Stonehill College

Preferred Provider Option

Description of Benefits

This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see below for additional information.

New Members—Register Now at **www.tuftshealthplan.com** for Fast Access to Your Personal Benefit Information

With Administrative Services Provided by

TUFTS Health Plan

705 Mount Auburn Street
Watertown, MA 02472-1508

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE

The Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that were effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT WERE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, MA 02472-1508

Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.S.T.
Friday 8:00 a.m. to 5:00 p.m. E.S.T.

IMPORTANT PHONE NUMBERS:

Emergency Care

For routine care, you should always call your *Provider* before seeking care. If you have an urgent medical need and cannot reach your *Provider*, you should seek care at the nearest emergency room.

Important Note: If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

Liability Recovery

Call the Liability and Recovery Department at 1-888-880-8699, x. 21098 for questions about coordination of benefits and workers compensation. For example, call the Liability and Recovery Department if you have any questions about how *Tufts Health Plan* coordinates coverage with other health care coverage that you may have. The Liability and Recovery Department is available from 8:30 a.m. – 5:00 p.m. Monday through Friday.

For questions related to subrogation, call a Member Specialist at 1-800-462-0224. If you are uncertain which department can best address your questions, call Member Services.

Member Services Department

Call the *Tufts Health Plan* Member Services Department at 1-800-462-0224 for general questions, benefit questions, and information regarding eligibility for enrollment and billing.

Behavioral Health Services

If you need assistance obtaining a provider or receiving information regarding behavioral health/substance use disorder benefits, please contact the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565.

Services for Hearing Impaired Members

If you are hearing impaired, the following services are provided:

Telecommunications Device for the Deaf (TDD)
If you have access to a TDD phone, call 711. You will reach the *Tufts Health Plan* Member Services Department.

Massachusetts Relay (MassRelay)
711

IMPORTANT ADDRESSES:

Appeals and Grievances Department

If you need to call *Tufts Health Plan* about a concern or appeal, contact a Member Specialist at 1-800-462-0224. To submit your appeal or grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
Fax: 617-972-9509

Web site

For more information about *Tufts Health Plan* and to learn more about the self-service options that are available to you, please see the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

Translating services for more than 200 languages

Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For no cost translation in English, call the number on your ID card.

Arabic . الهوية بطاقة على المدون الرقم على الاتصال يرجى العربية، باللغة المجانية الترجمة خدمة على للحصول بك الخاصة

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτας σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

Japanese 日本語の無料翻訳については**ID**カードに書いてある番号に電話してください。

Khmer (Cambodian)

សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo

Doo bąąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian. فارسی به شماره تلفن مندرج در کارت شناسائی تان زنگ بزنید برای ترجمه رایگا

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

Portuguese Para tradução grátis para português, ligue para o número no seu cartão de identificação.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

Spanish Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

Tagalog Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

Vietnamese Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

Telecommunications Device for the Deaf (TDD)

711

MassRelay

711

Plan Information

***Plan* Name**	Stonehill College Major Medical Plan
Employer (also referred to herein as Sponsor or *Group*)	Stonehill College
Employer Address	320 Washington Street, Easton MA 02357
Employer's ID Number (EIN)	04-2104229
***Plan* Number**	Tufts Health Plan 49698-000; ERISA Plan 502
***Tufts Health Plan* Effective Date**	This plan became effective as of January 1, 2000.
***Description of Benefits* Effective Date**	This *Description of Benefits* is effective July 1, 2018 and remains in effect until the *Plan Year* which commences July 1, 2019. It may be amended in accordance with Chapter 7.
Plan Year	July 1 – June 30
Benefit Year	July 1 – June 30
Plan Administrator	Plan Administrator Representative: Jeanne Finlayson, Vice President of Finance and Treasurer, Stonehill College Actions and decisions of the Plan Administrator will be deemed actions of the Plan Administrator without further action by any Board or officer of Stonehill College. All communications for the Plan Administrator should be sent in care of the Human Resource Office: Plan Administrator of Stonehill College Major Medical Plan C/O Stonehill College Human Resource Office 320 Washington Street, Easton MA 02357
Agent for Service of Legal Process	Thomas V. Flynn, General Counsel, Stonehill College All communications for the General Counsel should be sent to: Thomas V. Flynn, General Counsel, Stonehill College 320 Washington Street, Easton MA 02357
Type of Plan	Medical Benefits. This is considered a "welfare benefits plan" under ERISA.
Plan Administration	The *Plan* is administered according to a contract between the Sponsor and Tufts Health Plan. This *Plan* is self-insured, meaning that benefits are paid through contributions of the Sponsor and the *Members*. This is not a contract of insurance by Tufts Health Plan or the Sponsor. There is no trust fund separate from the Sponsor for payment of benefits.

Plan Information, continued

Collective Bargaining Agreement

The health benefits option under the *Plan* described in this *Description of Benefits* is maintained pursuant to a collective bargaining agreement.

A copy of such agreement may be obtained upon written request to the *Plan Administrator*.

Plan Fiscal Year

The fiscal records of the *Plan* are kept on a plan year basis ending on each June 30th.

Loss of Benefits

The *Plan Administrator* may terminate the *Plan* at any time. The *Plan Administrator* may modify, amend, or change the provisions, terms and conditions of the *Plan*. No consent of any *Member* shall be required to terminate, modify, amend or change the *Plan*.

Employee Contribution to Benefits

REQUIRED at the level established by the *Plan Administrator* in its sole discretion. Different levels of contribution may be required for single coverage, Employee plus spouse, Employee plus child(ren) and family coverage. Employee contributions are "pre-tax" under the terms of a Section 125 Flex Plan that is not part of the contract with *Tufts Health Plan*. Internal Revenue Code rules prohibit the dropping or change of coverage during a *Benefit Year* unless consistent with Internal Revenue Code rules that are not described in this document.

Preferred Provider Option Plan

Overview

Introduction

This booklet contains your *Description of Benefits*. It describes Stonehill College's employee health benefits plan, which is referred to here as the "*Plan*." This is a self-funded plan, which means your employer is responsible for the cost of the *Covered Services* you receive under it, provided you pay your required share of contributions on a timely basis. Capitalized words are defined in the Glossary in Appendix A.

How the *Plan* works

The *Sponsor (*acting through the Plan Administrator) has contracted with *Tufts Health Plan*. *Tufts Health Plan* offers a preferred provider organization ("PPO") and performs certain services for the *Plan*, such as claims processing and enrollment. *Tufts Health Plan* also offers you access to a network of preferred providers known as *Network Providers*.

Tufts Health Plan does not, however, insure the *Plan* benefits or determine your eligibility for benefits under the *Plan*. This is the *Plan's* responsibility. It is a self-insured plan and not a contract of insurance. It does not provide for vested rights to any level of care and may be amended or terminated by the *Plan Administrator* at any time.

About the Network

Network Providers are hospitals, community-based physicians and other health care professionals who work out of their private offices throughout the *Network Contracting Area*.

These *Providers* enter into arrangements either with *Tufts Health Plan* directly or with a *Provider* network with whom *Tufts Health Plan* contracts. *Network Providers*, in turn, provide you with *Covered Services*. This means that *Tufts Health Plan* itself does not provide these services. *Network Providers* are independent contractors and are not, for any purposes, employees or agents of the *Plan* or *Tufts Health Plan*.

With *Tufts Health Plan*, each time you need health care services, you may choose to obtain your health care from either:

- a *Network Provider*. This is the *In-Network Level of Benefits*.
- any *Non-Network Provider*. This is the *Out-of-Network Level of Benefits*.

Your choice will determine the level of benefits you receive for your health care services:

- ***In-Network Level of Benefits*:** If your care is provided by a *Network Provider*, you will be covered at the *In-Network Level of Benefits*.
- ***Out-of-Network Level of Benefits*:** If your care is provided by a *Non-Network Provider*, you will be covered at the *Out-of-Network Level of Benefits*.
- ***Covered Services* Outside of the 50 United States**: *Emergency* care services provided to you outside of the 50 United States qualify as *Covered Services*. In addition, *Urgent Care* services provided to you while you are traveling outside of the 50 United States qualify as *Covered Services.* However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan.

For additional information about these levels of benefits and how to receive *Covered Services*, please see Chapter 1. If you have any questions, please call the *Tufts Health Plan* Member Services Department.

PLEASE READ THIS *DESCRIPTION OF BENEFITS* CAREFULLY.

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Chapter 3 -- *Covered Services*, continued

Table of Contents, continued

Benefit Overview

This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COINSURANCE
In-Network Level of Benefits: There is no *Coinsurance* for most *Covered Services* provided by a *Network Provider*. Except as shown in Chapter 3, the *Member* pays the applicable *Copayment* for all *Covered Services* provided by a *Network Provider*. The *Plan* will cover the remaining charges for *Covered Services*. ***Out-of-Network Level of Benefits***: Except as shown below, the *Member* pays 30% *Coinsurance* for all *Covered Services* provided in the 50 United States by a *Non-Network Provider*. The *Plan* will cover the remaining charges for *Covered Services*, up to the *Reasonable Charge*. (The *Member* is responsible for any charges in excess of the *Reasonable Charge*.) *Coinsurance* for behavioral health/substance abuse services and *Durable Medical Equipment* may not be used to satisfy *Out-of-Pocket Maximums, and* will continue to apply after *Out-of-Pocket Maximums* are reached.

COPAYMENTS

• *Emergency* Care (*In-Network* and *Out-of-Network Levels of Benefits*):
  • Emergency room ..... $300 per visit.
Notes:
  • An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.
  • A *Day Surgery Copayment* may apply if *Day Surgery* services are received.
 	
• *In-Network Level of Benefits*:
  • Office Visit or visit to an *Urgent Care Center* ..... $40 per visit.
  • *Inpatient* Services ..... $500 per admission.
  • *Day Surgery* ..... $250 per admission.
 	
Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. Please see the following Benefit Overview chart for more information. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to a *Copayment* at the *In-Network Level of Benefits.* Please see the following Benefit Overview chart for more information. Also, please note that *Copayments* for *Urgent Care* services vary depending upon location in which services are rendered (for example, *Provider's* office*, Limited Service Medical Clinic, Urgent Care Center*, or *Emergency* room).

Benefit Overview, continued

This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

***DEDUCTIBLE* (*Out-of-Network* Services Only)**
This plan has an *Out-of-Network Deductible*. Your *Out-of-Network* individual *Deductible* is $500 per *Benefit Year*. **The following amounts do not count towards your *Deductible*s;** • Any amount you pay for services, supplies or medications that are not *Covered Services*. • Costs in excess of the *Reasonable Charge.* Please Note: Any *Deductible* amount paid by the *Member* for a *Covered Service* received during the last 6 months of a *Benefit Year* shall be carried forward to the next *Benefit Year's Deductible*. This amount does apply towards the next Benefit *Year's Out-of-Pocket Maximum*.

OUT-OF-POCKET MAXIMUM - MEDICAL AND PHARMACY

This plan has separate *In-Network* and *Out-of-Network Out-of-Pocket Maximums.* This means you must satisfy each *Out-of-Pocket Maximum* separately.
 	
Your *In-Network* individual *Out-of-Pocket Maximum* is $4,000 per *Benefit Year*.
 	
Your *In-Network* family (two or more *Members*) *Out-of-Pocket Maximum* is $4,000 per *Member* and $8,000 per family per *Benefit Year*.
 	
Your *Out-of-Network* individual *Out-of-Pocket Maximum* is $8,000 per *Benefit Year*.
 	
Your *Out-of-Network* family (two or more *Members*) *Out-of-Pocket Maximum* is $8,000 per *Member* and $16,000 per family per *Benefit Year*.
 	
Note: Under a family plan, any combination of enrolled *Members* in a family can contribute towards meeting the family *Out-of-Pocket Maximum.* Once the family *Out-of-Pocket Maximum* is met during a *Benefit Year* the *Plan* will begin to pay for *Covered Services* for all enrolled *Members* in a family, under the terms of this *Description of Benefits.* **However:**
• ***In-Network:*** If any enrolled *Member* in a family meets the Individual *Out-of-Pocket Maximum* before the Family *Out-of-Pocket Maximum* is met, then that *Member* has met his/her *In-Network Out-of-Pocket Maximum* requirement, and the *Plan* will begin to pay for his/her *Covered Services* under the terms of this *Description of Benefits.*
• ***Out-of-Network:*** If any enrolled *Member* in a family meets the Individual *Out-of-Pocket Maximum* before the Family *Out-of-Pocket Maximum* is met, then that *Member* has met his/her *Out-of-Network Out-of-Pocket Maximum* requirement, and the *Plan* will begin to pay for his/her *Covered Services* under the terms of this *Description of Benefits*.
 	
• **The following amounts do not count towards your *Out-of-Pocket Maximum:***
  • Because your *In-Network* and *Out-of-Network Out-of-Pocket Maximums* are separate, any amounts you pay for *Covered Services* received at the *In-Network Level of Benefits* do **not** count towards your *Out-of-Network Out-of-Pocket Maximum,* and any amounts you pay for *Covered Services* received at the *Out-of-Network Level of Benefits* do **not** count towards your *In-Network Out-of-Pocket Maximum.*
  • Any amount you pay for services, supplies or medications that are not *Covered Services*.
  • Costs in excess of the *Reasonable Charge.*

Benefit Overview, continued

This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

NOTIFICATION PENALTY

You must pay the *Notification Penalty* listed below for failure to notify *Tufts Health Plan* or an *Inpatient* hospitalization or transfer to another hospital in accordance with Chapter 1.

