Behavioral Health Provider near you.
- Sign up for *Network Health Member Connect*, and:
  - Change your address or phone number.
  - Choose or change your PCP.
  - Use the secure messaging center to send us information and questions.
  - Get answers to your questions.
  - Order one or several of your extra benefits.
- Get important information, such as:
  - How you can file a Grievance or Appeal
  - How you have the right to request an Independent External Review if we deny an Appeal, as well as your other Rights and Responsibilities
  - How we make sure you get the best care possible (our Quality Management and Improvement Program)
  - How we make sure you get the right care in the right place (our Utilization Management Program). Please note: We never reward our staff for denying care.
  - How we use information your health care Providers give us to decide what services you need to make you better or keep you healthy (our Utilization Review criteria)
  - Our privacy practices, including how we may collect, use, and release information about you and your health (your Protected Health Information)
- And much more!

Since 1997, Network Health has provided high-quality health care coverage to Massachusetts residents. Network Health serves MassHealth Members through our *Network Health Together* plan, which provides all the benefits of MassHealth, plus additional free and discounted benefits. In our efforts to improve the health and well-being of our Members and their diverse communities, Network Health partners with a growing network of Primary Care Providers, Specialists, Hospitals, and community organizations across Massachusetts.

NCQA is a private, nonprofit organization dedicated to improving health care quality.

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# The benefits of Network Health

You deserve great care. As a MassHealth Member on the *Network Health Together* plan, you get all the benefits of MassHealth, PLUS additional free and discounted extra benefits from Network Health. We want you to get the most out of your *Network Health Together* Membership. To help explain terms you need to know and that are capitalized throughout this *Member Handbook*, we have included a glossary of definitions on page 37.

## Translation and other formats

If you have questions, need this document translated, need someone to read this or other printed information to you, 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. We can give you information in other formats, such as Braille, large type size and American Sign Language video clips, and different languages. We offer translation services in 170 languages. All translation services are FREE to Members. Members with partial or total hearing loss should call our TTY line at 888-391-5535 for help.

## Getting the care you need

### In an Emergency

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An Emergency situation is when you believe your life or health is in danger or would be if you do not get immediate care.

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For medical and Behavioral Health emergencies, call 911, or go to the nearest Emergency room right away. For Behavioral Health emergencies, you may also call the local Emergency Services Program (ESP) Provider in your area. Please call us at 888-257-1985, or visit us online at [www.network-health.org](http://www.network-health.org) for a complete list of Emergency rooms and ESPs in Massachusetts. You can also find this list in our printed *Provider Directory*. You can call us at 888-257-1985 to ask for a copy of the *Provider Directory*.

Bring your *Network Health Together* and MassHealth ID Cards with you.

You do not need approval from your health care Provider to get Emergency care. You can get Emergency care 24 hours a day, seven days a week, wherever you are, even when you're traveling. We also cover Emergency-related ambulance transportation and Post-stabilization Care Services, which is care to help you get better after an Emergency. A health care Provider will examine and treat your Emergency health needs before sending you home or moving you to another Hospital, if necessary.

Tell your PCP and, if applicable, your Behavioral Health services Provider what happened within 48 hours of an Emergency in order to get follow-up care, if necessary.

### Examples of medical Emergency conditions:

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

### Examples of Behavioral Health Emergency conditions:

- Violent feelings toward yourself or others
- Hallucinations

## Post-stabilization Care Services

Post-stabilization Care Services include Inpatient Services, additional tests, or outpatient care that help you recover and maintain your health after an Emergency. *Network Health Together* Members can get Post-stabilization Care Services at Hospitals and all health care centers that provide Emergency services. Please call us at 888-257-1985 or use our online Provider Directory at [www.network-health.org](http://www.network-health.org) for a complete list of Emergency rooms and Emergency Services Program (ESP) Providers in Massachusetts. You can call us at 888-257-1985 if you would like a printed copy of our *Provider Directory*, which also has this information.

## Urgent Care situations

An Urgent Care situation is when you experience a health problem that needs attention right away — like when you have flu-like symptoms that are getting worse or when you have a cough or cold that is not getting better — but you do not believe you are having an Emergency.

### In urgent situations:

- Call your PCP or Behavioral Health Provider. You can contact any of your health care Providers' offices 24 hours a day, seven days a week.
- If appropriate, make an appointment to visit your health care 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 Emergency room. If you have a Behavioral Health (mental health and/or substance abuse) concern, you may also call your local Emergency Services Program (ESP) Provider.

## Region and Service Area information

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Service Area is the geographic area in which Network Health has developed a Network of Providers to provide adequate access to Covered Services.

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We offer *Network Health Together* throughout Massachusetts and we work with doctors, hospitals, and other Providers to offer health care services across the state. You can choose any PCP in *Network Health Together's* Service Area. You should choose a PCP in the Region where you live. For more information about the Regions where we offer *Network Health Together*, call our Customer Service Team at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m.

## ID Card information

Everyone in your family with *Network Health Together* will get a *Network Health Together* Member ID Card. Your *Network Health Together* Member ID Card has important information about you and your benefits. Your Member ID Card also tells Providers and pharmacists that you are a *Network Health Together* Member.



When you get your *Network Health Together* Member ID Card, please read it carefully and make sure all information is correct. If you have questions or concerns about your *Network Health Together* Member ID Card, if you lose your Member ID Card, or if you do not get your Member ID Card, call our Customer Service Team at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m.

## Your MassHealth Card

As a MassHealth Member of *Network Health Together*, you will also have a MassHealth ID Card. For information about your MassHealth ID Card, call the MassHealth Customer Service Center at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m. Your MassHealth ID Card looks like this:



Always carry your *Network Health Together* and MassHealth Member ID Cards with you so you have them when you need care. Show both your *Network Health Together* and MassHealth ID Cards when you get health care or fill a prescription.

## Getting information about Network Health Together Providers

For information about Network Health Providers:

- Call us at 888-257-1985.
- Visit us online at [www.network-health.org](http://www.network-health.org).
- Call us and ask for a *Provider Directory*.

## Network Health Together Provider Directory

Our *Provider Directory* lists the following type of *Network Health Together* Providers by Region:

- Primary Care sites
- Primary Care Providers (PCPs)
- Hospitals
- Specialty Providers
- Behavioral Health (mental health and substance abuse) Providers

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 regional Provider directories also list all *Network Health Together* pharmacies, facilities, Ancillary Providers, Hospital Emergency services, Emergency Services Program (ESP) Providers for Behavioral Health (mental health and/or substance abuse), and durable medical equipment suppliers.

For the most up-to-date information about Providers, visit our Web site at [www.network-health.org](http://www.network-health.org). For a copy of our *Provider Directory*, call our Customer Service Team at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m.

## Your Primary Care Provider (PCP)

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A PCP is the Provider who manages your care. You can choose a doctor or a nurse practitioner as your PCP.

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As a Member of *Network Health Together*, you must choose 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 will be able to help you. If you have problems contacting your health care Provider, please call us at 888-257-1985. If you want to talk to a customer service representative who can help you with any questions you may have, call during our office hours, from 8 a.m. to 5 p.m., Monday through Friday. We're also available 24 hours a day, seven days a week for Behavioral Health (mental health and substance abuse) issues and questions at 888-257-1985.

To choose a *Network Health Together* PCP and find out where the PCP's office is located, please visit us online at [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985. You can choose any PCP in *Network Health Together's* Service Areas. You should choose a PCP in the Region where you live.

If you want a copy of our *Provider Directory*, please call and ask us to send one to you. If you would like additional information about a Provider that we do not list in the *Provider Directory*, upon request, we can also give you information about PCPs, and other Providers, listed in our *Provider Directory* (like a Provider's professional qualifications, the names of any medical or professional school(s) he/she attended, where a residency or training took place, malpractice information and/or, for doctors, board certification status). We are happy to help.

## Your PCP:

- Gives you regular checkups and health screenings, including Behavioral Health (mental health and/or substance abuse) screenings
- Makes sure you get the health care you need
- Arranges necessary tests, laboratory procedures, or Hospital visits
- Keeps your medical records
- Recommends Specialists, when necessary
- Provides information on Covered Services that need Prior Authorization (permission) before you get treatment
- Writes prescriptions, when necessary
- Helps you get Behavioral Health services, when necessary

## PCP assignment

If you do not choose a PCP within 15 calendar days of joining Network Health, we will choose one for you and tell you your PCP's name. We will also choose a PCP for you if the PCP you choose is not available. If MassHealth assigned you to Network Health because you did not select a health plan, we picked a PCP for you near to where you live. You can always choose a different PCP by calling us at 888-257-1985 or by visiting [www.network-health.org](http://www.network-health.org).

## Getting care after office hours

Talk to your PCP to find out about getting care after normal business hours. Some PCPs may have longer office hours. If you need Urgent Care after regular business hours, call your PCP's office. PCPs have covering Providers after hours. If you have any problems seeing your health care Provider, please call us at 888-257-1985, from 8 a.m. to 5 p.m., Monday through Friday.

You can get free health support from our NurseLine to help you stay healthy 24 hours a day, seven days a week. Call any time at 888-MY-RN-LINE (888-697-6546),

TTY: 800-942-1859. You can get help in many languages! Remember, the NurseLine doesn't replace your PCP.

## Prior Authorizations

To make sure you get the care you need, your PCP will work with your other health care Providers. Your Providers will need to ask us for Prior Authorization (permission) for certain services before giving them to you. Then, we will decide if the service is Medically Necessary.

Except as listed below, we must give your health care Providers Prior Authorization before you see certain In-network Providers. Preferred In-network Providers are Providers you can see without your PCP or other Provider asking for Prior Authorization. Nonpreferred In-network Providers and Out-of-network Providers are Providers who need Prior Authorization from us before you can see them. Your PCP will ask us for Prior Authorization when you need a service or need to get care from a Provider or at a location that requires prior approval. For these requests, we will determine whether we have a qualified In-network Provider who can provide the service and if the service is Medically Necessary. Please visit us online at [www.network-health.org](http://www.network-health.org) for the most up-to-date listing of all our Providers.

Emergency health care, Post-stabilization Care Services, Family-planning Services, and the first 26 outpatient Behavioral Health visits do not require Prior Authorization.

You can get Emergency services from any Provider of Emergency care in Massachusetts. You can get Family-planning Services from any MassHealth-contracted Family-planning Services Provider. If you become a Network Health 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 will review that treatment and may approve your continued treatment by the same Provider. Also, if we do not have an In-network Provider able to treat your health condition, we will authorize an Out-of-network Provider for you.

Please see the enclosed *Covered Services List* for more details about which services require Prior Authorization.

When a medical Covered Service requires Prior Authorization, your health care Provider will need to submit a Prior Authorization request to us. Your Provider can request an expedited (fast) Authorization decision if taking the time for a standard decision could seriously risk your life, health, or your ability to get, maintain, or regain maximum function. We review standard and expedited (fast) Authorization requests and make decisions within the time frames we list in the next sections.

## Standard Prior Authorizations

We make standard Prior Authorization decisions as fast as your health condition requires, but in no more than 14 calendar days after we get the request. You, your Authorized Representative, your health care Provider, or we can extend this time frame by an additional 14 calendar days if:

- You, your Authorized Representative, or your health care Provider ask for an extension, or
- We can show that the extension is in your interest; we need more information; we believe we will 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 will send you a letter explaining the reasons for the extension. We will also tell you of your right to file a Grievance if you disagree with our decision to take an extension. If we do not act within these time frames, you may also file an Internal Appeal.

## Expedited (fast) Prior Authorizations

We make expedited (fast) Prior Authorization decisions as fast as your health requires, but in no more than 72 hours after we get the expedited (fast) service request. You, your Authorized Representative, your health care Provider, or we can extend this time frame by an additional 14 calendar days if:

- You, your Authorized Representative, or your health care Provider ask for an extension, or
- We can show that: the extension is in your interest; we need more information; we believe we will have the information within 14 calendar days; and, there is a reasonable likelihood that such information would lead to approving the request.

