Covered Services List: for Primary Care ACO (including Partners HealthCare Choice) and PCC Plan Members with MassHealth CarePlus Coverage

This is a list of covered services and benefits for MassHealth CarePlus members enrolled in a Primary Care Accountability Collaborative (ACO) or the Primary Care Clinician (PCC) Plan. All services and benefits are covered directly by MassHealth, except for behavioral health services, which are covered by the MassHealth behavioral health services contractor, the Massachusetts Behavioral Health Partnership (MBHP).

You can call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) for more information about services and benefits or to ask questions.

• For questions about behavioral health services, please call the MBHP at 1-800-495-0086 (TTY: 617-793-4130 for people who are deaf, hard of hearing, or speech disabled).
• For more information about pharmacy services, go to the MassHealth Drug List at www.mass.gov/druglist.
• For questions about dental services, please call 1-800-207-5019 (TTY: 1-800-466-7566 for people who are deaf, hard of hearing, or speech disabled) or go to www.masshealth-dental.net

A “Yes” in either the “Prior Authorization Required for Some or All of the Services?” or the “Referral Required for Some or All of the Services?” column means that advance authorization or a referral is required. If a referral is required, the referral must come from your PCP or PCC. There is more information about prior authorizations and referrals in your member handbook. Please keep in mind that MassHealth services and benefits change from time to time. This Covered Services List is for your general information only. MassHealth regulations control the services and benefits available to you. To access MassHealth regulations:
• go to MassHealth’s website at www.mass.gov/masshealth or
• call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) Monday through Friday from 8:00 a.m. – 5:00 p.m.

MassHealth CarePlus Covered Services

<table>
<thead>
<tr>
<th>Emergency Services</th>
<th>Prior authorization required for some or all of the services?</th>
<th>Referral required for some or all of the services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Transportations—ambulance (air and land) transport that generally is not scheduled, but is needed on an emergency basis. This includes specialty care transport (that is, an ambulance transport of a critically injured or ill enrolled from one facility to another, requiring care beyond the scope of a paramedic).</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Emergency Inpatient and Outpatient Hospital Services</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical Services

| Abortion Services | No | No |
| Acupuncture Treatment— for pain relief or anesthesia | No | Yes |
| Acute Inpatient Hospital Services | Yes | Yes |
| This benefit is limited to acute hospital inpatient services of up to 20 days per admission. This limitation excludes administratively necessary days (ANDs) and stays in a Department of Mental Health (DMH)-licensed acute psychiatric unit within a Department of Public Health (DPH)-licensed acute hospital, freestanding psychiatric hospital, or in a rehabilitation unit within a DPH-licensed acute hospital. | Yes | No |
| Ambulatory Surgery Services—outpatient surgical, related diagnostic, medical, and dental services | Yes | Yes |
| Audiologist (Hearing) Services | No | Yes |
| Chiropractor Services | No | Yes |
| Chronic Disease and Rehabilitation Inpatient Hospital Services* | Yes | No |

Community Health Center Services. For example:
• Specialty office visit
• OB/GYN (other than prenatal care and annual gynecological exams)
• Pediatric services, including EPSDT
• Medical social services
• Nutrition services, including diabetes self-management training and medical nutrition therapy
• Health education
• Vaccines/immunizations not covered (HEP A and B)

Dental Services

| Emergency-related treatment for dental pain and infection | No | No |
| Oral surgery performed in an outpatient hospital or ambulatory surgery setting that is medically necessary to treat an underlying medical condition | Yes | No |
| Preventive, restorative, and basic services for the prevention and control of dental diseases and the maintenance of oral health for adults | No | No |

Dialysis Services | No | No |

Durable Medical Equipment (DME)—including but not limited to the purchase or rental of medical equipment, replacement parts, and repair for such items | Yes | No |

Family Planning Services | No | No |

Hearing Aid Services | Yes | Yes |

Home Health Services | Yes | Yes |

Hospice Services2 | Yes | No |

Infertility—Diagnosis of infertility and treatment of underlying medical condition | Yes | Yes |

Laboratory Services—all services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of health | Yes | No |

Nursing Facility Services3 | Yes | No |

Orthotic Services—braces (nondental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. | Yes | Yes |

Outpatient Hospital Services—services provided at an outpatient hospital. For example:
• Outpatient surgical and related diagnostic, medical, and dental services
• Specialty office visits
• OB/GYN (other than prenatal care and annual gynecological exam)
• Therapy services (physical, occupational, and speech)
• Diabetes self-management training
• Medical nutritional therapy

*Chronic Disease and Rehabilitation Inpatient Hospital Services—覆盖的医疗服务

1 When you enter a chronic disease and rehabilitation inpatient hospital, you will be transferred from your Primary Care ACO plan or the PCC Plan to receive services from MassHealth on a fee-for-service basis.

2 When you elect hospice services, you will be transferred from your Primary Care ACO plan or the PCC Plan to receive services related to your illness from your hospice service provider and from MassHealth on a fee-for-service basis.

3 When you enter a nursing facility, you will be transferred from your Primary Care ACO plan or the PCC Plan to receive services from MassHealth on a fee-for-service basis.