- *In-Network Level of Benefits*:

  There is no *Notification Penalty* for an *Inpatient* hospitalization or transfer to another hospital at *the In-Network Level of Benefits*. As long as your hospitalization procedure is provided by a *Network Provider*, you are not responsible for notifying *Tufts Health Plan* of the hospitalization or transfer. Your *Network Provider* will notify *Tufts Health Plan* of the hospitalization or transfer the procedure for you.

- *Out-of-Network Level of Benefits:*

  You must pay a $300 *Notification Penalty* for failure to notify *Tufts Health Plan* of a hospitalization or transfer to another hospital at the *Out-of-Network Level of Benefits* in accordance with Chapter 1. For more information, please see "*Preregistration*" in Chapter 1.

Note: This *Notification Penalty* cannot be used to meet the *Deductibles* or *Out-of-Pocket Maximums* described earlier in this section.

Important Note about your coverage under the Affordable Care Act ("ACA"): Under the ACA, preventive care services -- including women's preventive health services, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription -- are now covered in full at the *In-Network Level of Benefits*. These services are listed in the following Benefit Overview. For more information on what services are now covered in full, please see the website at **https:///www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**. You can find information about women's preventive health services at https://www.hrsa.gov/womensguidelines2016/index.html.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	**YOUR COST**	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Emergency* Care**		
Treatment in an Emergency room	Emergency room *Copayment*. (waived if admitted as an *Inpatient* or for *Day Surgery*)	Emergency room *Copayment*. (waived if admitted as an *Inpatient* or for *Day Surgery*)
	Note: Observation services will not take an *Emergency* room *Copayment.*	
You should call *Tufts Health Plan* within 48 hours after *Emergency* care is received. If admitted as an *Inpatient* after receiving *Out-of-Network Emergency* care, you or someone acting for you must call *Tufts Health Plan* within 48 hours in order to be covered at the *In-Network Level of Benefits*. Note: A *Day Surgery Copayment* may apply if *Day Surgery* services are received.		

COVERED SERVICE	**YOUR COST**	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Outpatient* Care**		
Allergy injections	Covered in full.	*Deductible* and *Coinsurance.*
Allergy testing and treatment	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Cardiac rehabilitation services	Covered in full.	*Deductible* and *Coinsurance*.
Chemotherapy	Covered in full.	*Deductible* and *Coinsurance*.
Chiropractic Care **(BL)**	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Cytology examinations (Pap Smear)	Routine annual cytology testing: Covered in full. Diagnostic cytology examination: Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Diabetes self-management training and educational services	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.

(AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Outpatient* Care,** continued		
Diagnostic Imaging • General imaging (such as x-rays and ultrasounds) and • MRI / MRA, CT/CTA, PET and nuclear cardiology **(AR)**	**General Imaging**: Covered in full. **MRI/MRA:** $150 *Copayment* applies per visit. **CT/CTA:** $150 *Copayment* applies per visit. **PET:** $150 *Copayment* applies per visit. **Nuclear cardiology:** $150 *Copayment* applies per visit. Note: Diagnostic imaging, except for general imaging, will be covered in full when the imaging is required as part of an active treatment plan for a cancer diagnosis.	*Deductible* and *Coinsurance*.
Diagnostic or preventive screening procedures (for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies) **(AR)**	**Screenings for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention:** Covered in full. **Diagnostic procedure only (for example, colonoscopies associated with symptoms):** Covered in full. **Diagnostic procedure accompanied by treatment/surgery (for example, polyp removal):** *Day Surgery Copayment*.	*Deductible* and *Coinsurance*.
Diagnostic testing **(AR)**	Covered in full.	*Deductible* and *Coinsurance*.
Early intervention services for a *Dependent Child*	Covered in full.	*Deductible* and *Coinsurance*.

(AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Outpatient* Care,** continued		
Family planning	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Hemodialysis	Covered in full.	*Deductible* and *Coinsurance*.
Human leukocyte antigen testing or histocompatibility locus antigen testing	Covered in full.	*Deductible* and *Coinsurance*.
Immunizations and vaccinations	**Routine preventive immunizations**: Covered in full. **All other immunizations**: Covered in full.	*Deductible* and *Coinsurance*.
Infertility services (Diagnostic procedures and tests provided in connection with an infertility evaluation)	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Laboratory tests **(AR)** **Note:** In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full at the *In-Network Level of Benefits*.	Covered in full.	*Deductible* and *Coinsurance*.
Lead screenings	Covered in full.	*Deductible* and *Coinsurance*.
Mammograms	**Routine annual mammogram**: Covered in full. **Diagnostic mammograms**: Covered in full.	*Deductible* and *Coinsurance*.

(AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	**YOUR COST**	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Outpatient* Care,** continued		
Nutritional counseling **(BL)**	Preventive nutritional counseling: Office Visit *Copayment*. All other nutritional counseling services: Office Visit *Copayment*. **Note:** Nutritional services are covered in full at the *In-Network Level of Benefits* when they are provided as preventive services, as defined by the U.S. Preventive Services Task Force. Please see "Nutritional" counseling" in Chapter 3 for more information.	*Deductible* and *Coinsurance*.
Office visits to diagnose and treat illness or injury Note: This includes consultations, and visits to a *Limited Services Medical Clinic*.	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Oral health services **(AR)**	**Emergency room visit:** Emergency Room *Copayment*. **Office Visit**: Office Visit *Copayment* per office visit. ***Inpatient***: *Inpatient Copayment* per *Inpatient* admission. ***Day Surgery***: *Day Surgery Copayment* per *Day Surgery* admission.	***Emergency* care in an Emergency room:** Emergency Room *Copayment*. **All other services:** *Deductible* and *Coinsurance*.

(AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	**YOUR COST**	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Outpatient* Care,** continued		
Outpatient surgery in a *Provider's* office	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Patient care services provided as part of a qualified clinical trial for treatment of cancer or other life-threatening diseases and conditions	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Preventive care for *Members* under Age 6	Covered in full. Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to an Office Visit *Copayment.* In addition, *Member* cost sharing will also apply to diagnostic tests or laboratory tests when they are ordered as part of a preventive services visit or routine annual gynecological exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recomendations/ for more information about which laboratory services are considered preventive.	*Deductible* and *Coinsurance*.

(AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Outpatient* Care,** continued		
Preventive care for *Members* age 6 and older	Covered in full. Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to an Office Visit *Copayment.* In addition, *Member* cost sharing will also apply to diagnostic tests or laboratory tests when they are ordered as part of a preventive services visit or routine annual gynecological exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recomendations/ for more information about which laboratory services are considered preventive.	*Deductible* and *Coinsurance*.
Radiation therapy	Covered in full.	*Deductible* and *Coinsurance*.
Respiratory therapy or pulmonary rehabilitation services	Covered in full.	*Deductible* and *Coinsurance*.
Rehabilitation services **(AR) (BL)**	Office Visit *Copayment*.	*Deductible* and *Coinsurance.*
Smoking cessation counseling services	Covered in full.	*Deductible* and *Coinsurance.*
Urgent Care services in an *Urgent Care Center*	Office Visit *Copayment*.	*Deductible* and *Coinsurance.*

(AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Outpatient* Care,** continued		
Vision care services		
Annual routine eye examination	Office Visit *Copayment*.	*Deductible* and *Coinsurance*.
Other vision care services	Office Visit *Copayment*. Note: One eyeglass lenses and standard frames following cataract surgery or other surgery to replace the natural lens of the eye are covered in full. See Chapter 3 for more information.	*Deductible* and *Coinsurance*. Note: One eyeglass lenses and standard frames following cataract surgery or other surgery to replace the natural lens of the eye are covered subject to *Deductible* and 30% *Coinsurance.* See Chapter 3 for more information.
Day Surgery		
Day Surgery **(AR)**	*Day Surgery Copayment*.	*Deductible* and *Coinsurance*.
Physician/surgeon fees	Covered in full.	*Deductible* and *Coinsurance*.

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
***Inpatient* Care**		
Physician/surgeon fees	Covered in full.	*Deductible* and *Coinsurance*.
Bone marrow transplants, hematopoietic stem cell transplants, and human solid organ transplants **(AR)**	*Inpatient* Services *Copayment*.	*Deductible* and *Coinsurance*.
Extended care services **(AR) (BL)**	Covered in full.	*Deductible* and *Coinsurance*.
Hospital services (Acute care)/facility fees **(AR)**	*Inpatient* Services *Copayment*.	*Deductible* and *Coinsurance*.
Patient care services provided a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions	*Inpatient* Services *Copayment*.	*Deductible* and *Coinsurance*.
Reconstructive surgery and procedures **(AR)**	*Inpatient* Services *Copayment*.	*Deductible* and *Coinsurance*.

AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
Maternity Care		
Outpatient Note: *Providers* may collect *Copayment*s in a variety of ways for this coverage (for example at the time of your first visit, at the end of your pregnancy or in installments). Please check with your *Provider*.	Routine maternity care: Covered in full. Non-routine maternity care: Office Visit *Copayment* for first visit only. Note: In accordance with the ACA, routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits*. In addition, *Member* cost-sharing will apply to diagnostic tests or diagnostic laboratory tests when they are ordered during a routine maternity care visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services.	*Deductible* and *Coinsurance*.
Inpatient	*Inpatient* Services *Copayment*.	*Deductible* and *Coinsurance*.

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
Behavioral Health and Substance Use Disorder Services		
Behavioral Health and Substance Use Disorder Services **To contact the *Tufts Health Plan* Behavioral Health Department, call 1-800-208-9565.**		
Outpatient services **(AR)**	Office Visit *Copayment.*	*Deductible* and *Coinsurance.*
Inpatient services, including *Medically Necessary* treatment in a behavioral health residential treatment facility **(AR)**	*Inpatient* Services *Copayment*.	*Deductible* and *Coinsurance*.
Intermediate care **(AR)**	Covered in full.	*Deductible* and *Coinsurance*.

AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see the table below and the "Benefit Limits" section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***
Other Health Services		
Ambulance services **(AR)**	$100 *Copayment* per trip.	$100 *Copayment* per trip.
Durable Medical Equipment **(AR)**	Covered in full.	*Deductible* and *Coinsurance*.
Home health care	Covered in full.	*Deductible* and *Coinsurance*.
Hospice care services	Covered in full.	*Deductible* and *Coinsurance*.
Injectable, infused, or inhaled medications **(AR)**	Covered in full.	*Deductible* and *Coinsurance*.
Medical supplies	Covered in full.	*Deductible* and *Coinsurance*.
Oral medications for the treatment of cancer **(AR)**	Covered in full for up to a 30-day supply.	*Deductible* and *Coinsurance.*
Prosthetic devices **(AR)**	Covered in full.	*Deductible* and *Coinsurance*.
Scalp hair prostheses or wigs for cancer or leukemia patients **(BL)**	Covered in full.	*Deductible* and *Coinsurance*.
Special medical formulas		
Low protein foods	Covered in full.	*Deductible* and *Coinsurance*.
Nonprescription enteral formulas **(AR)**	Covered in full.	*Deductible* and *Coinsurance*.
Special medical formulas **(AR)**	Covered in full.	*Deductible* and *Coinsurance*.

Prescription Drug Benefit
For information about your *Copayment*s for covered prescription drugs, see the "Prescription Drug Benefit" section in Chapter 3.

IMPORTANT NOTE REGARDING COVERAGE FOR CONTRACEPTIVES: It is a federal requirement that health plans cover all Food and Drug Administration approved contraceptive services for women of child bearing age, as prescribed by a healthcare provider, without cost sharing. Because your employer has certified to Tufts Health Plan that it qualifies for an accommodation under the law, Tufts Health Plan will, separately from your employer, cover qualified contraceptive services that you use without cost sharing and at no other cost, for the duration that you are covered on this health plan.

(AR) – These services may require approval by an *Authorized Reviewer* on both the *In-Network* and *Out-of-Network Levels of Benefits*. At the *In-Network Level of Benefits*, your *Provider* will obtain this approval for you. At the *Out-of-Network Level of Benefits,* you are responsible for obtaining this approval. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.

(BL) – Benefit Limit applies. See "Benefit Limits" section following this section and "*Covered Services*" in Chapter 3.

Benefit Limits

Chiropractic Services

The maximum benefit payable in each *Benefit Year* including up to three covered modalities per visit and manual manipulation of the spine is $1,000 (*In-Network* and *Out-of-Network Levels* combined).

Extended Care Services

The maximum benefit payable in each *Benefit r Year* is 100 days (*In-Network* and *Out-of-Network Levels* combined).

Nutritional Counseling

The maximum benefit payable in each *Benefit Year* is one consultation and up to seven visits.

Prescription Drugs

The Plan includes a prescription drug benefit. Your prescription drug *Copayments* are shown in Chapter 3.

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients

Covered up to a maximum benefit of $350 per *Benefit Year* (*In-Network* and *Out-of-Network* Levels combined).