If we decide to extend the 72-hour time frame, we will send you a letter explaining the reasons for the extension. We will also tell you of your right to file a Grievance if you disagree with the extension request. If we do not act within the time frames, you may also file an Internal Appeal.

For details on filing an Internal Appeal or Grievance, please see the “Your concerns” section in this *Member Handbook*.

## Prior Authorization approvals and denials

Once we review the request for service(s), we will tell you, your Authorized Representative if you identify one, and your Provider our decision. If we authorize the service(s), we will send your Provider an Authorization letter that will state the service(s) we agree to cover. The Provider providing the service(s) must have this Authorization letter before you can get any service(s) requiring an Authorization. Your Provider will ask us for additional Authorization if you need a service or services beyond what we authorized. If we approve the request for additional service(s), we will send you, your Authorized Representative if you identify one, and your Provider another Authorization letter.

If we do not authorize any of the service(s) requested, authorize only some of the service(s) requested, or do not authorize the full amount, duration, or scope of service(s) requested, we will send you, your Authorized Representative if you identify one, and your Provider a denial letter. We will not pay for any unauthorized services. We will also send you, your Authorized Representative if you identify one, and your Provider a notice if we decide to reduce, suspend, or stop providing previously authorized service(s). If you disagree with any of these decisions, you can file an Internal Appeal. For details on filing an Internal Appeal, please see the “Your concerns” section in this *Member Handbook*.

## Specialists

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

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Sometimes you may need to visit a Specialist, such as a cardiologist (heart doctor), dermatologist (skin doctor), or ophthalmologist (eye doctor). You can visit most Specialists without Prior Authorization as long as the Specialist is a Preferred In-network Specialist. To make an appointment, call the Specialist’s office. It’s best to discuss your need to see a Specialist with your PCP first.

For some services, like for the first 26 outpatient Behavioral Health (mental health and/or substance abuse) visits and for any Family-planning Services visits, you do not need to have Prior Authorization.

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**Preferred In-network Providers are Providers you can see without your Provider asking for Prior Authorization.**

**Nonpreferred In-network Providers are Providers, facilities, or clinicians in our Network who/that require Prior Authorizations.**

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If the Specialist your PCP wants to send you to is a Nonpreferred In-network Specialist or Out-of-network Specialist, your PCP will need to ask us for Prior Authorization before sending you to see this Specialist. We may approve your PCP's request, deny your PCP's request, or ask your PCP to make a different Prior Authorization request. Our list of Providers online at [www.network-health.org](http://www.network-health.org) shows which Providers need Prior Authorization, or you can call us at 888-257-1985 to find out which Providers need Prior Authorization. Remember, if you do not get written approval to see a Nonpreferred In-network or Out-of-Network Specialist, we will not cover the services. If you choose to get the service, you will be responsible for payment.

To find a *Network Health Together* Specialist, talk to your PCP. You can also call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to search for a Specialist. We also list Specialists in our *Provider Directory*; you can call us to get a copy.

## Continuity of Care

As a new Network Health Member, we will make sure any care you currently get continues as smoothly as possible. To ensure Continuity of Care, we may be able to cover some health services, including Behavioral Health (mental health and substance abuse) services, from a Provider who is not part of our Network:

- If you are in the second or third trimester of your pregnancy, you can keep seeing your current OB/GYN (even if Out-of-Network) through delivery and a follow-up checkup within the first six weeks of delivery. Your second trimester begins at the start of the fourth month of pregnancy based on your expected delivery date.
- For up to 30 days, if you are getting ongoing covered treatment or management of chronic issues (like dialysis, home health, chemotherapy, and radiation), including previously authorized services or Covered Services.

You must make sure that your Provider asks us for and gets Prior Authorization before you see an Out-of-Network Provider. You may ask your Provider to ask for the Prior Authorization or call our Customer Service Team at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m.

If your PCP or another Provider is disenrolled from our Network for reasons not related to quality of care or Fraud, we will make every effort to tell you at least thirty (30) days before the Disenrollment, and we may be able to provide coverage:

- For up to 30 calendar days if the Provider is your PCP, or up to 90 calendar days if the Provider, including a PCP, is actively treating a chronic or acute medical condition or until that Provider completes the active treatment, whichever comes first.
- If you are in the second or third trimester of your pregnancy, you can keep seeing your current OB/GYN (even if Out-of-Network) through delivery and a follow-up checkup within the first six weeks of delivery. Your second trimester begins at the start of the fourth month of pregnancy based on your expected delivery date.
- With respect to a terminal illness, until death.

*Network Health Together* also covers Providers who are not part of its Provider Network:

- When a participating In-network Provider is unavailable because of distance and travel
- To minimize disruption of care when delays in seeing a participating In-network Provider, other than Member-related delays, would result in interrupted access to Medically Necessary Services
- If there is not a participating In-network Provider with the qualifications and expertise that a Member needs to care for his or her health care needs

To continue getting care in these situations, your Provider must follow our quality standards and tell us about the care you're getting. Also, the Provider must follow our policies and procedures, ask for Prior Authorizations when necessary, and follow a treatment plan, if we approve one.

A disenrolled Provider must also agree to accept payment from us (at the rates in effect prior to Disenrollment) as payment in full. The Provider must not ask that you or we pay for any services that you or we would not have had to pay for *before* the Provider's disenrollment.

A Provider's failure to agree to these conditions may result in a denial of coverage for the provided service. If you have any questions, please call our Customer Service Team at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m.

## You can get a Second Opinion

*Network Health Together* Members can get a free Second Opinion from a different health care Provider about a medical or Behavioral Health (mental health and/or substance abuse) 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. You can see the most up-to-date list of our In-network Providers online at [www.network-health.org](http://www.network-health.org). If you want to get a Second Opinion about a Behavioral Health (mental health and/or substance abuse) issue or concern, you may need to ask for Prior Authorization. Please call us at 888-257-1985 for help or for more information about picking a Provider to see for the Second Opinion.

## Hospital services

If you need Hospital services for something 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 are 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 health care Provider's direction. For other routine health care issues, call your PCP. For routine Behavioral Health (mental health and/or substance abuse) issues, call your Behavioral Health Provider. If you are outside of Network Health's Service Area, we will only cover Emergency, Post-stabilization Care, or Urgent Care services. We will not cover:
  - Tests or treatment that your Primary Care Provider asked for before you left 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 (mental health and/or substance abuse) counseling

- Care that that you knew you were going to get before you left the Service Area, such as elective surgery

A Provider may ask you to pay for care you get outside of Network Health's Service Area at the time of service. If you pay for Emergency Care, Post-stabilization Care, or Urgent Care that you get outside of Network Health's Service Area, you may ask Network Health to reimburse you. You may also call a customer care specialist for help with any bills that you may get from a Provider.

## Covered Services

### Services Network Health covers

As a *Network Health Together* Member, you get some services from us and other services from MassHealth, but we coordinate all Covered Services and benefits for you. The services you get directly from us include all the Covered Services and benefits from MassHealth Standard/CommonHealth, Family Assistance, Basic, and Essential plans, PLUS EXTRA benefits and services just for *Network Health Together* Members. Make sure you always show your *Network Health Together* and MassHealth ID Cards when you get health care services.

As a *Network Health Together* Member, you get all of the Covered Benefits listed in your *Covered Services List*. Please see the enclosed *Covered Services List* for details, including Prior Authorization requirements, for *Network Health Together* Members on MassHealth Standard/CommonHealth, Family Assistance, Basic, or Essential plans. You can begin getting these Covered Benefits as of the Effective Date of your *Network Health Together* Enrollment. If you have questions about any Covered Services call us at 888-257-1985.

You can get Emergency Services from any Provider of Emergency Services. You can get Family-planning Services at any MassHealth-contracted Family-planning Services Provider. Most Covered Services, including Emergency health care, Post-stabilization Care Services, Family-planning Services, and the first 26 outpatient Behavioral Health (mental health and/or substance abuse) visits, do not require Prior Authorization. Prior Authorization means your health care Provider needs to ask us for approval before you get a health care service. We make a decision based on whether you need the service to get better or stay healthy, and if you would get the service in the right place.

Visits to most Out-of-network Providers and Nonpreferred In-network Providers require Prior Authorization. Your PCP or other health care Provider will ask us for Prior Authorization. Our list of Providers (available online at [www.network-health.org](http://www.network-health.org)) shows which Providers are Nonpreferred and need Prior Authorization. You can also call us to find out which Providers need Prior Authorization or use our *Provider Directory*. Call us and ask us to send you a copy.

For more information about Prior Authorizations, please see the “Getting the care you need” section of this *Member Handbook*.

## Services MassHealth covers

MassHealth covers some services, like personal care attendants, for eligible *Network Health Together* Members.

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

We can help you get these MassHealth Covered Services. Call us at 888-257-1985 or call the MassHealth customer service center at 800-841-2900 (TTY: 800-497-4648).

As a benefit from MassHealth, you may be eligible to get help setting up non-Emergency transportation to go to health care visits. We help coordinate this service with MassHealth for you. For help setting up non-Emergency transportation you may qualify for, you must:

- Have an appointment for a Medically Necessary service
- See a MassHealth Provider
- Have a medical reason why you can't use public transportation
- Not be able to access public transportation
- Not have anyone who can take you to your appointment

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

## Services not covered

MassHealth and Network Health do not cover the following services, except where indicated.

- Cosmetic surgery, except when determined to be Medically Necessary for:
  - Correcting or repairing damage after an injury or illness that occurred while you are a MassHealth Member
  - Mammoplasty after a mastectomy
- Infertility diagnosis and treatment
- Experimental treatments — please see page 12 for more information
- Personal comfort items, including air conditioners, radios, telephones, and televisions
- Services MassHealth does not cover, except what Network Health thinks is necessary for MassHealth Members under age 21
- Any service you get from someone other than a Network Health Provider or at the direction of someone other than a Network Health Provider, except for:
  - Emergency services
  - Family-planning Services
  - Services for newborns before the newborn is enrolled in Network Health
- Certain noncovered laboratory services

## Getting a bill for Covered Services

Your health care Provider should not bill you for any Covered Service. If you get a bill that you believe is in error, call us at 888-257-1985 (TTY: 888-391-5535). We can help.

If you have any questions about whether we or MassHealth cover a specific service, please call us at 888-257-1985 (TTY: 888-391-5535), Monday through Friday, from 8 a.m. to 5 p.m.

## Clinical guidelines and review criteria

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Utilization Review criteria is information from doctors and other clinicians that we use to help us decide what services you need to get better or stay healthy.

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When deciding what services you need to get better or stay healthy, we make consistent and objective decisions. And, we consider your health care needs. 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

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

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We base all Utilization Management (UM) decisions on how appropriate the care is and your coverage. We do not reward Providers, UM clinical staff, or consultants for denying care. We do not offer Network Providers, UM clinical staff, or consultants money or financial incentives that could encourage them not to use a certain service. Call us at 888-257-1985 if you want information or have questions about Utilization Management and how we determine the care we authorize.

## Evaluating experimental and/or investigational drugs and procedures

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Experimental and/or investigational procedures are new kinds of care that we have to decide whether to cover based on scientific evidence and what doctors and other clinicians recommend.

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As new technologies emerge, 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. Our medical management team, which our chief medical officer leads, makes all decisions on whether or not we cover experimental and/or investigational procedures, including clinical trials.

## Access to Covered Services

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Access to Covered Services is how fast you should be able to get the care you need.

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

### Medical

- Emergency care: Immediately.
- Urgent Care: Within 48 hours of your request for an appointment.
- Primary care:
  - Non-urgent, symptomatic care: Within 10 calendar days of your request for an appointment
  - Routine, non-symptomatic care: Within 45 calendar days of your request for an appointment
- Specialty care:
  - Non-urgent, symptomatic care: Within 30 calendar days of your request for an appointment
  - Routine, non-symptomatic care: Within 60 calendar days of your request for an appointment

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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.