If you have questions, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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PCCINSERT/CP (Rev. 04/18)
**Medical Services (continued)**

<table>
<thead>
<tr>
<th>Service</th>
<th>Prior authorization required for some or all of the services?</th>
<th>Referral required for some or all of the services?</th>
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</thead>
<tbody>
<tr>
<td><strong>Oxygen and Respiratory Therapy Equipment</strong></td>
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<tr>
<td>Primary Care (provided by member’s PCC or PCP). For example:</td>
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<td></td>
</tr>
<tr>
<td>- Primary care office visit</td>
<td>No</td>
<td>No</td>
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<tr>
<td>- Fluoride varnish to prevent tooth decay in children up to age 21</td>
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<tr>
<td>- Prenatal Care</td>
<td></td>
<td></td>
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<tr>
<td>- Annual gynecological exams</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Specialist Physician, Nurse Practitioner, and Nurse Midwife Services.</td>
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<tr>
<td>- Specialty office visits</td>
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<td></td>
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<tr>
<td>- OB/GYN visits (other than prenatal care and annual gynecological exam)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Podiatrist Services (Foot Care)</strong></td>
<td></td>
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<tr>
<td><strong>Prosthetic Services</strong></td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>**Radiology and Diagnostic Services. For example:</td>
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<tr>
<td>- X-rays</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>- Magnetic resonance imagery (MRI) and other imaging studies</td>
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<tr>
<td>- Radiation oncology services</td>
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<tr>
<td>**Therapy Services. For example:</td>
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<tr>
<td>- Occupational therapy</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>- Physical therapy</td>
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<tr>
<td>- Speech/language therapy</td>
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</tbody>
</table>

**Transportation Services (Nonemergency)**

- Nonemergency transportation by land ambulance, chair car, taxi, and common carriers that generally are prearranged to transport an enrollee to and from covered medical care in Massachusetts or within 50 miles

**Vision Care. For example:**

- Bandage lenses
- Comprehensive eye exams every 24 months and whenever medically necessary
- Contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus
- Ocular prostheses
- Prescription and dispensing of ophthalmic materials, including eyeglasses and other visual aids, excluding contacts
- Vision training

**Wigs**

As prescribed by a physician related to a medical condition

<table>
<thead>
<tr>
<th>Pharmacy Services (Medication)—see copayment information at the end of this section</th>
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<tbody>
<tr>
<td>Prescription Drugs</td>
</tr>
</tbody>
</table>

**Behavioral Health (Mental Health and Substance Use Disorder) Services**

Behavioral health services are paid for and provided by MassHealth’s behavioral health services contractor, the Massachusetts Behavioral Health Partnership (MBHP).

**Non-24-Hour Diversionsary Services.** For example:

- Community support programs (CSP)
- Structured outpatient addiction program (SOAP)
- Psychiatric day treatment

<table>
<thead>
<tr>
<th>Community crisis stabilization (CCS)</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Intensive outpatient program (IOP)</td>
<td>No</td>
<td>No</td>
</tr>
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</table>

**24-Hour Diversionsary Services.** For example:

- Acute treatment services (ATS) for substance use disorders (Level III)
- Clinical stabilization services (CSS) for substance use disorders (Level III) + Transitional care unit

<table>
<thead>
<tr>
<th>Transitional care unit</th>
<th>No</th>
<th>No</th>
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<tbody>
<tr>
<td>Partial hospitalization program (PHP)</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Community-based acute treatment for children and adolescents (CBAT)**

Yes | No

**Emergency Services (Inpatient and Outpatient)**

No | No

**Emergency Services Program (ESP) Services.** For example: Crisis assessment, intervention, and stabilization

No | No

**Inpatient Services.** For example:

- Inpatient mental health services
- Inpatient substance use disorder services (Level IV)
- Inpatient mental health services for individuals with intellectual disabilities (IIDs)
- Observation/holding beds

Yes | No

**Outpatient Services.** For example:

- Individual, group, and family counseling
- Diagnostic evaluations
- Electroconvulsive therapy (ECT)
- Narcotic-treatment services (including acupuncture and ambulatory detoxification)

No | No

**Copayments**

Most members pay the following copayments:

- $1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics;
- $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth; and
- $3 for certain inpatient hospital stays.

Members who do NOT have copayments:

- members who are pregnant in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ended (for example, if a woman gave birth May 15, she is exempt from copayment requirement until August 1);
- members who are inpatients in nursing facilities, chronic disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded who are admitted to a hospital from such a facility or hospital;
- members receiving hospice services;
- members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law.

In addition, members do not have to pay copayments for family-planning supplies (birth control), family-planning services and supplies; nonpharmacy behavioral health services; and emergency services.

**Copayment cap**

Members are responsible for the copayments described on the left, up to the following maximums:

- $250 for pharmacy services per calendar year;
- $36 for nonpharmacy services per calendar year; and
- five percent of the member’s MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, in a given calendar quarter, including both copayments and any applicable premium payments.

**Excluded services**

Except as otherwise noted or determined medically necessary, the following services are not covered under MassHealth.

1. Cosmetic surgery, except as determined by MassHealth to be necessary for:
   - a. correction or repair of damage following injury or illness;
   - b. mammaplasty following a mastectomy; or
   - c. any other medical necessity as determined by MassHealth
2. Treatment for infertility, including but not limited to in-vitro fertilization and gamete intrafallopian tube (GIFT) procedures
3. Experimental treatment
4. Personal comfort items including air conditioners, radios, telephones, and televisions

5. A service or supply that is not provided by or at the direction of MassHealth, except for:
   - a. emergency services
   - b. family planning services
   - c. noncovered laboratory services

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