Rehabilitation Services

The maximum benefit payable in each *Benefit Year* for physical therapy services is 2 evaluations and 60 visits (*In-Network* and *Out-of-Network Levels of Benefits* combined).

The maximum benefit payable in each *Benefit Year* for occupational therapy services is 2 evaluations and 60 visits (*In-Network* and *Out-of-Network Levels of Benefits* combined).

The maximum benefit payable in each *Benefit Year* for speech therapy is 2 evaluations and 60 visits (*In-Network* and *Out-of-Network Levels of Benefits* combined).

Note: Prior authorization by an *Authorized Reviewer* may be required for occupational therapy and speech therapy.

Chapter 1

How Your Preferred Provider Option Plan Works

Eligibility for Benefits

When you need health care services, you may choose to obtain these services from either:

- a *Network Provider* (*In-Network Level of Benefits*); or
- a *Non-Network Provider* (*Out-of-Network Level of Benefits*).

Your choice will determine the level of benefits you receive for your health care services. The *Plan* covers only the services and supplies described as *Covered Services* in Chapter 3.

There are no pre-existing condition limitations under this *Plan*. You are eligible to use your benefits as of your *Effective Date*.

In accordance with federal law (45 CFR § 148.180), *Tufts Health Plan* does not:

- adjust *Premiums* based on genetic information;
- request or require genetic testing; or
- collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

In-Network Level of Benefits

If your care is provided by a *Network Provider* or if you seek care at a *Limited Service Medical Clinic* or an *Urgent Care Center* that participates with *Tufts Health Plan*, you are entitled to coverage for *Covered Services* at the *In-Network Level of Benefits*.

In-Network Level of Benefits

You pay a *Copayment* for certain *Covered Services* you receive at the *In-Network Level of Benefits*. For more information about your *Member* costs for medical services, see "Benefit Overview" at the front of this *Description of Benefits*.

When a *Network Provider* provides your care, you do not have to submit any claim forms. The claim forms are submitted to *Tufts HP* by the *Network Provider*.

(There are special rules for *Inpatient* behavioral health and *Inpatient* substance use disorder services. Those rules are described under "*Inpatient* Behavioral Health and Substance Use Disorders" later in this chapter.)

Selecting a *Provider*

In order to receive coverage at the *In-Network Level of Benefits*, you must receive care from a *Network Provider* listed in the *Directory of Health Care Providers*. You should choose a *Provider* who is in a location convenient to you. If you have difficulty or need assistance in finding a *Provider*, please contact us at 1-800-423-8080.

Notes:

- Under certain circumstances required by law, if your *Provider* is not in the *Tufts HP* network, you will be covered for a short period of time for services provided by that *Provider*. A Member Specialist can give you more information. Please see "Continuity of Care" on page 24.
- For additional information about a *Network Provider* or specialist, the Massachusetts Board of Registration in Medicine provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (800) 377-0550 or **www.mass.gov/massmedboard.**

In-Network Level of Benefits, continued

No *Inpatient Notification* by You

As long as your *Inpatient* hospitalization is provided by a *Network Provider*, you are not responsible for notifying *Tufts Health Plan* of the *Inpatient* hospitalization or transfer to another hospital. Your *Network Provider* will notify *Tufts Health Plan* of the *Inpatient* hospitalization or transfer for you. See "*Preregistration*" in Chapter 1 for more information.

Canceling Appointments

If you have to cancel an appointment with any *Network Provider*, always give him or her as much notice as possible, but at least 24 hours. If the *Network Provider's* office policy is to charge for missed appointments that were not canceled in advance, you will have to pay the charges. The *Plan* will not pay for missed appointments that you did not cancel in advance.

Changes to *Provider* network

Tufts HP offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Network Contracting Area*. *Network Providers* may change during the year.

This can happen for many reasons, including a *Provider's* retirement, moving out of the *Network Contracting Area,* or failure to continue to meet credentialing standards. In addition, because *Providers* are independent contractors, this can also happen if the *Provider* does not reach an agreement on a network contract.

If you have any questions about the availability of a *Provider*, please call a Member Specialist.

Out-of-Network Level of Benefits

Out-of-Network Level of Benefits

If your care is not provided by a *Network Provider*, you are entitled to coverage for *Covered Services* at the *Out-of-Network Level of Benefits*. You pay the *Out-of-Network Deductible* and *Coinsurance* for certain *Covered Services* you receive at the *Out-of-Network Level of Benefits*. For more information about your *Member* costs for medical services, see "Benefit Overview" at the front of this *Description of Benefits*.

Please note that you must submit a claim form for each service that is provided by a *Non-Network Provider*. For information on filing claim forms, see Chapter 6.

Covered Services* Not Available from a *Network Provider

If a *Covered Service* is not available from a *Network Provider*, as determined by *Tufts HP*, with *Tufts HP's* approval, you may go to a *Non-Network Provider* and receive *Covered Services* at the *In-Network Level of Benefits*. The *Plan* will pay up to the *Reasonable Charge* for these services. You will be responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable *Cost Sharing Amount*). You may receive a bill for these services. If you receive a bill, please call Member Services or see "Bills from Providers" in Chapter 6 for more information about what to do if you receive a bill.

***Inpatient Notification* by You**

If you receive *Inpatient* services that are not provided by a *Network Provider*, you must notify *Tufts Health Plan* of these services. If you do not notify *Tufts Health Plan* of these services, you will be subject to a *Notification Penalty*. See "*Inpatient Notification*" later in this chapter for more information.

***Covered Services* Outside of the 50 United States**

Emergency care services provided to you outside of the 50 United States qualify as *Covered Services*. In addition, *Urgent Care* services provided to you while you are traveling outside of the 50 United States also qualify as *Covered Services.* However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan.

Continuity of Care

If you are an existing *Member*

If your *Provider* is involuntarily disenrolled from *Tufts Health Plan* for reasons other than quality or fraud, you may continue to see your *Provider* for *Covered Services* at the *In-Network Level of Benefits* in the following circumstances:

- Pregnancy. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- Terminal Illness. If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your *Provider* as long as necessary.

If you are enrolling as a new *Member*

When you enroll as a *Member*, if none of the health plans offered by the *Group* at that time include your *Provider*, you may continue to see your *Provider* if:

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* for up to 30 days from your *Effective Date*.
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* through your first postpartum visit.
- you are terminally ill. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* as long as necessary.

Conditions for coverage of continued treatment

Tufts Health Plan may condition coverage of continued treatment upon the *Provider's* agreement:

- to accept reimbursement from *Tufts Health Plan* at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to a *Member* in an amount that would exceed the cost sharing that could have been imposed if the *Provider* had not been disenrolled;
- to adhere to the quality assurance standards of *Tufts Health Plan* and to provide *Tufts HP* with necessary medical information related to the care provided; and
- to adhere to *Tufts Health Plan's* policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by *Tufts HP*.

Inpatient Behavioral Health and Substance Use Disorder Services

Coverage at the *In-Network Level of Benefits*

If you require *Inpatient* or intermediate behavioral health or substance use disorder services and wish to receive coverage for these services at the *In-Network Level of Benefits*, your *Inpatient* or intermediate behavioral health or substance use disorder services must be provided by a *Network* Provider. There is no need to contact *Tufts HP* first. Simply call or go directly to any *Network Provider*. Identify yourself as a *Tufts HP Member*. The *Network Provider* is responsible for providing all *Inpatient*/intermediate behavioral health and substance use disorder services. You are not responsible for notifying *Tufts Health Plan* of your admission at a *Network Provider*.

Coverage at the *Out-of-Network Level of Benefits*

If you wish to receive *Inpatient* or intermediate behavioral health or substance abuse services at a *Provider* that is not a *Network Provider,* your coverage will be at the *Out-of-Network Level of Benefits*. Coverage at the *Out-of-Network Level of Benefits* means that you pay a *Deductible* and *Coinsurance* and are responsible for notifying *Tufts Health Plan* of your admission. In order to receive care for *Inpatient* or intermediate behavioral health or substance use disorder services at the *Out-of-Network Level of Benefits*, you must receive authorization from an *Authorized Reviewer*. Please call the *Tufts HP* Behavioral Health Department at 1-800-208-9565 for more information on how to receive this authorization.

Emergency Admission to a non-*Network Provider*

If you are admitted in an *Emergency* to a non-*Network Provider*, you will be covered at the *In-Network Level of Benefits* as long as you notify *Tufts HP* within 48 hours of the admission. Once it is determined that transfer to a *Network Provider* is medically appropriate, you will be transferred to a *Network Provider*. If you choose not to accept the transfer and to remain at the non-*Network Provider,* then your coverage as of that time will revert to the *Out-of-Network Level of Benefits*.

Emergency Care

To Receive *Emergency* Care

If you are experiencing an *Emergency*, you should seek care at the nearest Emergency facility. If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.

***Outpatient* Care**

If you receive Emergency services but are not admitted as an *Inpatient*, you will be covered at the *In-Network Level of Benefits*. You will be required to pay a $300 *Copayment* for each Emergency room visit.

If you receive *Emergency Covered Services* from a *Non-Network Provider*, the *Plan* will pay up to the *Reasonable Charge.* You will be responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable $300 *Copayment*. You may receive a bill for these services. If you receive a bill, please see "Bills from Providers in Chapter 6 or call Member Services for more information about what to do if you receive a bill.

***Inpatient* Care**

If you receive *Emergency* services and are admitted as an *Inpatient*, you or someone acting for you must notify *Tufts HP* within 48 hours of seeking care in order to be covered at the *In-Network Level of Benefits*. (Notification from the attending physician satisfies this requirement.) Otherwise, coverage for these services will be provided at the *Out-of-Network Level of Benefits*.

Also, if you are admitted as an *Inpatient* to a hospital that is a *non-Network Provider* after receiving *Emergency* care, an *Inpatient Copayment* will apply. In addition, you must notify *Tufts Health Plan* of the admission or you will be charged a *Notification Penalty*. *Inpatient Notification* guidelines are described later in this chapter.

Financial Arrangements between Tufts HP and Network Providers

Methods of payment to Network Providers

Tufts HP's goal in compensation of *Providers* is to encourage preventive care and active management of illnesses. *Tufts HP* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards *Providers* for providing high quality care to *Members*. *Tufts HP* uses a variety of mutually agreed upon methods to compensate *Network Providers*.

The *Directory of Health Care Providers* indicates the method of payment for each *Provider*. Regardless of the method of payment, *Tufts HP* expects all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures which can be both harmful and costly to *Members*.

You should feel free to talk to your *Provider* about how he or she is paid.

Member Identification Card

Introduction

Tufts HP gives each *Member* a member identification card (Member ID card).

Reporting errors

When you receive your Member ID card, check it carefully. If any information is wrong, call a Member Specialist.

Identifying yourself as a *Tufts HP Member*

Your Member ID card is important because it identifies you as a *Tufts HP Member*. Please:

- carry your Member ID card at all times;
- have your Member ID card with you for medical, hospital and other appointments; and
- show your Member ID card to any *Provider* before you receive health care.

When you receive services, you must tell the office staff that you are a *Tufts HP Member*.

Membership requirement

You are eligible for benefits if you are a *Member* when you receive care. A Member ID card alone is not enough to get you benefits. If you receive care when you are not a *Member*, you are responsible for the cost.

Membership identification number

If you have any questions about your member identification number, please call a Member Specialist.

Utilization Management

Utilization management

The purpose of the program is to control health care costs by evaluating whether health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. This program includes prospective, concurrent, and retrospective review of health care services.

Prospective review is used to determine whether proposed treatment is *Medically Necessary* before that treatment begins. It is also referred to as "pre-service review".

Concurrent review is used to monitor the course of treatment as it occurs and to determine when that treatment is no longer *Medically Necessary*.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, retrospective review is used to more accurately determine the appropriateness of health care services provided to *Members*. Retrospective review is also referred to as "post-service review".

TIMEFRAMES FOR *TUFTS HP* TO REVIEW YOUR REQUEST FOR COVERAGE

Type of Review	Timeframe for Determinations*
Prospective (Pre-service) review	15 days
Concurrent review	Determination is made prior to treatment being reduced or terminated to allow you to appeal the determination.
Retrospective (Post-service) review	30 days
Urgent care review	72 hours

*Timeframes for determinations may be extended under certain circumstances.

See Appendix B for more details on determination procedures under the Department of Labor's (DOL) Regulations.

If your request for coverage is denied, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal.

Tufts HP makes coverage determinations. You and your *Provider* make all treatment decisions.

IMPORTANT NOTE: Members can call *Tufts Health Plan* at the following numbers to determine the status or outcome of utilization review decisions:

- Behavioral health and substance use disorder utilization review: 1-800-208-9565;
- All other utilization review decisions: 1-800-462-0224.

Care Management

Some *Members* with Severe Illnesses or Injuries may warrant care management intervention under a case management program. Under this program, use of the most appropriate and cost-effective treatment is encouraged, and the *Member's* treatment and progress is supported.

If a *Member* is identified by us as an appropriate candidate for care management or referred to the program, the *Member* and his or her *Network Provider* may be contacted to discuss a treatment plan and establish prioritized goals. A *Tufts Health Plan* Complex Care Manager may suggest alternative services or supplies available to the *Member*.