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### Behavioral Health (mental health and/or substance abuse) services

- Emergency care: Immediately.
- Urgent Care: Within 48 hours of your request for an appointment
- Other services: Within 14 calendar days of your request for an appointment
- For services described in 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 twenty-four (24) hours of Referral, including self-Referral, offering a face-to-face interview with the family

## Children in the care or custody of the Department of Children and Families (DCF)

If you have a child in the care or custody of DCF, a Provider must:

- Give your child a health care screening within seven calendar days after you or a DCF worker asks for it
- Give your child a full medical exam within 30 calendar days after you or a DCF worker asks for it (unless the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services schedule calls for an earlier time frame. See page 16 for EPSDT information).

If your health care Provider does not provide you with care within these time frames, you may file an Internal Appeal. We describe our Internal Appeal process in the “Your concerns” section of this *Member Handbook*.

## Covered drugs and pharmacy

We have enclosed with this *Member Handbook* a *Covered Services List* for each MassHealth plan (Standard/CommonHealth, Family Assistance, Basic, or Essential). The *Covered Services List* describes the *Network Health Together* covered drugs and pharmacy benefits.

## Co-payments

If you are 19 and older, and you have a prescription from your health care Provider, you can get your covered drugs for a small Co-payment. Some Members ages 19 and older do not need to pay a Co-payment.

You do not need to pay a Co-payment if you:

- Are under 19 years old
- Are enrolled in MassHealth because you were in the care and custody of the Department of Children and Families (DCF) when you turned 18, and you continue to have MassHealth
- Are pregnant, or your pregnancy ended fewer than 60 days ago
- Are a patient in a nursing facility; chronic-disease, acute, or rehabilitation Hospital; or intermediate-care facility for the developmentally delayed
- Get hospice care
- Have already met the Co-payment Cap for the current year as described in the next section

*\*Be sure to tell the pharmacist if you do not need to pay a Co-payment when you drop off your prescription — especially if you are pregnant.*

A pharmacist at any large-chain or independent pharmacy in Massachusetts can fill your prescription. For a complete list of participating pharmacies, please visit us online at [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985. When you call, you can ask us to send you a copy of our *Provider Directory*.

**If at any time you cannot pay a pharmacy Co-payment, the pharmacist must still fill your prescription.** The pharmacy may bill you later for any unpaid Co-payments. If you have any questions about Co-payments or pharmacy bills, please call us at 888-257-1985 for help.

You do not have to pay a Co-payment for Family-planning Services supplies, such as birth control pills, or for diabetic supplies or spacers and peak flow meters for asthma, as long as you have a doctor’s prescription.

## Yearly Co-payment limit

Unless you do not need to pay a Co-payment as previously described, MassHealth Members ages 19 and older have a \$200 Co-payment Cap (limit) on the Co-payments pharmacists can charge each calendar year (January 1 through December 31). The cap is the total amount of Co-payments pharmacists have charged you, not what you have paid. A pharmacy should never charge you a Co-payment after you reach the cap, even if you have not paid all the charges up to \$200.

We will send you a letter when you reach your Co-payment Cap. If your pharmacy continues to charge you a Co-payment, tell the pharmacist you met the Co-payment Cap. If you have any problems, call us at 888-257-1985. We can help.

If you reached your pharmacy Co-payment Cap but did not get a letter from us to confirm it, send us a printout of your pharmacy record or copies of original Co-payment receipts and bills. Send the copies with your name and *Network Health Together* Member ID number to: Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155. Once we get this information, we will tell your pharmacy and send you the letter.

*Please note: All MassHealth Members ages 19 and older who pay Co-payments pay the same Co-payment amount and have the same yearly Co-payment Cap.*

## Medicare Part D

If you have Medicare coverage, your Medicare prescription drug coverage (Part D) plan will cover most of your prescription drugs. You should have a separate ID Card for your Medicare prescription drug coverage. Please show your pharmacist your Medicare Part D ID Card when you fill a prescription.

Even if you have Medicare Part D, we will cover some drugs, such as select over-the-counter (OTC) drugs. The Co-payment amounts and exceptions we describe earlier still apply to these covered drugs. For more information, please call us at 888-257-1985. You can also find out more about your Medicare prescription drug coverage by calling Medicare at 800-633-4227 (TTY: 877-486-2048), visiting Medicare's Web site at [www.medicare.gov](http://www.medicare.gov), or referring to your *Medicare and You Handbook*. Remember to carry all your ID Cards with you when you go to the pharmacy. When you fill a prescription, please show your Network Health Member ID Card and your Medicare Prescription ID Card.

## 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 for a variety of conditions and diseases. Network Health covers first-time prescriptions and refills. We also cover some over-the-counter (OTC) drugs with a prescription.

Our pharmacy program does not cover all drugs and prescriptions. Some drugs must meet certain clinical guidelines before we can cover them. Your Provider must ask for Prior Authorization from us before we will cover one of these drugs. Please see the following Prior Authorization section for more information.

## Preferred Drug List

*Network Health Together* uses a *Preferred Drug List (PDL)* as our list of covered drugs. We update the *PDL* every three months. The *PDL* applies only to drugs you get at retail and specialty pharmacies. The *PDL* does not apply to drugs you get if you are in the Hospital. For the most current *PDL*, please visit [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985.

## Exclusions

We do not cover some drugs. If it is Medically Necessary for you to take an excluded drug, your Provider must ask for and get Prior Authorization from us before we will cover the drug. A clinician will review the request. If we do not approve the Prior Authorization request, you and/or your Authorized Representative can appeal the decision. See the "Your concerns" section of this *Member Handbook* for Grievance and Appeal information. If you want more information about our pharmacy program, visit our Web site at [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985.

We do not cover:

- Anorectics or any drug used for weight loss
- Any drug products used for cosmetic purposes
- Brand-name products when you can get FDA-approved generics
- Contraceptive implants (we may cover these implants as a non-pharmacy benefit)
- Immunization agents, blood, or blood plasma products (we may cover these products as a non-pharmacy benefit)
- Infertility agents
- Medical supplies (we may cover these supplies as a non-pharmacy benefit)
- Mifepristone (Mifeprex) (we cover Mifepristone as a non-pharmacy benefit)

## Prior Authorization

Some drugs always require Prior Authorization, which means your Provider must ask us for approval before we will cover the drug. A clinician will review this request. We will cover the drug according to our clinical guidelines if:

- There is a medical reason you need the particular drug.
- Depending on the drug, other drugs on the *PDL* have not worked.

If we do not approve the Prior Authorization request, you and/or your Authorized Representative can appeal the decision. See the "Your concerns" section of this *Member Handbook* for Grievance and Appeal information. If you want more information about our pharmacy program, visit our Web site at [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985.

## Step therapy program

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### Step therapy means that before we pay for some drugs, you have to first try a certain drug.

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We cover some types of drugs only through our step therapy program. Our step therapy program requires you to try certain drugs first before we will cover another drug of that type. If you and your Provider feel a certain drug is not appropriate for treating your health condition, your Provider can ask us for Prior Authorization. A clinician will review the request. We will cover the drug according to our clinical guidelines if:

- There is a medical reason you need the particular drug.
- Depending on the drug, other drugs on the *PDL* have not worked.

If we do not approve the Prior Authorization request, you and/or your Authorized Representative can appeal the decision. See the “Your concerns” section of this *Member Handbook* for Grievance and Appeal information. If you want more information about our pharmacy program, visit our Web site at [www.network-health.org](http://www.network-health.org), or call us at 888-257-1985.

### Quantity limits

To make sure the drugs you take are safe, 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. A clinician will review the request. We will cover the drug according to our clinical guidelines if there is a medical reason you need this particular amount. We must give Prior Authorization before we will cover larger amount. If we do not approve the Prior Authorization request, you and/or your Authorized Representative can appeal the decision. See the “Your concerns” section of this *Member Handbook* for Grievance and Appeal information. If you want more information, visit our Web site at [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985.

### Specialty pharmacy program

A specialty pharmacy needs to supply you with some drugs, such as injectable and intravenous (IV) drugs health care Providers often use 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 you and your health care Providers.

Caremark is our specialty pharmacy. It will provide you with these types of drugs if you need them. In addition to providing specific specialty drugs, Caremark will:

- Deliver drugs to your home, Provider’s office, or any delivery address you choose (except for a P.O. box)
- Answer your questions and offer help with your medicine
- Give you information, materials, and ongoing support to help you manage your health condition and make sure you take your drugs the right way
- Provide staff pharmacists who can help you 24 hours a day, seven days a week at 800-237-2767

Please visit us at [www.network-health.org](http://www.network-health.org) for a list of the drugs Caremark provides. You cannot get these drugs at a retail pharmacy.

### Generic drugs

When you can get a generic drug, we will not cover the brand-name drug without Prior Authorization. Generic drugs have the same active ingredient, work the same as brand-name drugs, and have lower Co-payments. If you and your Provider feel a brand-name drug is Medically Necessary, your Provider can ask for Prior Authorization. A clinician will then review the request.

We will cover the brand-name drug according to our clinical guidelines if there is a medical reason you need the particular brand-name drug. If we do not approve the Prior Authorization request, you and/or your Authorized Representative can appeal the decision. See the “Your concerns” section of this *Member Handbook* for Grievance and Appeal information. If you want more information about our pharmacy program, visit our web site at [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985.

### New-to-market drugs

We review new drugs for safety and effectiveness before we add them to our *PDL*. A Provider who feels a new-to-market drug is Medically Necessary for you can submit a Prior Authorization request. A clinician will review this request. If we approve the request, we will cover the drug according to our clinical guidelines. If we do not approve the Prior Authorization request, you and/or your Authorized Representative can appeal the decision. See the “Your concerns” section of this *Member Handbook* for Grievance and Appeal information.

If you have questions about our pharmacy program or benefits, please call us at 888-257-1985.

## Health care for children

### Preventive Pediatric Health Care Screening and Diagnosis (PPHSD) Services

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Diagnostic services are tests and other things a doctor does or sends you to have (like X-rays and lab tests) to help find out why you are sick or hurting.

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If you, or your child, are under 21 years old and enrolled in MassHealth Basic, Family Assistance, or Essential, we will pay for all Medically Necessary Covered Services. This means that when a PCP (or any other health care Provider) finds a health condition, we will pay for any Medically Necessary covered treatment.

### Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

If you, or your child, are under age 21 and enrolled in MassHealth Standard or CommonHealth, we will pay for all Medically Necessary services federal Medicaid law covers, even if the services are not in your *Covered Services Lists*. These services, called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), include health care, diagnosis, treatment, and other care you or your child need to correct or improve defects and physical and mental illnesses and conditions.

When a PCP (or any other health care Provider) discovers a health condition, we will pay for any Medically Necessary treatment covered under Medicaid law if a Provider who is qualified and willing to provide the service gives it to you. Your health care Provider must also tell us in writing why you need the service. 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 do not cover the service, or if the *Covered Services List* does not include the service, the Provider delivering the service can ask us for Prior Authorization. We will pay for the service if we agree the service is necessary and we approve the Prior Authorization request.

If we do not approve the Prior Authorization request, you have a right to Appeal. See the “Your concerns” section of this *Member Handbook* for more information about the Grievances and Appeals process. Talk to your child’s PCP, Behavioral Health (mental health and/or substance abuse) Provider, or other Specialist for help getting these services.

### Preventive and well-child care for all children

Children who are under age 21 should go to their PCP for checkups even when they are well. As part of a well-child checkup, your child’s PCP will offer necessary screenings to find out if there are any health problems. These screenings include health, vision, dental, hearing, Behavioral Health (mental health and/or substance abuse), developmental, and immunization status screenings.

Network Health pays your child’s PCP for well-child checkups. 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 two through 20 — children should visit their PCP once a year

Children should also visit their PCP any time you are concerned about a medical, emotional, or Behavioral Health (mental health and/or substance abuse) 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, to check a child’s Behavioral Health (mental health and/or substance abuse) status during well-child visits. Screening tools are short questionnaires or checklists that a parent or child (depending on the child’s age) fill out and then discuss with the PCP or nurse.