The *Member's* treatment plan may be periodically reviewed. The *Member* and the *Member's Network Provider* will be contacted if alternatives to the *Member's* current treatment plan are identified that qualify as *Covered Services*, are cost effective, and are appropriate for the *Member*.

A Severe Illness or Injury may include, but is not limited to, the following:

- high-risk pregnancy and newborn *Children*;
- serious heart or lung disease;
- cancer;
- certain neurological diseases;
- AIDS or other immune system diseases;
- severe traumatic injury.

Care Management, continued

Individual case management (ICM)

In certain circumstances, *Tufts HP* may authorize an individual case management ("ICM") plan for a *Member* with a Severe Illness or Injury who is already participating in the care management program. The ICM plan is designed to arrange for the most appropriate health care services and supplies for the *Member*.

As a part of the ICM plan, *Tufts HP* may authorize coverage for certain alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if *Tufts HP* determines, in its sole discretion, that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary* to treat the *Member's* condition;
- the alternative services and supplies are provided directly to the *Member* with the condition;
- the alternative services and supplies are provided in place of or to prevent more expensive services or supplies that the *Member* otherwise might have incurred during the current episode of illness;
- the *Member* and an *Authorized Reviewe*r agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

Tufts HP will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. If, at any time, these services and supplies fail to satisfy any of the conditions described above, *Tufts HP* may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan at our sole discretion Please note that ICM plans are not used to authorize services or supplies that are specifically excluded under the *Member's* plan or that fall within the parameters of the Utilization Review program described above and do not meet the relevant *Medical Necessity* criteria for authorization.

Authorized Reviewer Approval

Prior approval by an *Authorized Reviewer* is required for certain *Covered Services. Covered Services* that require this approval are identified by **(AR)** in the "Benefit Overview".

- If you receive these services from a *Network Provider,* the *Provider* is responsible for obtaining approval from *an Authorized Reviewer* .
- If your services are not provided by a *Network Provider,* you are responsible for obtaining prior approval from *an Authorized Reviewer*. If prior approval is not received, *Tufts HP* will not cover those services and supplies. In addition, if you receive services that *Tufts HP* determines are not *Covered Services*, you will be responsible for the cost of those services.

For more information about how to obtain this prior approval, please call Member Services.

If a request for coverage is denied, you have a right to appeal. Please see Chapter 6, "How to File a Claim and *Member* Satisfaction Process", for information on how to file an appeal.

Services that you receive in an *Emergency* do not require the prior approval of an *Authorized Reviewer*.

Inpatient Notification (formerly known as Preregistration)

Introduction

Inpatient Notification is the process that makes *Tufts Health Plan* aware of all *Inpatient* admissions and transfers to another hospital. We will evaluate the anticipated hospital stay, your proposed medical care, verify medical necessity, and assess the need for a care management program after discharge or recommend an alternative treatment setting.

The *Inpatient Notification* to *Tufts Health Plan* by your *Provider* does not guarantee payment. The *Plan* is not obligated to pay claims for persons who fail to meet eligibility criteria, who receive care that is determined not to be *Medically Necessary*, or if the claim is not for a *Covered Service*.

When Care is Provided by a *Network Provider*

When a *Network Provider* is directing your care, he or she is responsible to notify *Tufts Health Plan* of your *Inpatient* admission or transfer. In this case, you do not need to notify us of the admission or transfer.

When Care is Not Provided by a *Network Provider*

When your care is not provided by a *Network Provider*, you are responsible to notify *Tufts Health Plan* of any *Inpatient* admission or transfer.

If you do not notify *Tufts Health Plan*, **you will have to pay a *Notification Penalty*** in addition to the *Deductible* and *Coinsurance*. (Please see "Benefit Overview" for the amount of the *Notification Penalty*.) Please read carefully the following description of the *Inpatient Notification* process that you must complete when a *Network Provider* is not directing your care.

Note: If your *Group* does not have an *Inpatient Notification Penalty*, this provision does not apply to you. Please see "Benefit Overview" at the front of this *Description of Benefits* to determine if a *Notification Penalty* applies to you.

How to Notify *Tufts Health Plan* of a Hospital Admission

Call the Member Services number on your ID card to report your hospital admission. You, or someone acting on your behalf, will need to provide the following information:

- Patient name, address and phone number (work and home)
- Hospital name, address and phone number
- Member identification number (from your Member ID card)
- Employer
- Diagnosis and proposed procedure
- Proposed admission and discharge dates
- Admitting *Provider* name, address and phone number

Inpatient Notification (formerly known as Preregistration), continued

When to Notify *Tufts Health Plan*

For Elective Hospitalization or Transfers

Notification to *Tufts Health Plan* for elective hospitalizations or transfers must occur at least five (5) days prior to hospitalization. After you call *Tufts HP,* we may consult with your *Provider* and will notify you or your *Provider* of the determination of the admission and the anticipated hospital stay or will recommend an alternative treatment setting.

For an Urgent or Emergent Admission

Notification to *Tufts Health Plan* for an urgent admission should be completed as soon as possible, but no later than one business day after the admission. An urgent admission is one which requires prompt medical intervention but one in which there is a reasonable opportunity to notify *Tufts Health Plan* prior to, or at the time of, admission. Notification for an *Emergency* admission should be completed within one business day following the admission. For a definition of *Emergency*, see Appendix A.

For Deliveries

Notification to *Tufts Health Plan* for delivery of your newborn *Child* should occur within 30 days of your due date.

For A Newborn *Child*

- In cases where the newborn *Child* leaves the hospital with the mother after delivery, there is no need to notify *Tufts Health Plan* of that newborn *Child's* hospital stay.
- In cases where the newborn *Child* remains in the hospital after the mother is discharged after delivery and the newborn *Child's* care is not provided by a *Network Provider*, you must notify *Tufts Health Plan* immediately of your newborn *Child's* hospital stay. (In order to be covered for any *Medically Necessary* care, the newborn *Child* must be enrolled in the *Plan* within 30 days after birth. See Chapter 2 for more information. For a description of the Level of Benefits applicable to the newborn *Child's* care, see Chapter 1.)

After You Notify *Tufts Health Plan* of a Hospital Admission

After you call with the necessary admission information, your *Provider* or the hospital will be notified of the decision made by *Tufts Health Plan*.

Changes to Hospital Admission Information

Notification of your hospital admission is valid only for the diagnosis, admission date and medical facility specified at the time of the notification. You must provide notification of any delays, changes or cancellations of your proposed admission. A separate notification to *Tufts Health Plan* must be obtained for a new admission date, readmission, hospitalization, or transfer or surgery for conditions other than those designated during the initial hospital admission.

If you do not provide notification of changes, you will be required to pay a *Notification Penalty* for that admission. See "Benefit Overview" at the front of this *Description of Benefits* for the amount of the *Notification Penalty*.

Extension of Hospitalization

All *Inpatient* hospitalizations are monitored. When it is *Medically Necessary* to extend hospitalization beyond the originally determined stay, *Tufts HP* staff will request additional clinical information from your attending physician or hospital for additional *Medically Necessary* hospital days.

Note: If the review team, after conferring with your *Provider*, determines that *Inpatient* hospitalization is no longer *Medically Necessary*, you will be notified that any additional hospital days will not be covered and that you will be responsible to pay for all hospital and *Provider* charges if you choose to remain in the hospital beyond the discharge date.

Chapter 2

Eligibility, Enrollment, & Continuing Eligibility

Note: The Plan offers two separate PPO options administered by Tufts Health Plan. These PPO options have different *Network Contracting Are*as. *Members* are enrolled in one of these plans, depending on where they maintain their primary residence.

Eligibility

Subscribers

You are eligible to enroll as a *Subscriber* when you are in the class of eligible employees established by the *Plan*, live, work, or reside in the *Network Contracting Area*; and you are a permanent full-time employee working the minimum number of hours per week as described below.

Dependents

Dependents are eligible under *Family Coverage* if they meet the definition of *Dependent* in Appendix A and live, work, or reside in the *Network Contracting Area.*

Notes:

- *Children* are not required to maintain live, work, or reside in the *Network Contracting Area.* However, coverage outside of the *Network Contracting Area* is limited to the *Out-of-Network Level of Benefits* only.
- In some cases, other *Dependents* who live, work, or reside outside the *Network Contracting Area* can be eligible for coverage under this plan. Please see "If you do not live, work, or reside in the *Network Contracting Area*" below for more information.

If You Do Not Live, Work, or Reside In the *Network Contracting Area*

If you do not live, work, or reside in the *Network Contracting Area*, you can be covered only if:

- you are a *Child*;
- you are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO).

Note: Coverage outside of the Network Contracting Area is limited to the *Out-of-Network Level of Benefits* only.

Proof of Eligibility

Tufts HP may ask you for proof of your and your *Dependents'* eligibility or continuing eligibility. You must give *Tufts HP* proof when asked. This may include proof of residence, marital status, birth or adoption of a *Child*, and legal responsibility for health care coverage.

Minimum Hours

In order to be eligible for coverage under the *Plan*, you must be in an eligible class of employees as determined by the *Plan Administrator:*

- Non-faculty regularly scheduled to work at least 30 hours per week and 39 weeks per year;
- Faculty member with a full-time schedule;
- Faculty member on a part-time schedule under the Early Retirement Incentive Plan;
- Former Faculty member Retiree under the Early Retirement Incentive Plan;
- Member of a collective bargaining unit which has negotiated for one or more *Plan* benefits and working at a schedule agreed to in collective bargaining for eligibility.

Notes:

- Independent Religious Contractors are eligible under the same terms as employees.
- Temporary, seasonal and leased employees are not eligible. If an independent contractor is reclassified as am employee, due to government review or any procedure, he or she will not be considered to be employed in a class of employee eligible to participate in this plan. In its sole discretion, the *Plan Administrator* may permit any such person to participate prospectively.

Enrollment

When to enroll

You may enroll yourself and your eligible *Dependents*, if any, for this coverage only during the annual *Open Enrollment Period* or within 30 days of the date you or your *Dependent* is first eligible for this coverage.

Note: If you fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible *Dependents*, if any, at a later date. This will apply only if you:

- declined this coverage when you were first eligible because you or your eligible *Dependent* were covered under another group health plan or other health care coverage at that time; or
- declined this coverage when you were first eligible, and you have acquired a *Dependent* through marriage, birth, adoption, or placement for adoption.

In these cases, you or your eligible *Dependent* may enroll for this coverage within 30 days after any of the following events:

- your coverage under the other health coverage ends involuntarily;
- your marriage; or
- the birth, adoption, or placement for adoption of your *Dependent Child*.

In addition, you or your eligible *Dependent* may enroll for this coverage within 60 days after either of the following events:

- you or your *Dependent* are eligible under a state Medicaid plan or state children's health insurance program (CHIP) and the Medicaid or CHIP coverage is terminated; or
- you or your *Dependent* become eligible for a premium assistance subsidy under a state Medicaid plan or CHIP.

Effective Date of coverage

Enrolled *Dependents'* coverage starts when the *Subscriber's* coverage starts, or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

If you or your enrolled *Dependent* are an *Inpatient* on your *Effective Date*, your coverage starts on the later of the *Effective Date*, or the date *Tufts HP* is notified and given the chance to manage your care.

Adding *Dependents*

When *Dependents* may be added

After you enroll, you may apply to add any *Dependents* who are not currently enrolled under the *Plan* only:

- during your *Group's Open Enrollment Period*; or
- within 30 days after any of the following events:
  - a change in your marital status;
  - the birth of a *Child*;
  - the adoption of a *Child* as of the earlier of the date the *Child* is placed with you for the purpose of adoption or the date you file a petition to adopt the *Child*;
  - a court orders you to cover a *Child* through a qualified medical child support order;
  - a *Dependent* loses other health care coverage involuntarily; or
  - if your *Group* has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add *Dependents*

Follow the steps in the table below to add *Dependents.*

Step	Action
1	Do you have *Family Coverage*? • If yes, go to the next step. • If no, ask your *Group* to change your *Individual Coverage* to *Family Coverage*.
2	Fill out a member application listing the *Dependents*.
3	Give the form to your *Group* either • during your *Group's Open Enrollment Period*, or • within 30 days after the date of an event listed above, under "When *Dependents* may be added."

***Effective Date* of *Dependents'* coverage**

If the *Plan* accepts your application to add *Dependents*, the *Plan Administrator* will notify you of the *Effective Date* of each *Dependent's* coverage.

Effective Dates will be no later than:

- the date of the *Child's* birth, adoption or placement for adoption; or
- in the case of marriage or loss of prior coverage, the date of the qualifying event.

Availability of benefits after enrollment

Covered Services for an enrolled *Dependent* are available as of the *Dependent's Effective Date*. There are no waiting periods. Maternity benefits are available even if the pregnancy began before your *Effective Date*.

Note: The *Plan* will only pay for *Covered Services* which are provided on or after your *Effective Date*.

Newborn *Children* and *Adoptive Children*

Importance of enrolling newborn *Children* and *Adoptive Children*

You must enroll your newborn *Child* within 30 days after the *Child's* birth for the *Child* to be covered from birth. Otherwise, you must wait until the next *Open Enrollment Period* to enroll the *Child*.

You must enroll your *Adoptive Child* within 30 days after the *Child* has been adopted or placed for adoption with you for that *Child* to be covered from the date of his or her adoption. Otherwise, you must wait until the next *Open Enrollment Period* to enroll the *Child*.

Continuing Eligibility for *Dependents*

When coverage ends
Dependent coverage for a *Child* ends on the last day of the month in which the *Child's* 26th birthday occurs.

Coverage after termination
When a *Child* loses coverage under this *Description of Benefits*, he or she may be eligible for federal continuation coverage or to enroll in coverage under an individual contract. See Chapter 5 for more information.

How to continue coverage for *Disabled Dependents*
The *Subscriber* must follow the steps in the table below to continue coverage for a *Disabled Dependent*.

Step	Action
1	About 30 days before the *Child* no longer meets the definition of *Dependent*, call a Member Specialist at **1-800-462-0224** or go to our Web site at **www.tuftshealthplan.com** for instructions on Step 2 below.
2	Give proof, acceptable to *Tufts HP*, of the *Child's* disability.

When coverage ends
Disabled Dependent coverage ends when:

- the *Dependent* no longer meets the definition of a *Disabled Dependent*, or
- the *Subscriber* fails to give *Tufts HP* proof of the *Dependent's* continued disability.

Coverage after termination
The former *Disabled Dependent* may be eligible for federal continuation coverage or to enroll in coverage under an individual contract. See Chapter 5 for more information.

Keeping the *Plan's* records current
You must notify the *Plan* of any changes that affect you or your *Dependents'* eligibility. Examples of these changes are:

- birth, adoption, changes in marital status, or death;
- your remarriage;
- moving out of the *Service Area* or temporarily residing out of the *Service Area* for more than 90 consecutive days;
- address changes; and
- changes in an enrolled *Dependent's* status as a *Child* or *Disabled Dependent*.

Forms to report these changes are available from your *Plan Administrator*.

Chapter 3

Covered Services

Covered Services

When health care services are *Covered Services*

Health care services are *Covered Services* only if they are:

- listed as *Covered Services* in this chapter;
- *Medically Necessary*;
- consistent with applicable law;
- consistent with *Tufts Health Plan's Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available to you on our Web site at www.tuftshealthplan.com or by calling Member Services;
- obtained within the 50 United States. The only exceptions to this rule are for *Emergency* care services, and for *Urgent Care* services provided to you while you are traveling, which are *Covered Services* when provided outside of the 50 United States;
- provided to treat an injury, illness, or pregnancy, except for preventive care; and
- approved by an *Authorized Reviewer*, in some cases.

Important Notes:

- *Authorized Reviewer approval*: All claims for services (whether or not the services were provided by a *Network Provider*) are subject to retrospective review by an *Authorized Reviewer*. *Authorized Reviewers* review claims to be sure that the claims are for *Covered Services* only. A *Covered Service* is one that is described in this chapter. The *Plan* will only pay claims that are for *Covered Services.*
- Certain services require the prior approval of an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*. Please see Chapter 1 for more information about how this prior approval is obtained at the *In-Network Level of Benefits*. If you wish to receive these services at the *Out-of-Network Level of Benefits*, you are responsible for obtaining prior approval from *an Authorized Reviewer*. If prior approval is not received, *Tufts HP* will not cover those services. Please contact Member Services, or, for behavioral health and substance use disorder services, the *Tufts HP* Behavioral Health Department at 1-800-208-9565, for more information.
- *Inpatient Notification*: You must notify *Tufts Health Plan* of any *Out-of-Network Inpatient* admissions or hospital transfers. Please see "*Inpatient Notification*" in Chapter 1 for more information.
- At the *In-Network Level of Benefits*, for certain *Outpatient* services listed as "covered in full" below, you may be charged an *Office Visit Copayment* when these services are provided in conjunction with an office visit.

YOUR BENEFIT AMOUNTS:

The table below includes references to the amounts you must pay for *Covered Services* under this plan (for example, *Copayments* and *Deductibles*). Please see "Benefit Overview" at the front of this *Description of Benefits* for the actual amounts you must pay for:

- *Deductibles*
- Emergency room *Copayments*
- Office Visit *Copayments*
- *Coinsurance*
- *Out-of-Pocket Maximums*

Emergency care

In an *Emergency*, you should call 911 for emergency medical assistance (or the local number for emergency medical services) and seek care at the nearest emergency facility.

Notes :

- The Emergency Room *Copayment* is waived if the emergency room visit results in immediate hospitalization or *Day Surgery*.
- If you receive *Emergency Covered Services* from a *Non-Network Provider*, the *Plan* will pay the *Provider* up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable *Copayment)*. You may receive a bill for these services. If you receive a bill, please see "Bills from Providers" in Chapter 6 or call Member Services for more information about what to do if you receive a bill.
- An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.
- A *Day Surgery Copayment* may apply if *Day Surgery services* are received.

Outpatient care

Allergy testing and treatment

Allergy testing (including antigens) and treatment, and allergy injections.

Cardiac rehabilitation services

Coverage is provided for the cost of *Outpatient* treatment of documented cardiovascular disease that is initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

- the *Outpatient* convalescent phase of the rehabilitation program following hospital discharge; and
- the *Outpatient* phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise.

Note: The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.

Chemotherapy

Chiropractic care

Manual manipulation of the spine and up to three covered modalities.

Note: Coverage is provided up to the maximum benefit listed in "Benefit Overview" at the front of this *Description of Benefits*. You pay all subsequent charges in that *Benefit Year*. Spinal manipulation services for *Members* age 12 and under are not covered.

Cytology examinations

One annual screening, or as otherwise *Medically Necessary*.

Diabetes self-management training and educational services

Outpatient self-management training and educational services, including medical nutrition therapy, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes.

Important Notes:

- The *Plan* will only cover these services at the *In-Network Level of Benefits* when provided by a *Network Provider* who is a certified diabetes health care provider.
- Medical nutrition therapy provided under this benefit is not subject to any visit limit such as that described in the "Nutritional counseling" benefit later in this chapter.

Diagnostic imaging

Including general imaging (such as x-rays and ultrasounds), and MRI/MRA, CT/CTA, and PET tests, and nuclear cardiology.

Important Note: MRI/MRA, CT/CTA, PET, and nuclear cardiology may require the prior approval of an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*. Please contact Member Services for more information.

Diagnostic or preventive screening procedures

Including, but not limited to, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies.

Important Note: These procedures may require the prior approval of an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on the first page of this chapter for more information about when you are responsible for obtaining this approval.

Diagnostic testing

Examples include, but **are not limited to, ambulatory** EKG testing, sleep studies, and diagnostic audiological testing. Prior approval by an *Authorized Reviewer* may be required at both the ***In-Network*** and ***Out-of-Network*** *Levels of Benefits*. Please call Member Services with questions about specific tests.

Early intervention services

Services provided by early intervention programs. *Medically Necessary* early intervention services include, but are not limited to, occupational therapy, physical therapy, speech therapy, nursing care, and psychological counseling.

These services are covered for *Members* from birth until their third birthday.

Family planning

Coverage is provided as described in this section for:

- **Services**
  - medical examinations;
  - consultations; and
  - genetic counseling.

Hemodialysis

Includes *Outpatient* hemodialysis (including home hemodialysis) and *Outpatient* peritoneal dialysis (including home peritoneal dialysis).

Note: Home hemodialysis is a Covered Service.

Human leukocyte antigen (HLA) testing

or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens.

Immunizations and vaccinations

Infertility services

Diagnostic procedures and tests provided in connection with an infertility* evaluation.

*Infertility is defined as the condition of a *Member* who has been unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35. For purposes of meeting the criteria for infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period, as applicable.

Laboratory tests

Including, but not limited to, blood tests, urinalysis, throat cultures, glycosylated hemoglobin (HbA1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles. (**Important:** Laboratory tests must be ordered by a licensed *Provider*, and must be performed at a licensed laboratory. Some laboratory tests (e.g., genetic testing) may require the approval of an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*. Please see the "Important Notes" on the first page of this chapter and contact Member Services for more information.) In addition, in compliance with the ACA, laboratory tests associated with routine preventive care are covered in full at the *In-Network Level of Benefits*.

Lead screenings

Mammograms

Provided at the following intervals:

- one baseline at 35-39 years of age,
- one every year at age 40 and older,
- when otherwise *Medically Necessary*.

Nutritional counseling

For an individual consultation and up to seven (7) follow-up visits with a registered dietician per *Benefit Year* (*In-Network* and *Out-of-Network Levels* combined).

Note: This visit limit does not apply to *Outpatient* nutritional counseling provided as part of:

- an approved home health care plan (see the "Home health care" benefit later in this chapter); or
- diabetes self-management training and educational services (see that benefit earlier in this chapter).

Office visits to diagnose and treat illness or injury

Note: This includes *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions, consultation and visits to a *Limited Service Medical Clinic*.

Oral health services

The following oral health services are covered:

- *Emergency* care
  X-rays and *Emergency* oral surgery in an emergency room to temporarily stabilize damaged tissues or reposition sound, natural and permanent teeth that have moved or have broken due to injury. You must receive this care within 48 hours after the injury. The injury must have been caused by a source outside the mouth.

  Note: The Emergency room *Copayment* is waived if the Emergency room visit results in immediate hospitalization and *Day Surgery*.

- Non-*Emergency* care

Important Note: All Non-*Emergency* oral health services performed in an *Inpatient* or *Day Surgery* setting must be approved in advance by an *Authorized Reviewer* and meet *Medical Necessity* guidelines in order to be covered. For more information or to review the *Medical Necessity* guidelines, please call Member Services or see our Web site at www.tuftshealthplan.com.

IF you require these services…	THEN you are covered for:
Surgical removal of impacted or unerupted teeth when embedded in bone.	Hospital, *Provider*, and surgical charges.
Extraction of seven or more permanent teeth during one visit.	Hospital, *Provider*, and surgical charges.
Surgical treatment of skeletal jaw deformities.	Hospital, *Provider*, and surgical charges.
Surgical repair related to Temporomandibular Joint Disorder.	Hospital, *Provider*, and surgical charges.

Note: The above procedures are covered without the approval of an *Authorized Reviewer* when performed in an office setting.

- Coverage for hospital charges **only** may be provided when a *Member* requires treatment in an *Inpatient* or *Day Surgery* setting for oral health services not described in this benefit. In order for hospital services to be covered, the *Member* must meet **all** of the following clinical criteria:
  - the *Member* cannot safely and effectively receive oral health services in an office setting: (1) due to being of young age; or (2) because of a specific and serious non-dental organic impairment (for example, hemophilia);
  - the *Member* requires these services in order to maintain his/her health; AND
  - the services are not cosmetic or *Experimental*.

Outpatient surgery in a _Provider's_ office

Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions

To the extent required by applicable law, patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions are covered to the same extent as those *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Preventive care for _Members_ under age 6

Preventive care services from the date of birth until age 6, including:

- physical examination, including limited developmental testing with interpretation and report;
- history;
- measurements;
- sensory screening;
- neuropsychiatric evaluation; and
- developmental screening and assessment at the following intervals:
  - 6 times during the first year after birth,
  - 3 times during the second year after birth, and
  - annually from age 2 until age 6.

Coverage is also provided for:

- hereditary and metabolic screening at birth;
- appropriate immunizations and tuberculin tests;
- hematocrit, hemoglobin, or other appropriate blood tests;
- urinalysis as recommended by a *Provider*; and
- newborn auditory screening tests, as required by applicable law.

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an Office Visit *Copayment* at the *In-Network Level of Benefits. Member* cost-sharing will also apply at the *In-Network Level of Benefits* to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at: **https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** for more information about which laboratory services are considered preventive.

Preventive care for _Members_ age 6 and older

- routine physical examinations, including appropriate immunizations and lab tests as recommended by a *Provider;*
- routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam, and hormone replacement therapy services; and
- hearing examinations and screenings.

Please note: Office Visit *Copayment* at the *In-Network Level of Benefits. Member* cost-sharing will also apply at the *In-Network Level of Benefits* to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam or routine annual gynecological exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at: **https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** for more information about which laboratory services are considered preventive.

Radiation therapy

Respiratory therapy or pulmonary rehabilitation services

Rehabilitation services

Outpatient Physical therapy, Speech therapy, and Occupational therapy are covered up to 60 visits per calendar year (*In-Network* and *Out-of-Network Levels* combined) for each therapy.

Short term speech, physical and occupational therapy services, including up to 2 evaluations per *Benefit Year*,

- are covered only when provided to restore function lost or impaired as the result of an accidental injury cerebrovascular accident (stroke), vocal cord surgery, or illness.

Massage therapy may be covered as a treatment modality when administered as part of a physical therapy visit that is:

- provided by a licensed physical therapist; and
- in compliance with *Tufts Health Plan's Medical Necessity* guidelines, and, if applicable, prior authorization guidelines.

Notes:

- Prior authorization by an *Authorized Reviewer* may be required for Occupational Therapy and Speech Therapy.
- This limit does not apply to short-term physical, occupational, or speech therapy provided in conjunction with a physician's approved home health care plan. For more information, see "Home health care" described later in this chapter.

Smoking cessation counseling services

Smoking cessation counseling sessions, including individual, group, and telephonic smoking cessation counseling services that:

- are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
- meet the requirements of the federal Affordable Care Act.