Your PCP will discuss the completed screening with you. The screening will help you and your health care Provider decide if your child may need further assessment by a Behavioral Health (mental health and/or substance abuse) Provider or other medical professional. If you or your doctor or nurse thinks that your child needs to see a Behavioral Health (mental health and/or substance abuse) Provider, please call us at 888-257-1985 and we can give you information and help.

## Behavioral Health (mental health and/or substance abuse) care for children

Your child's Behavioral Health (mental health and/or substance abuse) care Provider will conduct a Behavioral Health assessment, including the Child and Adolescent Needs and Strengths (CANS) tool. The CANS tool gives Behavioral Health (mental health and/or substance abuse) Providers a standardized way of organizing information during Behavioral Health (mental health and/or substance abuse) 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 (mental health and/or substance abuse) Provider will use the CANS tool during an initial assessment and at least every 90 days after 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

Your child's Behavioral Health (mental health and/or substance abuse) 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 (mental health and/or substance abuse) services, or to find a Behavioral Health (mental health and/or substance abuse) Provider, you can talk to your PCP, or call our Customer Service Team at 888-257-1985. You can also find this information on our Web site, [www.network-health.org](http://www.network-health.org), and in our *Provider Directory*. Call us if you'd like a copy of the *Provider Directory*.

## Children's Behavioral Health Initiative (CBHI)

The Children's Behavioral Health Initiative is a state initiative to make sure you and your children with significant behavioral, emotional, and mental health needs, if any, get any necessary services to do well at home, in school, and in your community.

As part of the Children's Behavioral Health Initiative, 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

A Community Service Agency (CSA) offers care coordination 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 PCP, or call our Customer Service Team at 888-257-1985. You can also find this information on our Web site, [www.network-health.org](http://www.network-health.org) and in our *Provider Directory*. Call us if you'd like a copy of the *Provider Directory*.

Your child can also get 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 us at [www.network-health.org](http://www.network-health.org).

## 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 three, or younger if there are problems. Your child's PCP will tell you to start taking your child to the dentist after his/her third birthday.

When your child goes to the dentist for a regular exam, your child will get a full dental exam, teeth cleaning, and fluoride treatment. Make sure that your child gets:

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

Network Health also covers Medically Necessary fluoride varnish for Members under 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 licensed practical nurses can apply fluoride varnish.

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

Children under age 21 and enrolled in MassHealth Basic, Family Assistance, or Essential 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 three.

## Other services for children

Children under 21 years old 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 early intervention services from health care Providers who are early intervention specialists such as:

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

All of these Providers work with children under three years old — and their families — to make sure a child gets any necessary extra help. 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 development problems. You can also contact your local early intervention program directly.

## Preventive care for adults ages 21 and older

You should visit your Primary Care Provider (PCP) for preventive care. Examples of covered preventive care for adults ages 21 and older include:

- Checkups: every one – 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 – 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

# Care Management

Care Management is everything we do to help keep you well and improve your health. Our Care Management services include helping you make and keep appointments, getting you health information, and coordinating your care with your health care Provider(s). Care Management includes four main types: health and wellness supports, disease management, care coordination (Utilization Management aftercare), and Integrated Care Management, which includes Complex Care Management and Intensive Clinical Management. Care Management services do not replace the care you get from your PCP or other health care Provider(s) but help support it. Please remember to continue to schedule regular and ongoing visits with your health care Providers.

Our care managers work with your health care Provider(s) to coordinate your care and make sure you get the care you need when you need it. To help us do this, be sure to fill out a Your Health form each year or any time your health status changes. You can fill it out over the phone or on our Web site, [www.network-health.org](http://www.network-health.org). Call us at 888-257-1985 to talk to our Care Management team, Monday through Friday, from 8 a.m. to 5 p.m., or our on-call service at night and on the weekends.

## Health coaching

We understand how important it is for you to feel in control of your health. Learning to take control of your health when you have a chronic health problem (such as diabetes or asthma) can feel overwhelming. You can use health coaching services if you have asthma, diabetes, congestive heart failure, coronary artery disease, chronic lung disease, and other chronic diseases, as appropriate. If you have one of these conditions, learn how our health coaching can help you feel good about the health care decisions you're making.

Visit us at [www.network-health.org](http://www.network-health.org) or call us at 888-MY-RN-LINE (888-697-6546) about health coaching services for:

- **Personalized health coaching**  
Our health coaches are specially trained health professionals available 24 hours a day, seven days a week to talk to you about your immediate or everyday health concerns.
- **Valuable health information**  
We have easy-to-understand articles on thousands of health topics for you at [www.network-health.org](http://www.network-health.org).

- **Information on local health classes and services**  
We have information about health classes and other health-related services in your community. We can help you quit smoking, lose weight, manage your diabetes, reduce stress, and more.
- **Healthy reminders throughout the year**  
Depending on your health needs, we may send reminders about important tests or information you should discuss with your health care Provider(s).

## Wellness services

Along with health coaching, we also offer wellness services. These services include:

- Providing you with general health information
- Covering children and adolescents under age 21 for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services
- Coordinating maternal and child health services through our Early Intervention Partnership Program if you are pregnant
- Offering a free 24/7 NurseLine you can call for help with any health question: 888-MY-RN-LINE (888-697-6546)

## Maternal and child health wellness program

We work closely with you and your health care Provider(s) to make sure you get ongoing prenatal care if you're pregnant. We can also help coordinate care for you and your newborn after you deliver.

For information about the benefits and services we offer pregnant *Network Health Together* Members, see page 25.

## NurseLine

We have a 24-hour NurseLine for help with health questions, seven days a week. When you call our NurseLine at 888-MY-RN-LINE (888-697-6546), you can talk with a caring and supportive health care professional at any hour and at no cost. Our NurseLine is staffed by specially trained health care professionals. NurseLine staff can give you information and support on health care issues like symptoms, diagnoses, treatments, tests, test results, and procedures your Provider orders. NurseLine staff do not give medical advice. They are not a replacement for your Provider.

## Disease management programs

We want to help you get the best health care possible. We use evidence-based practice guidelines (guidelines based on the best research) as a clinical basis for our disease management programs. These programs help you live as healthfully as possible and to feel your best. We have health care specialists who are experts on many health topics, so we can connect you with information and community resources you can really use. For more information, please visit us at [www.network-health.org](http://www.network-health.org) or call us at 888-257-1985.

We have disease management programs for the following conditions:

### Asthma

There is a lot you can do to keep asthma from keeping you down. Working with your Provider, we can help you avoid trips to the Emergency room and live life to its fullest. The first step is learning more about asthma and how to manage it. We have the information, tools, and experts available to help you understand asthma and its causes, triggers, and symptoms. This information includes how to spot the warning signs of a flare-up (attack) before it happens. To help you get the most from our asthma program, we can even send a nurse to your home to help you get started.

To help you better manage your asthma, you and your Provider can develop a personalized written action plan. It can help you know what to do if you experience a flare-up of your asthma symptoms. By using the traffic light colors of green, yellow, and red to describe your symptom severity, the action plan will guide you in the steps to take to treat your symptoms. Talk to your Provider today about developing this action plan together. Don't wait until your next breath becomes a problem. If you have asthma or think you have asthma, please contact our asthma program manager today at 888-257-1985.

For more information about the benefits and services we offer our Members who have asthma, please see page 26.

### Diabetes

Our diabetes program has staff available to help you manage type 1, type 2, and gestational (when you are pregnant) diabetes. Diabetes supplies and lab work are covered benefits, including hemoglobin A1c, lipids, and yearly dilated eye exams. A Network Health clinician can arrange your health care with your PCP and any Specialists you may need to see. You also can use our Behavioral Health (mental health and/or substance abuse) and social Care Management programs. If you need it, you can also take American Diabetes Association-approved diabetes classes.

We stay in touch with our Members with diabetes.

We may send you helpful information, such as the need for certain tests and how to better manage diabetes. Additionally, we may call to remind you about yearly lab work and PCP appointments. Visiting Nurse Association (VNA) services are available to help you get any needed ongoing medical care. We also offer, when appropriate, diabetes education if you are homebound.

For more information about the benefits and services we offer our Members who have diabetes, please see page 27.

### HIV/AIDS

To support your care, we can help you identify and reduce or remove social barriers to appropriate care. We can also identify services that will benefit you.

### Help with quitting smoking

*Network Health Together* Members can get medications and counseling to help quit smoking from the Massachusetts Tobacco Control Program and MassHealth. For more information about quitting smoking, talk to your PCP. For free counseling over the phone, call our 24/7 NurseLine at 888-MY-RN-LINE (888-697-6546). To get daily quit tips in English and Spanish call 800-9-GET-A-TIP

### Care coordination (Utilization Management aftercare)

When you leave a 24-hour-care facility (like a skilled-nursing facility, transitional care unit, rehabilitation Hospital, or acute Hospital), our care managers will help you with "Utilization Management aftercare" (the care you need to help you keep getting better). Our care managers will work with ancillary Providers (like a Visiting Nurse Association and durable medical equipment Providers) to make sure you get the services you need when you need them.

Utilization Management aftercare services also include:

- Teaching you about your condition
- Teaching you about managing your disease and its stages, if necessary
- Giving you individual and integrated care
- Developing a plan to help you get and use the services you need
- Improving your overall health

Your health care Provider can ask us to give you Utilization Management aftercare services by calling us at 888-257-1985 or visiting [www.network-health.org](http://www.network-health.org).

## Behavioral Health (mental health and/or substance abuse) care services

We have different levels of Behavioral Health (mental health and/or substance abuse) services, based on your need, what type 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 abuse disorder services, and diversionary services) in your *Covered Services List*. You do not need Prior Authorization for the first 26 outpatient Behavioral Health (mental health and/or substance abuse) visits each calendar year (January 1 – December 31). You can find a list of Providers who can provide these services online at [www.network-health.org](http://www.network-health.org).

Network Health's Behavioral Health (mental health and/or substance abuse) care managers are licensed clinicians who can help you by:

- Monitoring your treatment
- Reviewing your needs 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 help:

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

If you need help finding a Behavioral Health (mental health and/or substance abuse) Provider, please call us at 888-257-1985.

At any time, if you are having a Behavioral Health (mental health and/or substance abuse) Emergency, call 911 or go to your local Emergency room, or call your local Emergency Services Program (ESP) Provider. For a complete list of Emergency rooms and Emergency Services Program (ESP) Providers throughout the state, please call us at 888-257-1985 or visit us at [www.network-health.org](http://www.network-health.org).

## 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 (mental health and/or substance abuse), medical, and social care managers work closely with each other and with you to coordinate the care you need.

Our Care Management services can help if you have complex and/or specific medical needs and conditions. If you have a physical disability; special health condition like a high-risk pregnancy, cancer, or HIV/AIDS; a Behavioral Health (mental health and/or substance abuse) problem; 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
- Have one of our care managers work with you and your health care Provider to coordinate your care

We provide three types of care management services:

- Complex Care Medical Management
- Behavioral Health – Intensive Clinical Management (ICM)
- Social Care Management

## Complex Care Medical Management

Our Complex Care Medical Management program is for Members with hard-to-manage, unstable, and/or long-lasting Medical conditions. Members in these programs get help from a team of dedicated health care Providers who can help them get and stay healthy.

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

- Multiple health conditions
- Intensive-care needs (newborn)
- Cancer
- HIV/AIDS
- Organ transplantation
- Severe disability or impairment

Our care managers can give you valuable information and help coordinate your care. Call 888-257-1985 to talk to a care manager.

## Behavioral Health - ICM

We can offer you Behavioral Health - ICM if you:

- Have severe Behavioral Health (mental health and/or substance abuse) issues
- Have three or more Behavioral Health (mental health and/or substance abuse) 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 special needs or cultural issues that require multiple agencies to coordinate service delivery

## Social Care Management

Our social Care Management team can help you with more than health care issues. Social care managers are here to support you with anything in your life that could affect your health, including getting health care. Social care managers can help you:

- 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 conjunction with 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

To get social Care Management services or for more information, call us at 888-257-1985.

Your team of dedicated health care Providers includes nurse practitioners, nurses, Behavioral Health (mental health and/or substance abuse) clinicians, social care managers, and health advocates. This team understands how to work with you if you have special health care needs, and will 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 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 health (mental health and/or substance abuse), social, and financial needs.

## Extra benefits

Only current, eligible *Network Health Together* Members can get the extra benefits we give our Members who are on MassHealth. However, some restrictions may apply, and we reserve the right to stop giving an extra benefit at any time.

### **FREE Network Health bike helmets**

Get your FREE bike helmet for each *Network Health Together* Member in your household. We have helmets available for toddlers, kids, and adults.

#### How to get this benefit:

1. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to fill out the online bike helmet order form.
2. Watch your mail for your FREE bike helmet, which should come in four to six weeks.

**PLEASE NOTE:** You must be a Network Health Member at the time you fill out the online bike helmet order form and when we process your reward form. Each Member can get one bike helmet every 12 months.

## FREE home safety kits

Protect your kids from the hidden dangers in any home. Network Health helps keep your little ones secure by sending you a FREE home safety kit, recommended for kids up to age six. The kit has doorknob covers, cabinet and drawer latches, and outlet plugs.

### How to get this benefit:

1. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to fill out the online home safety kit order form.
2. Watch your mail for your FREE home safety kit, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member at the time you fill out the online home safety kit order form and when we process your reward form. Each household can get one home safety kit every 12 months.

## FREE child ID kits

We can help you keep your kids safe. We offer a FREE McGruff Safe Kids Identification Kit, which includes a fingerprinting tool, for each child who is a Network Health Member. ID kits are recommended for children ages 3 – 8 years of age.

### How to get this benefit:

1. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to fill out the online child ID kit order form.
2. Watch your mail for your FREE child ID kit, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member at the time you fill out the online child ID kit order form and when we process your reward form. Each Member can get one child ID kit every 12 months.

## FREE gift cards to use to buy children's car seats

We help your kids ride in style. Members ages 0 – 8 years, or their mothers who are 32 or more weeks pregnant, are eligible to get a:

- \$50 Toys R Us gift card to use to buy 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 Network Health Member, you can get a:

- \$25 Toys R Us gift card to use to buy a booster car seat (for kids 30 – 100 pounds and 43 – 57 inches tall)

### How to get these benefits:

1. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to get the form(s) you need to fill out and sign to order your FREE Toys R Us gift card.
2. Fill out your information.
3. Make a copy of the form to keep for yourself.
4. Mail the completed form to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
5. Watch your mail for your gift card, which should come in four to six weeks.

PLEASE NOTE: Members can get one Toys R Us gift card to use to buy a car seat every 12 months, and two gift cards during their Membership. Gift cards are valid only for a convertible or booster car seat. You must be a Network Health Member at the time you send in the form and when we process your reward form.

## FREE rewards for healthy behaviors

To help our young Members get and stay healthy, we reward their healthy choices with a CHOICE of a gift card to a variety of places. We list below how you can help your kids earn a FREE gift card from us.

- Get a yearly checkup (ages 3 – 9) and we'll send your choice of a FREE \$10 CVS, Kohl's, Toys R Us, or Wal-Mart gift card.
- Get a yearly checkup (ages 10 – 17) and we'll send your choice of a \$10 AMC Theatres, GameStop, iTunes, or Toys R Us gift card.
- Get all required childhood immunizations and screenings by age 2 and we'll send you a \$25 CVS, Kohl's, Toys R Us, or Wal-Mart gift card. The required childhood immunizations and screenings are: 4 Dtap, 3 OPV/IPV, 1 MMR, 4HiB, 2 hepatitis A, 3 hepatitis B, 1 VZV, 4 PCV, 3 Rota, the flu shot each year, and a blood lead screening. 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.

## How to get these benefits:

1. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to get the form(s) you need your child's doctor to fill out and sign for each of the rewards.
2. Bring the form with you when you go to your child's doctor.
3. Fill out your information and have your child's doctor sign the form.
4. Make a copy of the form to keep for yourself.
5. Mail the completed form to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
6. Watch your mail for your gift card, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member at the time of the doctor visit and when we process your reward form.

## FREE Weight Watchers registration, PLUS \$50 back on program costs

Any Member age 21 or older can join Weight Watchers with no fee. Once you sign up, we'll reimburse you up to \$50 every 12 months toward the cost of your weekly meetings.

Too busy to attend meetings? Check out the Weight Watchers At Home Kit. You'll get \$10 off when you order it, PLUS we reimburse you \$50 of the cost of the kit. Remember, you should discuss any diet or exercise program with your PCP before you begin.

## How to get your reimbursement:

1. With your PCP's approval, sign up for Weight Watchers meetings or order an At Home Kit by calling Weight Watchers at 800-710-4663.
2. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to get the form you need for your reimbursement.
3. Make a copy of your receipt for your records.
4. Mail the completed form and original receipt to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
5. Watch your mail for your reimbursement of up to \$50, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member when you sign up for Weight Watchers or order the At Home Kit and when we process your form. Members age 21 and older can get one \$50 reimbursement every 12 months.

## Fitness reimbursement

We help you stay fit. After you've been a gym member for three months, or completed one of several types of fitness activities, we'll give you \$50 back. While this benefit is available to all Members every 12 months, Members age 18 years and younger must get a parent's permission to join a gym or participate in a fitness activity.

Eligible fitness-related 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 dancing 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. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) after you've been a gym member for three months to get the form you need for your reimbursement.
2. Make a copy of your receipt for your records.
3. Mail the completed form and original receipt to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
4. Watch your mail for your reimbursement of up to \$50, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health member when you sign up for your gym membership and when we process your form. Members can get one \$50 reimbursement every 12 months.

## Eyeglasses and contact lenses

MassHealth covers free eyeglasses and contact lenses for all MassHealth Members. You can choose from MassHealth's selection of free eyeglasses and contact lenses.

We also offer our Members a second choice. You can choose to get your eyeglasses from a participating EyeMed Provider. You'll get a larger selection of eyeglasses and contacts at an EyeMed Provider than from MassHealth. If you choose to get your eyeglasses or contacts from an EyeMed Provider instead of MassHealth, you are responsible for paying the price of the eyeglasses or contacts. We would then send you up to \$30 back from what you pay for your eyeglasses or contacts.

To use the participating EyeMed Provider's selection, just get an eye exam from your Network Health vision Provider and bring your vision prescription to a participating EyeMed Provider for savings on eyewear. Choose from private Providers and optical retailers, including LensCrafters, Target Optical, Sears Optical, JCPenney Optical, and most Pearle Vision locations. To find a participating Provider, visit [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) and click on the members section. You can also call 866-559-5252.

### Frames discount

- 35% off prescription eyeglass frames when purchased with lenses
- 20% off the retail price of eyeglass frames without lenses

### Lens discount

- 15% off the retail price of contact lenses
- Prices below retail on standard plastic lenses and lens options. See store for a complete list or call Network Health at 888-257-1985.

## How to get your discounts:

1. Bring your vision prescription to any participating EyeMed Provider, including LensCrafters, Target Optical, Sears Optical, JCPenney Optical, and most Pearle Vision locations.
2. Show your *Network Health Together* ID Card.
3. Get your discount every time you purchase glasses or contact lenses at these locations.

## How to get your reimbursement:

1. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to get the form you need for your reimbursement.
2. Make a copy of your receipt for your records.
3. Mail the completed form and original receipt to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
4. Watch your mail for your reimbursement of up to \$30, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member when you buy your eyeglasses and when we process your form. Members can get one reimbursement of up to \$30 every 12 months.

## Helping with your health care needs

Network Health clinicians can help you with your health needs. Call 888-257-1985 to speak with a clinician.

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

## If you are pregnant, you can:

- Get FREE childbirth, newborn, and breastfeeding classes — up to \$150 reimbursement during each pregnancy.
- Get a \$10 CVS, Kohl's, Toys R Us, or Wal-Mart gift card after your second visit to a WIC (Women, Infants, and Children) office 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 FREE gift card to use to buy a car seat. See page 23 in this *Member Handbook* for more information.

Call Network Health at 888-257-1985 as soon as you know you are pregnant to find out about these benefits.

## How to get your FREE childbirth class reimbursement:

1. Call Network Health at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to get the form you need for your reimbursement.
2. Fill out the information on the form.
3. Make a copy of the form for yourself.
4. Mail the completed form to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
5. Watch your mail for your reimbursement of up to \$150, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member when you go to the childbirth classes and when we process your form. Members can get one reimbursement of up to \$150 during every pregnancy.

## How to get the FREE \$10 gift card:

1. Call Network Health at 888-257-1985 and tell us your due date.
2. Fill out the information on the form we will send you. Have a WIC representative sign the form at each of your visits.
3. Make a copy of the signed form for yourself.
4. Mail the completed form to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
5. Watch your mail for your \$10 gift card, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member when you visit WIC and when we process your form. Members can get one \$10 gift card during every pregnancy.

## How to get the FREE calendar:

Call Network Health at 888-257-1985 to tell us you are pregnant. You should get your calendar in four to six weeks.

## After having a baby, you can:

- Get a \$10 CVS, Kohl's, Toys R Us, or Wal-Mart gift card if you visit your OB/GYN for a postpartum visit between 21 and 56 days after you have your baby.
- Get a FREE electric breast pump (if you're eligible).
- Get a calendar to help you keep track of your child's development and remind you to make appointments with your child's PCP.

Call us at 888-257-1985 as soon as you have your baby to get these benefits.

## How to get the \$10 gift card:

1. Call us at 888-257-1985 and tell us when you had your baby.
2. Visit your PCP, OB/GYN, or other pregnancy care Provider between 21 and 56 days after having your baby.
3. Fill out the form we will send you after we learn you gave birth and have your PCP, OB/GYN, or other pregnancy care Provider sign it.
4. Make a copy of the form for yourself.
5. Mail the completed form to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
6. Watch your mail for your \$10 gift card, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member when you have your postpartum visit and when we process your form. Members can get one \$10 gift card after every pregnancy.

## How to get the FREE electric breast pump:

Call us at 888-257-1985 after you have your baby to see if you are eligible.

## If you have asthma, you can:

- Get a \$10 CVS, Kohl's, Toys R Us, or Wal-Mart gift card for filling out an asthma action plan with your PCP.
- Get information on asthma by calling us at 888-257-1985 or by visiting [www.network-health.org](http://www.network-health.org).

## How to get the \$10 gift card:

1. Call us at 888-257-1985 or visit [www.network-health.org](http://www.network-health.org) to get an asthma action plan.
2. Visit your PCP and fill out the asthma action plan together.
3. Have your PCP sign the asthma action plan.
4. Make a copy of the plan for yourself.
5. Mail the completed asthma action plan to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
6. Watch your mail for your \$10 gift card, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member when you fill out the asthma action plan and when we process your form. Members can get one \$10 gift card every 12 months.

## If you have diabetes, you can:

- Get a \$25 CVS, Kohl's, or Wal-Mart gift card for getting an eye exam, two blood sugar (HbA1C) tests, a protein test, and a blood cholesterol test every 12 months.
- Take a FREE nutrition class about diabetes.
- Get information on diabetes by calling us at 888-257-1985 or by visiting [www.network-health.org](http://www.network-health.org).

## How to get the \$25 gift card:

1. Call us at 888-257-1985 and ask to speak to a diabetes clinician. We'll send you a form with a list of screenings to complete in a calendar year. Getting these screenings will help you manage your diabetes. You can also get the form from our Web site at [www.network-health.org](http://www.network-health.org).
2. Visit your PCP, complete the tests, and fill out the form.
3. Have your PCP sign the form.
4. Make a copy of the form for yourself.
5. Mail the completed form to Customer Service, Network Health, 101 Station Landing, Fourth Floor, Medford, MA 02155.
6. Watch your mail for your \$25 gift card, which should come in four to six weeks.