Note: Coverage is also provided for prescription smoking cessation agents and generic over-the-counter smoking cessation agents when prescribed by a physician. For more information, see the "What is Covered" provision within the "Prescription Drug Benefit" section later in this chapter.

Urgent Care* in an *Urgent Care Center

Vision care services

- **Annual routine eye examination.**
  Coverage is provided for one routine eye examination per *Benefit Year.* **Note:** You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network in order to obtain coverage for these services at the *In-Network Level of Benefits*. Please go to **www.tuftshealthplan.com** or contact Member Services for more information.

- **Other vision care services.**
  Coverage is provided for eye examinations and necessary treatment of a medical condition.
  Note: One pair of eyeglass lenses and standard frames will be covered following a *Member's* cataract surgery or other surgery to replace the natural lens of the eye, when the *Member* does not receive an intraocular implant. See "Benefit Overview" earlier in this document to determine the *Cost Sharing Amount* applicable to these lenses and frames.

Day Surgery

- *Outpatient* surgery done under anesthesia in an operating room of a facility licensed to perform surgery.
- You must be expected to be discharged the same day and be shown on the facility's census as an *Outpatient*.

Note: Prior approval by an *Authorized Reviewer* is required for certain *Day Surgeries* at both the *In-Network* and *Out-of-Network Levels of Benefits*. Call Member Services and see "Important Notes" on the first page of this chapter for more information about which *Day Surgeries* require this approval and about when you are responsible for obtaining this approval.

Inpatient care

Bone marrow transplants, hematopoietic stem cell transplants, and human solid organ transplants

Authorized Reviewer approval is required before you receive a bone marrow transplant, hematopoietic stem cell transplant, or a solid organ transplant (regardless of whether the procedure is provided by a *Network Provider* or a *Non-Network Provider*). Call the *Tufts HP* Member Services Department for more information. Coverage is provided for the cost of:

- Bone marrow transplants for *Members* diagnosed with breast cancer that has progressed to metastatic disease; and
- Hematopoietic stem cell transplants and human solid organ transplants which are generally accepted in the medical community for *Members* who are the stem cell or solid organ recipients. When the recipient is a *Member*, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:
  - evaluation and preparation of the donor; and
  - surgical intervention and recovery services when those services relate directly to donating the stem cells or solid organ to the M*ember*.

Notes:

- The *Plan* does not cover donor charges of *Members* who donate stem cells or solid organs to non-*Members*.
- The *Plan* covers a *Member's* donor search expenses for donors related by blood.
- The *Plan* covers the *Member's* donor search expenses for up to 10 searches for donors not related by blood. Additional donor search expenses for unrelated donors must be approved by an *Authorized Reviewer*.
- Prior approval by an *Authorized Reviewer* is required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on the first page of this chapter for more information about when you are responsible for obtaining this approval.
- The *Plan* covers a *Member's* human leukocyte antigen (HLA) testing. See "*Outpatient* care" earlier in this chapter for more information.

Extended care services

Extended care services are *Skilled* nursing, rehabilitation or chronic disease hospital services which are provided in a Medicare-certified:

- skilled nursing facility;
- rehabilitation hospital; or
- chronic hospital.

Custodial Care is excluded from coverage.

Important Note: Prior approval by an *Authorized Reviewer* is required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See the "Important Notes" on the first page of this chapter and call the *Tufts HP* Member Services Department for more information.

Hospital services (Acute care)

- anesthesia;
- diagnostic tests and lab services;
- drugs;
- dialysis;
- intensive care/coronary care;
- nursing care;
- physical, occupational, speech, and respiratory therapies;
- radiation therapy;
- semi-private room (private room when *Medically Necessary*);
- surgery*; and
- *Provider's* services while hospitalized.

*Important Note: Prior approval by an *Authorized Reviewer* is required for certain *Inpatient* surgeries at both the *In-Network* and *Out-of-Network Levels of Benefits*. Please contact Member Services for more information about which *Inpatient* surgeries require this approval and about when you are responsible for obtaining this approval.

Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions

To the extent required by applicable law, patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions are covered to the same extent as those *Inpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Reconstructive surgery and procedures

Coverage is provided for the cost of:

- services required to relieve pain or to restore a bodily function that is impaired as a result of a congenital defect, birth abnormality, traumatic injury, or covered surgical procedure.
- the following services in connection with mastectomy:
  - reconstruction of the breast affected by the mastectomy,
  - surgery and reconstruction of the other breast to produce a symmetrical appearance, and
  - prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema).

    *Breast prostheses are covered as described under "Prosthetic devices" later in this chapter.

Removal of a breast implant is covered when any one of the following conditions exists:

- the implant was placed post-mastectomy;
- there is documented rupture of a silicone implant; or
- there is documented evidence of autoimmune disease or infection.

Important: No coverage is provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Notes:

- Cosmetic surgery is not covered.
- Except as described above in connection with a mastectomy, *Authorized Reviewer* approval is required before you receive any reconstructive surgery or procedure (regardless of whether the procedure is provided by a *Network Provider* or a *Non-Network Provider*). See "Important Notes" on the first page of this chapter for more information about when you are responsible for obtaining this approval.
- This coverage is meant to be at least as extensive as the federal law protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Maternity care - Routine and Non-Routine (*Outpatient* and *Inpatient*)

Outpatient

- prenatal care, exams, and tests; and
- postpartum care provided in a *Provider's* office.

Notes:

- Providers may collect *Copayments* in a variety of ways for this coverage (for example, at the time of your first visit, at the end of your pregnancy, or in installments). Please check with your *Provider*.
- Routine prenatal tests are covered in full at the *In-Network Level of Benefits*, in accordance with the ACA. *Member* cost-sharing will apply at the *In-Network Level of Benefits* to diagnostic tests or diagnostic laboratory tests when they are ordered as part of routine maternity care. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services.

Inpatient

- hospital and delivery services, and
- well newborn *Child* care in hospital.

Includes *Inpatient* care in hospital for mother and newborn *Child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

Notes:

- *Covered Services* will include: one home visit by a registered nurse, physician, or certified nurse midwife; and additional home visits, when *Medically Necessary* and provided by a licensed health care provider. *Covered Services* will include, but not be limited to, parent education, assistance, and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests.
- These *Covered Services* will be available to a mother and her newborn *Child* regardless of whether or not there is an early discharge (hospital discharge less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery).

(For information about notifying *Tufts Health Plan* for a newborn *Child*, see Chapter 1.)

IMPORTANT NOTE - Benefits for Newborn *Children* at Time of Delivery:

1. *Member's* Delivery is Performed by a *Network Provider*

If a mother is a *Member* whose delivery was performed by a *Network Provider*, the *Plan* will cover *Medically Necessary* care as follows:

When newborn *Child* is enrolled: If the newborn *Child* is enrolled under the *Plan* as described under "Adding *Dependents*" in Chapter 2, the *Plan* will cover:

- *Routine Nursery Care* at the *In-Network Level of Benefits*; and
- *Medically Necessary* care other than *Routine Nursery Care*: (1) at the *In-Network Level of Benefits*, if that care is provided by a *Network Provider*, and (2) at the *Out-of-Network Level of Benefits*, if that care is not provided by a *Network Provider* (*Inpatient Notification* is required).

When newborn *Child* is not enrolled: If the newborn *Child* is not enrolled under the *Plan* as described under "Adding *Dependents*" in Chapter 2, the *Plan* (1) will cover *Routine Nursery Care* at the *In-Network Level of Benefits*; and (2) will not cover care other than *Routine Nursery Care*.

2. Non-*Member's* Delivery

Applicable law requires a newborn *Child's Routine Nursery Care* to be covered under the maternity coverage benefits of the mother's health plan. If the mother is not a *Member* under the *Plan* and has no other maternity coverage benefits, the *Plan* will cover *Medically Necessary* care that the newborn *Child* may require (either *Routine Nursery Care* or other care) if that newborn *Child* is enrolled under the *Plan*.

When newborn *Child* is enrolled: If the newborn *Child* is enrolled under the *Plan* as described under "Adding *Dependents*" in Chapter 2, the *Plan* will cover

- *Routine Nursery Care* (1) at the *In-Network Level of Benefits,* if that care is provided by a *Network Provider*; and (2) at the *Out-of-Network Level of Benefits*, if that care is not provided by a *Network Provider,* (*Inpatient Notification* is required); and
- *Medically Necessary* care other than *Routine Nursery Care* (1) at the *In-Network Level of Benefits*, if that care is provided by a *Network Provider*, and (2) at the *Out-of-Network Level of Benefits*, if that care is not provided by a *Network Provider* (*Inpatient Notification* is required).

When newborn *Child* is not enrolled: If the newborn *Child* is not enrolled under the *Plan* as described under "Adding *Dependents*" in Chapter 2, the *Plan* will not pay for any care for the newborn *Child*.

Behavioral Health and Substance Use Disorder Services (*Outpatient*, *Inpatient*, and Intermediate)

Outpatient* behavioral health and substance use disorder services for *Behavioral Health Disorders

Services to diagnose and treat *Behavioral Health Disorders* (including diagnosis, detoxification, and treatment of substance use disorders), given by the following *Providers*:

- psychiatrists;
- psychologists;
- licensed behavioral health counselors;
- licensed independent clinical social workers;
- licensed psychiatric nurses who are certified as clinical specialists in psychiatric and behavioral health nursing.

Notes:

- Psychopharmacological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury" as described earlier in this chapter.
- **Prior approval by a *Tufts Health Plan* Behavioral Health *Authorized Reviewer* is required for psychological testing and neuropsychological assessment services at both the *In-Network* and *Out-of-Network Levels of Benefits*. Please contact the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565 for more information on how to obtain this authorization.**

Inpatient* and intermediate behavioral health and substance use disorder services for *Behavioral Health Disorders

- *Inpatient* behavioral health and substance use disorder services for *Behavioral Health Disorders* in a facility that is licensed as a general hospital, a behavioral health hospital, a substance use disorder facility, or a behavioral health residential treatment facility.
- Intermediate behavioral health and substance use disorder services: *Medically Necessary* behavioral health and substance use disorder services that are more intensive than traditional *Outpatient* behavioral health and substance use disorder services, but less intensive than 24-hour hospitalization.

  Some examples of *Covered* intermediate behavioral health and substance use disorder services are:
  - level III community-based detoxification;
  - crisis stabilization;
  - partial hospital programs; and
  - intensive *Outpatient* programs.

Notes:

- ***Inpatient* and intermediate behavioral health and substance use disorder services must be obtained at a *Network Provider* in order to be covered at the *In-Network Level of Benefits*. See "*Inpatient* Behavioral Health and Substance Use Disorder Services" in Chapter 1 for more information.**
- **You must receive authorization from an *Authorized Reviewer* for *Inpatient* and intermediate behavioral health and substance use disorder services at the *Out-of-Network Level of Benefits.* Please contact the *Tufts HP* Behavioral Health Department at 1-800-208-9565 for more information on how to receive this authorization.**

Other Health Services

Ambulance services

- Ground, sea, and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance transportation (e.g., Medflight) when approved by an *Authorized Reviewer**.
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities (approval by an *Authorized Reviewer* may be required).
- Non-emergency ambulance transportation for *Medically Necessary* care when the medical condition of the *Member* prevents safe transportation by any other means. Approval by an *Authorized Reviewer* may be required*.

*Approval by an *Authorized Reviewer* may be required for these benefits at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on the first page of this chapter for more information about when you are responsible for obtaining this approval.

Important Note: If you are treated by Emergency Medical Technicians (EMTs) or other ambulance staff, but refuse to be transported to the hospital or other medical facility, you will be responsible for the costs of this treatment.

Durable Medical Equipment

Equipment must meet the following definition of "*Durable Medical Equipment*".

Durable Medical Equipment is a device or instrument of a durable nature that:

- is reasonable and necessary to sustain a minimum threshold of independent daily living;
- is made primarily to serve a medical purpose;
- is not useful in the absence of illness or injury;
- can withstand repeated use; and
- can be used in the home.

In order to be eligible for coverage, the equipment must also be the most appropriate available amount, supply or level of service for the *Member* in question considering potential benefits and harms to that individual, as determined by *Tufts Health Plan*.

Equipment that *Tufts Health Plan* determines to be non-medical in nature and used primarily for non-medical purposes (even though that equipment may have some limited medical use) will not be considered *Durable Medical Equipment* and will not be covered under this benefit.

Note: Certain *Durable Medical Equipment* may require *Authorized Reviewer* approval. This prior approval is required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on the first page of thus chapter for more information about when you are responsible for obtaining this approval.

Durable Medical Equipment, continued

The following examples of covered and non-covered items are for illustration only. Please call a Member Specialist with questions about whether a particular piece of equipment is covered.