PLEASE NOTE: You must be a Network Health Member when you get the five screenings and when we process your form. Members can get one \$25 gift card every 12 months for completing the five screenings.

## Renewing your benefits

Each year, most MassHealth Members, including *Network Health Together* Members, must renew their MassHealth benefits by filling out a MassHealth Eligibility Review Verification (ERV) form. One month before your benefits expire, you should get this form in the mail. Make sure you fill out and mail back the form with proof of your income as soon as you can. If you don't, you risk losing your MassHealth and *Network Health Together* benefits.

If you get Transitional Aid to Families with Dependent Children (TAFDC), you should renew your MassHealth benefits with your case worker or your local Department of Transitional Assistance (DTA) office. To find your local DTA office, call 800-445-6604.

If you would like to find out if other Members of your household are eligible for MassHealth and *Network Health Together*, just add their contact information to the form.

If you have questions about how to complete the ERV form, need help filling out the ERV form, or lose your ERV form, we can help. Call our Renewal Helpline at 877-849-0545. You can also call MassHealth Customer Service at 888-665-9993, from 8:45 a.m. to 5 p.m.

## Protecting your benefits

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

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

To report potential Fraud and abuse, or if you have questions, please call us at 888-257-1985 or e-mail [fraudandabuse@network-health.org](mailto:fraudandabuse@network-health.org). We do not need your name or Member information. You can also call our confidential hotline at 800-826-6762, or send an anonymous letter to us at:

**Network Health**  
**Attn: Fraud and Abuse**  
**101 Station Landing, Fourth Floor**  
**Medford, MA 02155**

## Disenrollment

### Voluntary Disenrollment

You may end your *Network Health Together* enrollment at any time. To disenroll from *Network Health Together*, call the MassHealth Customer Service Center at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m. Voluntary Disenrollments are usually effective one (1) business day after we get the request from MassHealth.

After Disenrollment, we will provide coverage for:

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

## Membership Disenrollment for Loss of Eligibility

- If you become ineligible for MassHealth coverage, MassHealth will disenroll you from *Network Health Together*. Your *Network Health Together* coverage will end as of the date of your MassHealth Disenrollment. MassHealth may automatically re-enroll you in *Network Health Together* if MassHealth determines you are eligible for MassHealth.

## Membership Disenrollment for Cause

We have the right to submit a written request to MassHealth to disenroll a Member from *Network Health Together*. We will not ask to disenroll Members because their health is poor, they use medical services, lack mental capacity, or display negative behavior related to their special needs.

MassHealth will decide whether to approve our Disenrollment request. If MassHealth disenrolls a Member from *Network Health Together*, MassHealth will send a letter of Disenrollment and contact the Member about choosing another health plan.

# Your rights and responsibilities

As a Network Health Member, you have the right to:

- Be treated with respect and dignity by all health care Providers, regardless of your race, ethnicity, creed, religious belief, sexual orientation, or source of payment for care
- Get Medically Necessary treatment, including Emergency care
- Make decisions about your medical care

- Get information about us and our services, PCPs, Specialists, other health care Providers, and your rights and responsibilities
- Have a candid 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 health care Providers to make decisions about your health care
- Accept or refuse medical or surgical treatment
- Call your PCP's and/or Behavioral Health (mental health and/or substance abuse) 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
- File a Grievance to express dissatisfaction with your health care Providers and 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, or retaliation
- Ask for more information or explanation on anything included in this *Member Handbook*, either verbally 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 a free copy 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 Network Health information translated into your preferred language or in your preferred format

## Advance Directives

Advance Directives are written instructions, sometimes called a living will or durable power of attorney for health care. 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 health care 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 health care Providers determine you are unable to make your own decisions.

As a Network Health 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 health care Provider or Network Health. 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 health care Provider's Advance Directive policies
- Have in your medical record your Advance Directive, if you have one

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

## Member responsibilities

As a Network Health Member, you have the responsibility to:

- Treat all health care 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 PCP, Specialists, and other health care 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 health care Providers if you do not understand what they tell you
- Participate with your PCP, Specialists, and other health care 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 abuse) Provider within 48 hours after you visit the Emergency Room for follow-up care
- Change your PCP or Behavioral Health (mental health and/or substance abuse) 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 Network Health Member, you have the right to make an Inquiry at any time. We will resolve your Inquiries immediately or, at the latest, within one business day of the day we get it. We will let you know the resolution the day we resolve your Inquiry.

## Grievances

A Grievance is an expression of dissatisfaction you or your Authorized Representative (someone you have authorized in writing to act on your behalf) make about any action or inaction by us other than an Adverse Action. As a Network Health Member, you, or your Authorized Representative, have the right to file a Grievance with us. You may file a Grievance at any time. You may file a Grievance for any reason, including:

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

Your Authorized Representative can file a Grievance for you. You can appoint an Authorized Representative by sending us a signed *Network Health Together* Authorized Representative Form. You can get a form by calling our Customer Service Team or our Grievance coordinator at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m. If we do not get your signed *Network Health Together* Authorized Representative Form within 30 calendar days of someone other than you filing a Grievance on your behalf, we will dismiss the Grievance.

You can find the forms you need to pick someone as your Authorized Representative on our Web site at [www.network-health.org](http://www.network-health.org).

## How to file a Grievance

You, or your Authorized 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.
- **TTY/TTD** — people with hearing loss can call our TTY line at 888-391-5535, Monday through Friday, from 8 a.m. to 5 p.m.
- **Mail** — mail a Grievance to: Network Health, Attn: Grievance Coordinator, 101 Station Landing, Fourth Floor, Medford, MA 02155
- **E-mail** — e-mail a Grievance via the Contact Us section of our Web site at [www.network-health.org](http://www.network-health.org)
- **Fax** — fax a Grievance to us at 781-393-7440
- **In person** — come by our 101 Station Landing (Medford, Mass.) address, Monday through Friday, from 8 a.m. to 5 p.m.

## Once you file a Grievance

We will:

- Tell you, or you and your Authorized Representative, in writing within one business day that we got your Grievance
- Look into your Grievance
- Tell you, or you and your Authorized Representative, in writing of the outcome of your Grievance within 30 calendar days from when we get your Grievance
- Provide interpreter services, if necessary

## How to file 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: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m. to file a complaint, and/or you, or your Authorized Representative, may file for a Grievance Decision Review with Network Health by:

- **Telephone** — call us at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m.
- **TTY/TTD** — people with hearing loss can call our TTY line at 888-391-5535, Monday through Friday, from 8 a.m. to 5 p.m.
- **Mail** — mail a Grievance Decision Review request to: Network Health, Attn: Grievance Coordinator, 101 Station Landing, Fourth Floor, Medford, MA 02155
- **E-mail** — e-mail a Grievance Decision Review request via the Contact Us section of our Web site at [www.network-health.org](http://www.network-health.org)
- **Fax** — fax a Grievance Decision Review request to us at 781-393-7440
- **In person** — come by our 101 Station Landing (Medford, Mass.) address Monday through Friday, from 8 a.m. to 5 p.m.

### Once we get your Grievance Decision Review request, we will:

- Tell you, or you and your Authorized Representative, in writing within one business day that we got your Grievance Decision Review request
- Look into your Grievance Decision Review request
- Tell you, or you and your Authorized Representative, in writing of the outcome of your Grievance Decision Review within 30 calendar days from when we get your Grievance Decision Review request
- Provide interpreter services, if necessary

If at any time you are dissatisfied with the outcome of the Grievance process, you can call MassHealth Customer Service to file a complaint at 800-841-2900 (TTY: 800-497-4648), Monday through Friday, from 8 a.m. to 5 p.m.

## Appeals

### What are my rights to file an Internal Appeal?

As a Network Health Member, you, or your Authorized Representative, have the right to file an Internal Appeal to ask 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 health care Providers' failure to provide covered services within the time frames we describe in this *Member Handbook* (see the "Access to Covered Services" section)
- Our decision to deny or provide limited authorization for a requested service
- Our decision to reduce, suspend, or end a previously authorized service
- Our failure to act on a Prior Authorization request within the time frames we describe in this *Member Handbook* (see the "Your Concerns" section)
- Our failure to follow the Internal Appeal time frames we explain below

You, and/or your Authorized Representative, have 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 like medical records and other documents and records we considered during the Internal Appeal process
- File a Grievance if we ask for more time to make an Internal Appeal decision and you, or your Authorized Representative, disagree
- File a Grievance if we deny your request for an Expedited (fast) Appeal and you, or your Authorized Representative, disagree with that decision
- File directly with the Executive Office of Health and Human Services (EOHHS), Office of Medicaid's Board of Hearings (BOH), if Network Health does not make an Internal Appeal decision within the required time frames (see the following pages for specific Appeal time frames)

You have the right to two levels of Internal Appeal for any Adverse Action if you file a standard Internal Appeal, and one level of Internal Appeal if you file an Expedited (fast) Internal Appeal. You also have the right to further appeal our decision about your upheld Internal Appeal decision by requesting a Fair Hearing through the BOH as outlined below. We will help you fill out forms and follow procedures related to all Appeals, including providing interpreter services.

## Filing an Internal Appeal (for First- and Second-Level Internal Appeals)

You, or your Authorized Representative, can file a First-Level Internal Appeal to ask that we review any Adverse Action, or a Second-Level Internal Appeal to ask that we review an upheld First-Level Internal Appeal decision in the following ways:

- **Telephone** — call us at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m.
- **TTY/TTD** — people with hearing loss can call our TTY line at 888-391-5535, Monday through Friday, from 8 a.m. to 5 p.m.
- **Mail** — mail an Internal Appeal request with a copy of the notice of Adverse Action for First-Level Internal Appeals or a copy of the First-Level Internal Appeal decision for Second-Level Internal Appeals and any additional information about the Internal Appeal to us at: Network Health, Attn: Appeals Coordinator, 101 Station Landing, Fourth Floor, Medford, MA 02155
- **E-mail** — e-mail an Internal Appeal request via the Contact Us section of our Web site at [www.network-health.org](http://www.network-health.org)
- **Fax** — fax an Internal Appeal request to us at 781-393-2643
- **In person** — come by our 101 Station Landing (Medford, Mass.) address, Monday through Friday, from 8 a.m. to 5 p.m.

*Please note: If you submit an Internal Appeal by telephone or in person, we will ask that you, or your Authorized Representative, follow up with a written Internal Appeal request, unless you ask for an Expedited (fast) Appeal. If you do not send us this written documentation, we may deny your Internal Appeal.*

If we do not have enough information to decide your Internal Appeal, we will ask you for it. If you do not give us the additional information, we may deny your Internal Appeal.

You, or your Authorized Representative, must file your Internal Appeal within 30 calendar days of the notification of Adverse Action, as described in this *Member Handbook* (or, if you do not get a notice, within 30 calendar days from when you learn of the Adverse Action). You, or your Authorized Representative, may also send us written comments, documents, or any additional information about your Internal Appeal. We will notify you, and your Authorized Representative, in writing within one business day, or 48 hours, whichever is less, that we got your Internal Appeal request.

If we do not get your Internal Appeal request within 30 calendar days, we will consider the Adverse Action final. We will dismiss Internal Appeals you, or your Authorized Representative, file after 30 days. If you, or your Authorized Representative, believe that you filed your Internal Appeal on time, you, or your Authorized Representative, have the right to ask that we reverse the dismissal and continue your Internal Appeal. To do so, you, or your Authorized Representative, must send a written request to us within 10 calendar days of the dismissal. We will decide whether to reverse the dismissal and continue your Internal Appeal. If we decide not to reverse the dismissal, you, or your Authorized Representative, can file for a Fair Hearing with the BOH through the process we describe in the following section.