Examples of commonly covered items (this list is not all-inclusive):

- the purchase of a manual or electric (non-hospital grade) breast pump or the rental of a hospital grade electric breast pump for pregnant or post-partum female *Members*, when prescribed by a physician (Note: These breast pumps are covered in full at the *In-Network Level of Benefits*);
- cranial helmets;
- the following equipment when used to diagnose or treat diabetes mellitus Type 1 (insulin-dependent diabetes), diabetes mellitus Type 2 (insulin or non-insulin dependent diabetes), or gestational diabetes:
  - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind,
  - therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease; and
  - visual magnifying aids;
- gradient stockings (up to three pairs per *Benefit Year*);
- oral appliances for the treatment of sleep apnea;
- oxygen concentrators (stationary and portable);
- prosthetic devices, except for arms, legs or breasts*;

  *Important Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Prosthetic Devices" benefit later in this chapter.
- scalp hair prostheses made specifically for an individual or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury Note: Please see "Scalp hair prostheses or wigs for cancer or leukemia patients" later in this chapter for more information about prostheses and wigs for these patients);
- power/motorized wheelchairs.

Tufts HP will decide whether to rent or purchase *Durable Medical Equipment* for use by the *Member*. At the *In-Network Level of Benefits*, this equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with *Tufts HP* to provide such equipment. Certain equipment is subject to recovery when no longer *Medically Necessary* or upon termination of coverage, whichever is earlier.

(continued on next page)

Other Health Services, **continued**

Durable Medical Equipment, continued

Below are examples of non-covered items (this list is not all-inclusive). Please call Member Services for all questions regarding coverage of *Durable Medical Equipment*:

- air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers;
- articles of special clothing, and mattress and pillow covers, including hypo-allergenic versions;
- bed-related items, including bed trays, bed pans, bed rails, bed cradles, over-the-bed tables, and bed wedges;
- car seats;
- car/van modifications;
- comfort or convenience devices;
- dentures;
- ear plugs;
- exercise equipment and saunas;
- externally powered exoskeleton assistive devices and orthoses;
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts, or stair climbers;
- foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease;
- heating pads, hot water bottles, and paraffin bath units;
- hot tubs, jacuzzis, swimming pools, or whirlpools;
- manual home blood pressure monitor with cuff and stethoscope;
- mattresses except for mattresses used in conjunction with a hospital bed and ordered by a *Provider*. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g., Tempur-Pedic® or Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered.
- wheelchair trays
- breast prostheses and prosthetic arms and legs. For more information about these covered devices, see "Prosthetic Devices" later in this chapter.

Other Health Services, continued

Home health care

Coverage is provided for the following services for *Members* who are homebound*:

- home visits by a *Provider*;
- skilled nursing care and physical therapy; and
- the following services, if determined to be a *Medically Necessary* component of skilled intermittent nursing or physical therapy:
  - speech therapy,
  - occupational therapy,
  - medical/psychiatric social work,
  - nutritional consultation,
  - the use of *Durable Medical Equipment;* and
  - the services of a part-time home health aide.

*Homebound: To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment. Please note that this homebound requirement does not apply to *Covered Services* for palliative care under this benefit.

Note: Home health care services for physical, speech, and occupational therapies following an injury or illness are only covered to the extent that those services are provided to restore function lost or impaired, as described under "Rehabilitation Services" earlier in this chapter. However, those home health care services are not subject to the 60-day limit listed under "Rehabilitation Services."

Hospice care services

The *Plan* will cover the following services for *Members* who are terminally ill (having a life expectancy of 6 months or less):

- *Provider* services;
- nursing care provided by or supervised by a registered professional nurse;
- social work services;
- volunteer services; and
- counseling services (including bereavement counseling services for the *Member's* family for up to one year following the *Member's* death).

"Hospice care services" are defined as a coordinated licensed program of services provided, during the life of the *Member*, to a terminally ill *Member*. Such services can be provided:

- in a home setting;
- on an *Outpatient* basis; and
- on a short-term *Inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.

Injectable, infused or inhaled medications

Coverage is provided for injectable, infused or inhaled medications that are: (1) required for and are an essential part of an office visit to diagnose and treat illness or injury; or (2) received at home with drug administration services by a home infusion Provider. Medications may include, but are not limited to, total parenteral nutrition therapy, chemotherapy, and antibiotics.

Notes:

- Prior authorization and quantity limits may apply.
- There are designated home infusion *Providers* for a select number of specialized pharmacy products and drug administration services. These *Providers* offer clinical management of drug therapies, nursing support, and care coordination to *Members* with acute and chronic conditions. Medications offered by these *Providers* include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. Please contact Member Services or see our Web site for more information on these medications and *Providers.*
- Coverage includes the components required to administer these medications, including, but not limited to, hypodermic needles and syringes, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.
- Medications that are listed on the *Tufts HP* Web site as covered under a *Tufts HP* pharmacy benefit are not covered under this "Injectable, infused, or inhaled medications" benefit. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

Medical supplies

The *Plan* covers the cost of certain types of medical supplies, including:

- ostomy, tracheostomy, catheter, and oxygen supplies; and
- insulin pumps and related supplies.

Contact a Member Specialist with coverage questions.

Oral medications for the treatment of cancer (prior authorization by an *Authorized Reviewer* may be required)

Coverage is provided for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Prosthetic devices

Tufts HP covers the cost (including repairs) of breast prostheses and prosthetic arms and legs. Coverage is provided for the most appropriate *Medically Necessary* model. Prior approval by an *Authorized Reviewer* is required. Please see the first page of this chapter for more information about when you are responsible for obtaining this approval *.

*Important Note: Prior approval by an *Authorized Reviewer* is not required for breast prostheses provided in connection with a mastectomy.

Scalp hair prostheses or wigs for cancer or leukemia patients

Coverage is provided for scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.

Note: Please see "*Durable Medical Equipment*" earlier in this chapter.

Special medical formulas

Included in this benefit are the following: special medical formulas; nonprescription enteral formulas; and low protein foods, when prescribed by a *Provider* for the treatments described below:

Low protein foods:

When given to treat inherited diseases of amino acids and organic acids.

Nonprescription enteral formulas (prior approval by an *Authorized Reviewer* may be required):

Coverage is provided:

- for home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.
- when *Medically Necessary*: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.

Important Note: Prior approval by an *Authorized Reviewer* may be required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on the first page of this chapter for more information about when you are responsible for obtaining this approval.

Special medical formulas (prior approval by an *Authorized Reviewer* may be required):

Coverage is provided

- For the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, and methylmaloric acidemia; or
- When *Medically Necessary*, to protect the unborn fetuses of women with PKU.

Important Note: Prior approval by an *Authorized Reviewer* may be required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on the first page of this chapter for more information about when you are responsible for obtaining this approval.

Exclusions from Benefits

There is no coverage for the following services, supplies, or medications:

- A service, supply or medication which is not *Medically Necessary*.
- A service, supply or medication which is not a *Covered Service*.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- A service, supply, or medication that is obtained outside of the 50 United States. The only exception to this rule is for *Emergency* care services, and for *Urgent Care* services provided to you while you are traveling, which qualify as *Covered Services* when provided outside of the 50 United States.
- *Custodial Care*.
- Services related to non-covered services.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

  This exclusion does not apply to:
  - long-term antibiotic treatment of chronic Lyme disease;
  - bone marrow transplants for breast cancer;
  - patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions; or

  If the treatment is *Experimental or Investigative*, the *Plan* will not pay for any related treatments which are provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter.
- The following exclusions apply to services provided by the relatives of a *Member*:
  - Services provided by a relative who is not a *Network Provider* are not covered;
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Network Provider*, are not covered.
  - If you are a *Network Provider*, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you or your covered dependent are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.
- Charges incurred when the *Member*, for his or her convenience, chooses to remain an *Inpatient* beyond the discharge hour.
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated).
- Facility charges or related services if the procedure being performed is not a *Covered Service*, except as provided under "Oral health services" earlier in this chapter.

Exclusions from Benefits, continued

- Preventive dental care; periodontal treatment; orthodontia, even when it is an adjunct to other medical and surgical procedures; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under "Oral health services" earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea, as described in Chapter 3), including those for TMJ disorders. TMJ disorder related therapies, including TMJ appliances, occlusal adjustment, and TMJ appliance-related therapies, are not covered.
- Surgical removal or extraction of teeth, except as provided under "Oral health services" earlier in this chapter.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under "Reconstructive surgery and procedures" earlier in this chapter.
- Rhinoplasty, except as provided under "Reconstructive surgery and procedures" earlier in this chapter; liposuction; the removal of tattoos; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.
- Hair removal, except when *Medically Necessary* to treat an underlying skin condition.
- Contraceptives and contraceptive services. Oral contraceptives, cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law.

IMPORTANT NOTE REGARDING COVERAGE FOR CONTRACEPTIVES: It is a federal requirement that health plans cover all Food and Drug Administration approved contraceptive services for women of child bearing age, as prescribed by a healthcare provider, without cost sharing. Because your employer has certified to Tufts Health Plan that it qualifies for an accommodation under the law, Tufts Health Plan will, separately from your employer, cover qualified contraceptive services that you use without cost sharing and at no other cost, for the duration that you are covered on this health plan.

- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcisions performed in any setting other than a hospital, *Day Surgery*, or a *Provider's* office.
- The following infertility services, supplies, and medications:
  - Infertility services, supplies, or medications, except as described in the "*Outpatient* Care" section earlier in this chapter;
  - experimental infertility procedures;
  - the costs of surrogacy;
  - reversal of voluntary sterilization;
  - sperm or embryo cryopreservation;
  - sterilization;
  - all infertility medications;
  - Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.

  *the costs of surrogacy means: (1) all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member.* These costs include, but are not limited to: costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a *Member.*

  A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo.

  A gestational carrier is a surrogate with no biological connection to the embryo/child.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Pregnancy terminations.
- Circumcisions performed in any setting other than a hospital, *Day Surgery*, or a *Provider's offic*e.
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of gender reassignment surgery; reversal of voluntary sterilization; or over-the-counter contraceptive agents.

Exclusions from Benefits, continued

- Breast pumps:
  - Female members: the purchase of an electric hospital-grade breast pump; donor breast milk
- Human organ transplants, except as described earlier in this chapter.
- Services provided to a non-*Member*, except as described earlier in this chapter for:
  - organ donor charges under "Human organ transplants";
  - bereavement counseling services under “Hospice care services”; or
- Spinal manipulation services for *Members* age 12 and under;
- Acupuncture or related diagnostic services;
- Biofeedback, except for the treatment of urinary incontinence, or related diagnostic services;
- Hypnotherapy or related diagnostic services;
- Psychoanalysis or related diagnostic services;
- Neuromuscular stimulators and related supplies or related diagnostic services;
- Electrolysis or related diagnostic services;
- *Inpatient* and *Outpatient* weight-loss programs and clinics or related diagnostic services;
- Relaxation therapies or related diagnostic services;
- Exercise classes or related diagnostic services;
- Cognitive rehabilitation programs or related diagnostic services;
- Cognitive retraining programs or related diagnostic services.
- Massage therapies or related diagnostic services, except as described under “Rehabilitation services”
- Services by a personal trainer or related diagnostic services;
- All *Non-Conventional Medicine* services, provided independently or together with conventional medicine, and all related testing, laboratory testing, services, supplies, procedures, and supplements associated with this type of medicine.
- Multi-purpose general electronic devices including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electronic devices including USB devices and direct connect devices (e.g., speaker, microphone, cables, cameras, batteries, etc.). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet, and all related accessories.
- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; educational, vocational or recreational settings; Outward Bound, wilderness, camp or ranch programs), even if performed or provided by a licensed *Provider* (including, but not limited to, behavioral health professionals, nutritionists, nurses, or physicians).
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the ”Note” below.

  Note: The following blood services and products are covered:
  - blood processing;
  - blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval by an *Authorized Reviewer* is required);
  - intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an *Authorized Reviewer* is required).
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided under “Early intervention services” earlier in this chapter. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and developmental delays. The term “developmental” refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.

Exclusions from Benefits, continued

- Eyeglasses, lenses or frames, except as described earlier in this chapter; refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described earlier in this chapter, the *Plan* will not pay for contact lenses or contact lens fittings.
- Hearing aids.
- Methadone treatment or methadone maintenance related to substance abuse disorders.
- Private duty nursing (block or non-intermittent nursing).
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.

  Note: This exclusion also does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:
  - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
  - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" in this chapter.
- Lodging related to receiving any medical service.

Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. The following topics are included in this section to explain your prescription drug coverage:

- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- *Tufts Health Plan* Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered

Prescription drugs will be considered *Covered Services* only if they comply with the "*Tufts Health Plan* Pharmacy Management Programs" section described below and are:

- listed below under "What is Covered";
- approved by the United Stated Food and Drug Administration (FDA);
- provided to treat an injury, illness, or pregnancy; and
- *Medically Necessary*.

For a current list of covered drugs, please go to *Tufts Health Plan's* Web site at **www.tuftshealthplan.com**, or call a Member Specialist.

The "Prescription Drug Coverage Table" below describes your prescription drug benefit amounts.

- Tier-1 drugs have the lowest level *Cost Sharing Amount*.
- Tier-2 drugs have the middle level *Cost Sharing Amount*.
- Tier-3 drugs have the highest level *Cost Sharing Amount.*
- Tier-4 drugs have the highest *Cost Sharing Amount*.

Notes: Smoking cessation agents (both prescription and generic over-the-counter agents when prescribed by a *Provider*) are covered in full.