### First-Level Internal Appeal

After looking into your First-Level Internal Appeal, including any additional information from you, your Authorized Representative, or your health care Providers, we will decide your First-Level Internal Appeal based on a review by a health care professional with the appropriate clinical expertise. We will make our decision within 20 calendar days from the date we get your request. If we need more information, and we expect our review to take longer than 20 calendar days, we will let you, or you and your Authorized Representative, know and ask for an extension of five calendar days. At that time, we will give you, or you and your Authorized 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, and there is a reasonable likelihood that such information would lead to us approving your request, and if we can reasonably expect to get this information in five calendar days. If you disagree with our need for an extension, you, or your Authorized Representative, can file a Grievance with us as we described previously. Also, you, or your Authorized Representative, have the right to ask for an extension of five calendar days to give us more information.

Unless you indicate to us that you do not want to get Continuing Services, we will keep covering previously approved services until we decide your First-Level Internal Appeal, as long as we get your request for a First-Level Internal Appeal within 10 calendar days from the notice of Adverse Action (or, if you do not get any notice, within 10 calendar days from when you learn of the Adverse Action). If you lose the First-Level Internal Appeal, you may have to pay back the cost of these services.

If we deny your Appeal, you, or your Authorized Representative, can file a Second-Level Internal Appeal with us. Or, you can waive your right to a Second-Level Internal Appeal and file directly for a Fair Hearing with the BOH, following the process we describe later.

## Second-Level Internal Appeal

You, or your Authorized Representative, must ask for a Second-Level Internal Appeal within 30 calendar days from the date we deny your First-Level Internal Appeal. You, or your Authorized Representative, may also send written comments, documents, or any other information about your Second-Level Internal Appeal. If you, or your Authorized Representative, file your Second-Level Internal Appeal after this time frame of 30 calendar days, we will dismiss it. If you believe that you, or your Authorized Representative, filed your Second-Level Internal Appeal on time, you, or your Authorized Representative, have the right to ask that we reverse the dismissal and continue your Second-Level Internal Appeal. To do so, you or your Authorized Representative must send a written request to us within 10 calendar days of the dismissal. We will decide whether to reverse the dismissal and continue your Second-Level Internal Appeal. If we decide not to reverse the dismissal, you, or your Authorized Representative, can file for a Fair Hearing with the BOH, following the process we describe later.

We will make a decision about your Second-Level Internal Appeal based on a review by a health care professional with the appropriate clinical expertise. This person will not have been involved in any prior review or determination of your Internal Appeal. We will make our decision within 20 calendar days from the date we get your request. If we did not use our option of taking an extension of five calendar days during your First-Level Internal Appeal, we can do so if we need more information to make a decision and there is a reasonable likelihood that such information would lead to the approval of your request, and if we can reasonably expect to get the information in five calendar days. You, or your Authorized Representative, may file a Grievance if you disagree with our need for this extension. If we did use our extension during the First-Level Internal Appeal, we are not allowed to extend the time frame of your Second-Level Internal Appeal. However, you, or your Authorized Representative, have the right to ask for an extension of five calendar days to give us more information.

Unless you, or your Authorized Representative, indicate to us that you do not want to get Continuing Services, we will keep covering previously approved services until we decide your Second-Level Internal Appeal, as long as we get your request for a Second-Level Internal Appeal within 10 calendar days

from the date of our denial of your First-Level Internal Appeal. If you lose the Second-Level Internal Appeal, you may have to pay back the cost of these services.

If we deny your Second-Level Internal Appeal, you, or your Authorized Representative, may file for a Fair Hearing with the BOH, following the process described later in the BOH section.

## Filing an Expedited (fast) Appeal

When you want to file an Internal Appeal about acute medical and/or Behavioral Health (mental health and/or substance abuse) services, and taking the time for a standard First-Level Internal Appeal could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, we have an Expedited (fast) Appeal process.

You, or your Authorized Representative, can file an Expedited (fast) Appeal any of the ways we described previously. You, or your Authorized Representative, must file your Expedited (fast) Appeal within 30 calendar days of the notification of Adverse Action (or, if you do not get a notice, within 30 calendar days from when you learn of the Adverse Action).

Unless you, or your Authorized Representative, indicate to us that you do not want to get Continuing Services, we will keep covering previously approved services until we decide your Expedited (fast) Appeal, as long as we get the request within 10 calendar days from the notice of Adverse Action (or, if you do not get a notice, within 10 calendar days from when you learned of the Adverse Action). If you lose the Expedited (fast) Appeal, you may have to pay back the cost of these services.

If a health care Provider acting as your Authorized Representative files your Expedited (fast) Appeal request, or if your health care Provider supports your Expedited (fast) Appeal request, then we will approve the request, unless the reason for the request is not related to your health status. Otherwise, we will decide if we will process your Expedited (fast) Appeal or not. If we deny your Expedited (fast) Appeal request, we will tell you, and your Authorized Representative, within one business day and treat your request as a standard First-Level Internal Appeal (as we describe earlier). You, or your Authorized Representative, may file a Grievance if you disagree with our decision to deny your Appeal request as an Expedited (fast) Appeal.

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

If we deny your Expedited (fast) Appeal, you, or your Authorized Representative, may file for a Fair Hearing with the BOH, following the process we describe later.

*Please note: If your Authorized Representative files an Expedited (fast) Appeal for you, we will process the Expedited (fast) Appeal even if we do not have an Authorized Representative form on file.*

### **Filing an External Review (Fair Hearing) with the EOHHS, Office of Medicaid's BOH**

You, or your Authorized Representative, may file for a Fair Hearing with the BOH after we deny a First-Level Internal Appeal, Second-Level Internal Appeal, or Expedited (fast) Appeal, or if we do not 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 “How to Ask for a Fair Hearing” form.

You, or your Authorized Representative, must file your request for a Fair Hearing within 30 calendar days from the date of our decision on your First- or Second-Level Internal Appeal. For Expedited (fast) Appeal denials, you, or your Authorized Representative, must file your request within 20 calendar days from the date we decide to process your Fair Hearing as Expedited (fast). If you, or your Authorized Representative, file your request after 20 calendar days but within 30 calendar days, the BOH will treat your request as a standard Fair Hearing.

If your Fair Hearing involves a decision by us to reduce, suspend, or terminate previously approved services, and you wish to keep getting the services under dispute during your Fair Hearing, the BOH must get your completed form within 10 calendar days of our decision, and you, or your Authorized Representative, must say on the BOH application form that

you want to keep getting these services. Please note: If the Fair Hearing decision upholds the Appeal decision, you may be responsible to pay back MassHealth for the cost of these services.

Network Health will comply with and implement the BOH's decision.

### **Questions or concerns?**

If you have questions or concerns about the Grievance and/or Appeal process, please call our Customer Service Team at 888-257-1985, Monday through Friday, from 8 a.m. to 5 p.m. People with hearing loss can call our TTY line at 888-391-5535, Monday through Friday, from 8 a.m. to 5 p.m.

### **Complaints**

You may contact MassHealth Customer Service at 800-841-2900 (TTY: 800-497-4648) to file a complaint about MassHealth or us. Representatives are available Monday through Friday from 8 a.m. to 5 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, either for yourself or your spouse
- Coverage under Workers' Compensation because of a job-related illness or injury
- Coverage for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through veteran's 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 Benefit Coordination 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 *Network Health Together* benefits. The way we work with the other companies depends on your situation. This process is called Coordination of Benefits. 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 do not cover, another insurer other than us may be able to cover you. If you have additional health insurance, please call us at 888-257-1985 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 managed care organizations, including Network Health. If you fit this category, MassHealth will disenroll you from Network Health. MassHealth will notify you about this.

## 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 [PIP] and/or medical payment coverage) before we will 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 health care 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. You must send to us any explanation of payment or denial letters from an auto insurance carrier for us to consider paying a Claim that your health care Provider sends us.

## Subrogation

If another person's action or omission injures you, your *Network Health Together* 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 will subrogate and succeed to all your rights to recover against such person or party 100% of the value of services we pay for or provide.

Your health care 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 that your health care Provider does not submit 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% of the amount you got for such services from us. 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 will 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.

## Member cooperation

As a *Network Health Together* Member, you agree to cooperate with us in exercising our Subrogation and Benefit Coordination 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(s) 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 get for services that we've provided or paid for
- Promptly notify us of any possible Subrogation or Benefit Coordination potential

You also must agree to do nothing to prejudice or interfere with our rights to Subrogation or Benefit Coordination. If you are not willing to help us, you will be liable to us for any expenses we may incur, including reasonable attorneys' fees, in enforcing our rights under this plan. 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 Benefit Coordination under this plan.

## Notice of Privacy Policy

We are committed to protecting your rights and privacy. Our Notice of Privacy Policy describes how we may use and disclose your Protected Health Information (PHI), and how you can access this information. Please review the Notice carefully. You can also read the Notice of Privacy Policy on our Web site at [www.network-health.org](http://www.network-health.org) or get another copy by calling us at 888-257-1985.

### 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 verbal, written, and electronic PHI. We ensure the privacy of your PHI in a number of ways. For example, employees do not 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 all of your PHI that we maintain, and we will make a copy of the revised Notice available on our Web site ([www.network-health.org](http://www.network-health.org)) or upon request.

### Uses and disclosures without your authorization

We may use and disclose your PHI without your written authorization for the following purposes, or as otherwise permitted or required by law:

- **Treatment** — to help health care Providers provide, coordinate, or manage your care. For example, we may share your PHI with another Provider to coordinate a Prior Authorization.
- **Payment** — to help us, or other health plans and health care Providers with whom you have or had a relationship, get payment of premiums for your health coverage, and meet our responsibility to provide your MassHealth benefits
- **Health care operations** — to help us, or other health plans and health care Providers with whom you have or had a relationship, improve the quality and cost effectiveness of the care we deliver
- **Disclosure to MassHealth** — to operate, monitor, audit, and administer benefits, or to report suspected MassHealth Member and/or Provider Fraud
- **Public health** — to prevent or control disease, injury, or disability; to report child abuse or neglect; to report information about a product or activity under the jurisdiction of the U.S. Food and Drug Administration; and if authorized by law, to notify a person about any exposure to a communicable disease
- **Health oversight** — to respond to a health oversight agency responsible for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs for which health information is necessary for determining compliance
- **Legal proceedings** — to respond to a legal order or other lawful process in a judicial or administrative proceeding
- **Law enforcement** — to respond to the police or other law enforcement officials as required by law or to be in compliance with a court order or other process authorized by law
- **Health or safety** — to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public
- **Specialized government functions** — to respond to units of the government with special functions, such as the U.S. military or the U.S. Department of State
- **Legal compliance** — to comply with applicable federal or state laws and regulations
- **Workers' compensation** — to comply with Workers' Compensation laws
- **Marketing activities** — to engage in a face-to-face encounter initiated by you; to give you a promotional gift; or to communicate with you about our benefits or services relating to your treatment, Care Management or coordination, or alternative treatments, therapies, Providers, or health care settings

## Uses and disclosures that need your written authorization

We will not use and disclose your PHI without your written approval for the following purposes, and as otherwise allowed or required by law:

- **Marketing activities** — We must get written authorization to use your PHI in any and all marketing activities, except in a face-to-face encounter or to give you a promotional gift.
- **Your highly confidential information** — We will not release your PHI relating to alcohol and/or drug abuse treatment, HIV/AIDS, sexually transmitted diseases, genetic testing, pregnancy termination, child abuse, abuse of an adult with a disability, psychotherapy notes, certain mental health or social work communications, or sexual assault counselor communications, except as required or permitted by law.

You may change your mind and tell us you no longer approve at any time by writing to us. This exclusion will not apply to information you have already released.

## Your rights for privacy practices

You have the right to:

- Ask us in writing to restrict use or disclosure of your PHI. We may not be able to comply with all requests.
- Ask us in writing to communicate your PHI to you in the way or at the location of your choice. We must comply with any reasonable request.
- Inspect and copy your PHI. If we decline your request, you can appeal our decision.
- Request changes, corrections, or deletions to your PHI that you believe are incorrect or incomplete. We may not be able to comply with all requests.
- Request an accounting of certain PHI disclosures we made on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12-month period, fees may apply.
- Get a paper copy of this notice at any time.

- Request further information or file a complaint by contacting Network Health's privacy officer. You may also file a written complaint regarding your privacy rights with the director of the Office for Civil Rights of the U.S. Department of Health and Human Services. Our privacy officer will provide you with the correct address for the director. Network Health will not retaliate against you if you file a complaint with us or the Office of Civil Rights.

For details or to find out how to exercise your rights, visit [www.network-health.org](http://www.network-health.org), call 888-257-1985, or contact:

**Privacy Officer**  
**Network Health**  
101 Station Landing, Fourth Floor  
Medford, MA 02155  
[www.network-health.org](http://www.network-health.org)  
Phone: 888-257-1985  
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## Glossary

**Advance Directives** are instructions specifying how someone wants their health care needs met if they are no longer able to make decisions due to illness or incapacity. A living will is one form of Advance Directive, leaving instructions for treatment. Another form authorizes a specific type of power of attorney or health care proxy. You use this form to appoint someone specifically to make decisions if you become incapacitated. You may also have a combination of both.

**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)
- If we deny or provide limited authorization for a requested service
- If we reduce, suspend, or end a service we previously authorized
- If we do not act on a Prior Authorization request within the time frames we describe in this *Member Handbook*
- If we do not 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.

**Authorized Representative** is someone you authorize in writing to act on your behalf regarding a specific Grievance, Grievance Decision Review, Internal Appeal, or Fair Hearing. If you are unable to pick an Authorized Representative, your health care Provider, a guardian, conservator, or holder of a power of attorney may be your Authorized Representative. You can give your Authorized Representative a standing authorization to act on your behalf if you make this request in writing. This standing authorization will remain in effect until you revoke it. If you are a minor, and you are able by law to consent to a medical procedure, you may appeal our denial of the medical procedure without parent or guardian consent. In that case, you can also pick an Authorized Representative without parent or guardian consent.

**Behavioral Health** includes mental health and/or substance abuse services, including inpatient, outpatient, detoxification, and diversionary services.

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

A **Board of Hearings (BOH) External Review** is a written request to the Executive Office of Health and Human Services (EOHHS), Office of Medicaid's Board of Hearings to review Network Health's First-Level, Second-Level, or Expedited Internal Appeal decisions. EOHHS refers to an External Review as a "Fair Hearing."

**Care Management** is how we systematically assess, coordinate, and give you interventions related to your medical, Behavioral Health (mental health and/or substance abuse) and/or social care health needs. Through our Care Management services, we strive to make sure you can access high-quality, cost-effective, and appropriate care; get information about disease prevention and wellness; and help you get and stay healthy.

The **Child Adolescent Needs and Strengths (CANS) Tool** gives Behavioral Health (mental health and/or substance abuse) Providers a standardized way of organizing information during Behavioral Health (mental health and/or substance abuse) Clinical Assessments for Members under the age 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 **Claim** is a bill your health care Provider sends us to ask us to pay for services you get.

A **Community Service Agency (CSA)** offers care coordination 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 PCP, or call our Customer Service Team at 888-257-1985. You can also find this information on our Web site, [www.network-health.org](http://www.network-health.org) 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 an Internal Appeal and/or a Board of Hearing (BOH) Appeal is pending, unless you specifically indicate that you do not want to get these services, when the Internal Appeal involves the reduction, suspension, or termination of a previously authorized service. You will continue to get these services until you withdraw the Internal Appeal or BOH Appeal 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 the cost of the requested services you got.

**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 were 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 **Co-payment** is a fixed amount you may have to pay for a covered pharmacy service.

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 *Network Health Together* and MassHealth cover. The *Covered Services List* we include with this *Member Handbook* includes all of your covered services and supplies.

**Customer Service Team** is the team at Network Health that handles all of your questions about policies, procedures, requests, and concerns. You can reach our Customer Service Team at 888-257-1985. For people with partial or total hearing loss, you can reach our Customer Service Team at our TTY line: 888-391-5535. We are available Monday through Friday, from 8 a.m. to 5 p.m.

**Disenrollment** is the process by which a Member's *Network Health Together* coverage ends.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** services are preventive care and treatment services MassHealth Standard and CommonHealth Members under the age of 21 can get from a Primary Care Provider on a periodic schedule. The schedule is determined by the age at which each procedure is to be provided and includes a complete assessment (e.g. health screens), service coordination, crisis intervention, and in-home services.

**Effective Date** is the date on which an individual becomes a Member of *Network Health Together* and eligible for Covered Services. Generally, your Effective Date is one business day after MassHealth tells Network Health about your Enrollment.

**Eligibility** is whether or not you qualify for MassHealth benefits.

**Emergency** is a medical or Behavioral Health (mental health and/or substance abuse) condition with symptoms of sufficient severity, including severe pain. In the absence of prompt medical attention, a prudent lay person who has an average knowledge of health and medicine could reasonably expect this condition to place your health, another person's health, or, in the case of a pregnant woman, the woman's and/or her unborn child's health, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as Section 1867(e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B) further defines.

**Emergency Services Program (ESP) Providers** provide Behavioral Health (mental health and/or substance abuse) Emergency services in Massachusetts 24 hours a day, seven days a week.

**Expedited (fast) Appeal** is a verbal or written request for an Expedited (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.

**Fair Hearing** is another term for an external Board of Hearings (BOH) review (see Board of Hearings (BOH) External Review).

**Family-planning Services** are services you can get from any contracted MassHealth Provider without a Referral. Family-planning Services include birth control methods, exams, counseling, pregnancy testing, and some lab tests. You may also see your PCP for Family-planning Services.

**First-Level Internal Appeals** are verbal or written requests for Network Health to review an Adverse Action.

**Fraud** is an intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth program to himself or herself, the corporation, or some other person. An example of fraud is Members lending their *Network Health Together* Member ID Cards to others so they can get health care or pharmacy services.

**Grievance** is any expression of dissatisfaction by you or your Authorized Representative about any action or inaction by Network Health other than an Adverse Action. Subjects of Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness on the part of a Provider or employee of Network Health, failure to respect your rights, a disagreement you may have with our decision not to approve a request that an Internal Appeal be expedited, 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 Network Health.

**Hospital** — any licensed facility that provides medical and surgical care for patients who have acute illnesses or injuries and that the American Hospital Association (AHA) lists as a Hospital or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits.

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

**In-network Provider** is a Provider Network Health 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** is a program certain Members with hard-to-manage, unstable, and/or long-lasting medical and Behavioral Health (mental health and/or substance abuse) 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 **Network Health Together** Members. ICM may include community support programs and services, in-home therapy, crisis-prevention planning, and follow-up support.

**Internal Appeals** include First-Level and Second-Level Internal Appeals. Internal Appeals are verbal or written requests for Network Health to review an Adverse Action.

**MassHealth** is the Medical Assistance or benefits programs that the Executive Office of Health and Human Services (EOHHS) administers pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible Members.

**MassHealth Basic** offers coverage to certain unemployed adults under age 65 who are getting services or are on a waiting list to get services from the Department of Mental Health and Emergency Aid to the Elderly, Disabled, and Children through the Department of Transitional Assistance.

**MassHealth CommonHealth** offers similar health care benefits as MassHealth Standard to disabled adults and disabled children who cannot get MassHealth Standard because their incomes are too high.

**MassHealth Essential** is health insurance coverage for long-term unemployed adults who do not qualify for MassHealth Basic, and for certain noncitizens with special status.

**MassHealth Family Assistance** offers coverage to children, some working adults, and HIV-positive men and women who cannot get MassHealth Standard or CommonHealth.

**MassHealth Standard** is the most complete coverage MassHealth offers. It pays for a wide range of health care benefits and is the only coverage that pays for long-term care services. It is available to individuals who are under age 19, pregnant, a parent with a child under age 19, an adult caretaker relative living with children under age 19, disabled (have a mental or physical condition that prevents them from working), and those eligible based on income level.

**Medically Necessary** or **Medical Necessity** means services that, in accordance with 130 CMR 450.204, are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure your conditions that endanger your life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity and for which there is no other medical service or site of service, comparable in effect, available, and suitable for you, 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 substantiated by records including evidence of such Medical Necessity and quality.

**Medicare Part D** is what will pay for your prescription drug benefit, if you have Medicare. Refer to page 14 for more information.

A **Member** is anyone enrolled in a Network 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 details covered services you get with **Network Health Together**. It is our agreement with you, and includes any riders, amendments, or other documents that add to the details of covered services.

**Network** or **Provider Network** is the collective group of health care Providers who have contracted with Network Health to provide covered services.

**Nonpreferred In-network Providers** are Providers you cannot see unless your PCP gets Prior Authorization from us first. If you see a Nonpreferred In-network Provider without Prior Authorization, we may not cover the cost.

**Nonsymptomatic 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 Policy** tells you about how we may use and disclose your PHI. We include our Notice of Privacy Policy in this *Member Handbook*.

**NurseLine** is our 24-hour help line for health questions, 24 hours a day, seven days a week. When you call our NurseLine at 888-MY-RN-LINE (888-697-6546), you can talk with a caring and supportive health care professional at any hour and at no cost. NurseLine staff can give you information and support on health care issues like symptoms, diagnoses and test results as well as treatments, tests and procedures your Provider has ordered. NurseLine staff does not give medical advice. They do not replace your Provider.

An **Out-of-network Provider** is a Provider we do not 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.

**Preferred In-network Providers** are Providers you can see without your PCP first asking for Prior Authorization.

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

**Primary Care** is a comprehensive, coordinated medical service you get during a first visit and at any visit after. Primary Care involves an initial medical history intake, medical diagnosis and treatment, Behavioral Health (mental health and/or substance abuse) screenings, communication of information about illness prevention, health maintenance, and authorizations.

A **Primary Care Provider (PCP)** is the individual health care Provider or team you selected, or to whom we assign you, to provide and coordinate all of your health care needs. Primary Care Providers 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). Primary Care Providers must be board-certified or eligible for board certification in their area of specialty. You may also choose a nurse practitioner as a PCP or may change your PCP to a nurse practitioner if the nurse practitioner 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 a process that determines if you need a specific health care service or where you can get a specific health care service. Network Health 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 (verbal or written) 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 individually identifiable health information, which 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 Network Health, or its subcontractor, to deliver the Covered Services under this contract.

The **Provider Directory** is a publication that lists *Network Health Together's* contracted health care facilities and professionals, including Primary Care Providers, Specialists listed by specialty, Hospitals, Emergency rooms and Emergency Services Program Providers, pharmacies, Ancillary Services, Behavioral Health (mental health and/or substance abuse) services, and school-based health centers. You can call us at 888-257-1985 to get a *Provider Directory*.

A **Region** is the area where you live and where you should pick your PCP.

**Second-Level Internal Appeals** are verbal or written requests for Network Health to review a First-Level Internal Appeal denial.

**Network Health Together** Members can get a **Second Opinion** on a medical procedure from an in-plan Provider. Your Primary Care Provider will refer you to a contracted in-network Provider for a Second Opinion consultation. Prior Authorization from Network Health is required when your Provider wants you to get a Second Opinion from a Provider who is not part of the **Network Health Together** Provider Network. Network Health will pay for any costs related to your getting a Second Opinion.

**Service Area** is the geographic area in which Network Health has developed a Network of Providers to provide adequate access to covered services for Members with **Network Health Together**.

A **Specialist** is a doctor 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 Network Health 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 process of reviewing and evaluating the care you get before, during, and after you get care to make sure the care you get is appropriate and that you get the care you need.

**Utilization Review** is our process of reviewing 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.

A **Your Health** form is a series of questions we ask Members so that we can get their most up-to-date health information.