Prescription Drug Benefit, continued

PRESCRIPTION DRUG COVERAGE TABLE	
Description	**Coverage**
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a *Tufts Health Plan* designated retail pharmacy.	**Tier-1 drugs:** $15 for up to a 30-day supply $30 for a 31-60 day supply $45 for a 61-90 day supply **Tier-2 drugs:** $30 for up to a 30-day supply $60 for a 31-60 day supply $90 for a 61-90 day supply **Tier-3 drugs:** $50 for up to a 30-day supply $100 for a 31-60 day supply $150 for a 61-90 day supply **Tier-4 drugs:** $100 for up to a 30-day supply $200 for a 31-60 day supply $300 for a 61-90 day supply Important Note: If you choose to obtain a covered prescription drug at a retail pharmacy which is **not** a *Tufts HP* designated pharmacy, you will be required to pay for the entire cost of the drug up front. Prescription drugs will not be covered, even in cases of emergency, when they are obtained from a pharmacy that does not participate with *Tufts Health Plan*.
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a *Tufts Health Plan* designated mail services pharmacy.	**Tier-1 drugs:** $30 for up to a 90-day supply **Tier-2 drugs:** $75 for up to a 90-day supply **Tier-3 drugs:** $150 for up to a 90-day supply

Note: If you fill your prescription in a state that allows you to request a brand-name drug even though your *Provider* authorizes the generic equivalent, you will pay the applicable Tier *Cost Sharing Amount* plus the difference in cost between the brand-name drug and the generic drug.

Prescription Drug Benefit, continued

What is Covered

The *Plan* covers the following under this *Prescription Drug Benefit*:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under "What is Not Covered" (see "Important Notes" below).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Fluoride for *Children*.
- Injectables and biological serum included on the list of covered drugs on the *Tufts Health Plan* Web site. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered. For more information, call Member Services or see our Web site at www.tuftshealthplan.com.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the Commissioner of Insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law and is FDA-approved. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call Member Services.
- Over-the-counter drugs included in the list of covered drugs on the formulary applicable to your plan when prescribed by a *Provider.*. You may find the formulary on our website or you can call Member Services for more information.
- Prescription smoking cessation agents.
- Certain medications used for bowel preparation in colonoscopy procedures are covered in full at the *In-Network Level of Benefits* for *Members* ages 50 through 74. For more information, please call Member Services or see the formulary on our Web site at www.tuftshealthplan.com.

Note: Certain prescription drug products may be subject to one of the "*Tufts Health Plan* Pharmacy Management Programs" described below.

Prescription Drug Benefit, continued

What is Not Covered

The *Plan* does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Drugs that are part of our "Non-Covered Drugs with Suggested Alternatives" pharmacy management program unless they are approved for coverage for you through the medical review process. See "Pharmacy Management Programs" and "Important Notes" later in this chapter.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins required under the Affordable Care Act, and fluoride for *Children*).
- Topical and oral fluorides for adults.
- Medications for the treatment of idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent, oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law, and FDA-approved female over-the-counter contraceptives (e.g., female condoms or contraceptive spermicides) when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription.

IMPORTANT NOTE REGARDING COVERAGE FOR CONTRACEPTIVES: It is a federal requirement that health plans cover all Food and Drug Administration approved contraceptive services for women of child bearing age, as prescribed by a healthcare provider, without cost sharing. Because your employer has certified to Tufts Health Plan that it qualifies for an accommodation under the law, Tufts Health Plan will, separately from your employer, cover qualified contraceptive services that you use without cost sharing and at no other cost, for the duration that you are covered on this health plan.

- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Products that are FDA approved as devices, including therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under Preventive health care earlier in this chapter.
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.
- Over-the-counter smoking cessation agents
- Drugs for asymptomatic onchomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status.
- Compounded medications, if no active ingredients require a prescription by law. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may also not be covered. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check our Web site at **www.tuftshealthplan.com**.
- Prescription medications when packaged with non-prescription products.
- Oral non-sedating antihistamines.
- Over-the-counter medications if not included on the list of covered drugs on our website.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).

Prescription Drug Benefit, continued

What is Not Covered, continued

The following services are not covered unless they have been proven to be medically necessary.

- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for Children).
- Oral contraceptives (except when prescribed for a medical purpose other than birth control. May require Clinical Review.)

IMPORTANT NOTE REGARDING COVERAGE FOR CONTRACEPTIVES: It is a federal requirement that health plans cover all Food and Drug Administration approved contraceptive services for women of child bearing age, as prescribed by a healthcare provider, without cost sharing. Because your employer has certified to Tufts Health Plan that it qualifies for an accommodation under the law, Tufts Health Plan will, separately from your employer, cover qualified contraceptive services that you use without cost sharing and at no other cost, for the duration that you are covered on this health plan.

- Drugs for asymptomatic onchomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status.
- Acne medications, unless *Medically Necessary.*

***Tufts Health Plan* Pharmacy Management Programs**

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, *Tufts Health Plan* has developed the following Pharmacy Management Programs:

Quantity Limitations Program:

Tufts Health Plan limits the quantity of selected medications that Members can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:

Tufts Health Plan restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing *Provider* to obtain prior approval from *Tufts Health Plan* for such drugs.

Step Therapy PA Program

Step therapy is a type of prior authorization program (usually automated) that uses a step-wise approach, requiring the use of the most therapeutically appropriate and cost-effective agents first, before other medications may be covered. *Members* must first try one or more medications on a lower step to treat a medical condition before a medication on a higher step is covered for that condition.

Designated Specialty Pharmacy Program:

We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services to *Members*. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-day supply of medication at one time and it is delivered directly to the *Member's* home via mail. This is NOT part of the mail order pharmacy benefit. Extended day supplies and *Copayment* savings do not apply to these designated specialty drugs.

Non-Covered Drugs With Suggested Alternatives:

While *Tufts Health Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered.

New-To-Market Drug Evaluation Process:

New-to-market drug products are reviewed for safety, clinical effectiveness, and cost by *Tufts Health Plan's* Pharmacy and Therapeutics Committee. *Tufts Health Plan* then makes a coverage determination based on the Committee's recommendation.

A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability.

IMPORTANT NOTES:

- If your *Provider* feels it is *Medically Necessary* for you to take medications that are restricted under any of the "*Tufts Health Plan* Pharmacy Management Programs*"* described above, he or she may submit a request for coverage. We will review the request and provide you with notification of our coverage determination within 72 (seventy-two) hours after receiving the request. *Tufts Health Plan* will approve the request if it meets the guidelines for coverage. For more information, call a Member Specialist.
- If a request is made to cover medications that are part of the "New-to-Market Drug Evaluation Process" program or the "Non-Covered Drugs with Suggested Alternatives" program, and that request is approved by *Tufts Health Plan*, the medications will generally be covered on the highest tier (e.g., Tier-3 on a 3-tier formulary, Tier 4 on a 4-tier formulary), with some exceptions. Please call Member Services for more information about on which tier your medications.
- The *Tufts Health Plan* Web site has a list of covered drugs with their tiers. *Tufts Health Plan* may change a drug's tier during the year. For example, if a brand drug's patent expires, *Tufts Health Plan* may change the drug's status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) moving the brand drug to our list of non-covered drugs when a generic alternative becomes available.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check our Web site at **www.tuftshealthplan.com**, or call a Member Specialist.

Filling Your Prescription

Where to Fill Prescriptions:

You can fill your prescriptions at any *Tufts Health Plan* designated pharmacy. *Tufts Health Plan* designated pharmacies include:

- for the majority of prescriptions, many of the pharmacies in Massachusetts, New Hampshire and Rhode Island, and additional pharmacies nationwide; and
- for a select number of drug products, a small number of special designated pharmacy providers. (For more information about *Tufts Health Plan's* special designated pharmacy program, see "*Tufts Health Plan* Pharmacy Management Programs" earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the *Tufts Health Plan* Member Services Department.

How to Fill Prescriptions:

- When you fill a prescription, provide your Member ID to any *Tufts Health Plan* designated pharmacy and pay your *Cost Sharing Amount*.
- If the cost of your prescription is less than your *Copayment*, then you are only responsible for the actual cost of the prescription.
- If you have any problems using this benefit at a *Tufts Health Plan* designated pharmacy, call the *Tufts Health Plan* Member Services Department.

Important: Your prescription drug benefit will only be honored at a *Tufts Health Plan* designated pharmacy. Prescription drugs will not be covered, even in cases of emergency, when they are obtained from a pharmacy that does not participate with *Tufts Health Plan*.

Filling Prescriptions for Maintenance Medications:

If you are required to take a maintenance medication, *Tufts Health Plan* offers you two choices for filling your prescription:

- you may obtain your maintenance medication directly from a *Tufts Health Plan* designated retail pharmacy; or
- you may have most maintenance medications* mailed to you through a *Tufts Health Plan* designated mail services pharmacy.

*The following may not be available to you through a *Tufts Health Plan* designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of *Tufts Health Plan's* Quantity Limitations program; or
- medications that are part of *Tufts Health Plan's* Special Designated Pharmacy program.

NOTE: Your *Cost Sharing Amounts* for covered prescription drugs are shown in the "Prescription Drug Coverage Table" earlier in this section.

Chapter 4

When Coverage Ends

Overview

Reasons coverage ends

Coverage (including federal COBRA coverage)ends when any of the following occurs:

- you lose eligibility because you no longer meet the *Plan's* or *Tufts HP's* eligibility rules, including the requirement for minimum hours and employment classification described in Chapter 2;
- you are a *Subscriber* and you no longer live, work, or reside in the *Network Contracting Area**
- you choose to drop coverage;
- you commit an act of physical or verbal abuse unrelated to your physical or behavioral health condition which poses a threat to any *Provider*, any *Tufts HP Member*, or *Tufts Health Plan* or any *Tufts HP* employee;
- you commit an act of misrepresentation or fraud; or
- your *Group's* contract with *Tufts HP* ends. (For more information, see "Termination of the *Group Contract*" later in this chapter.)

*Note: *Children* are not required to live, work, or reside in the *Network Contracting Area.* However, coverage outside of the *Network Contracting Area* is limited to the *Out-of-Network Level of Benefits* only. In addition, there are a few other exceptions in which *Dependents* are still eligible for coverage under this plan even if they do not live, work, or reside in the *Network Contracting Area*. Please see "If you do not live, work, or reside in the *Network Contracting Area*" in Chapter 2 for more information.

Benefits after termination

The *Plan* will not cover services you receive after your coverage ends even if:

- you were receiving *Inpatient* or *Outpatient* care when your coverage ended; or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends.

Continuation

Once your coverage ends, you may be eligible to continue your coverage with your *Group* or to enroll in coverage under an individual contract. See Chapter 5 for more information.

Note: Stonehill does not recognize Massachusetts mandates that may extend continuation of coverage to a former spouse who loses dependent status as a result of divorce. Stonehill refers to the FEDERAL COBRA guidelines in the event of divorce.

When a *Member* is No Longer Eligible

Loss of eligibility

Your coverage ends on the date you no longer meet your *Group's* eligibility rules.

Important Note: Your coverage will terminate retroactively to the date you are no longer eligible for coverage.

***Dependent* Coverage**

An enrolled *Dependent's* coverage ends when the *Subscriber's* coverage ends. Coverage of any *Child* of an enrolled *Dependent Child* ends when the enrolled *Dependent Child's* coverage ends.

An enrolled *Dependent Child's* or *Disabled Dependent* coverage ends when the *Child* reaches age 26. *Dependents* should only be allowed on the plan up to age 26 if they have no coverage options through their employer. See Chapter 2, "Continuing Eligibility for *Dependents*", for more information.

When a *Member* is No Longer Eligible, continued

You choose to drop coverage

Coverage ends if you decide you no longer want coverage and you meet any qualifying event your *Group* requires. To end your coverage, notify your *Group* at least 30 days before the date you want your coverage to end. You must pay the required contribution to the *Plan* up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

Coverage may be terminated if you commit acts of physical or verbal abuse which are unrelated to your physical or behavioral health condition; and pose a threat to any *Provider*, any *Tufts HP Member*, or *Tufts Health Plan* or any *Tufts HP* employee.

Membership Termination for Misrepresentation or Fraud

Policy

Your coverage may be terminated for misrepresentation or fraud. If your coverage is terminated for misrepresentation or fraud, *Tufts HP* may not allow you to re-enroll for coverage with *Tufts HP* under any other plan (such as a non-group or another employer's plan) or type of coverage (for example, coverage as a *Dependent* or *Spouse*).

Acts of misrepresentation or fraud

Examples of misrepresentation or fraud include:

- false or misleading information on your member application form;
- enrolling as a *Spouse* someone who is not your *Spouse*;
- receiving benefits for which you are not eligible;
- keeping for yourself payments made by the *Plan* that were intended to be used to pay a *Provider*;
- submission of any false paperwork, forms, or claims information; or
- allowing someone else to use your Member ID card.

Date of termination

The *Plan* will terminate coverage by sending a notice of termination to your last address as shown on the *Plan's* records. Termination will be retroactive to the *Effective Date*, unless the *Plan* determines that the termination shall be retroactive to the date of the misrepresentation or fraud or to such later date as the *Plan* designates in the notice of termination.

Payment of claims

The *Plan* will pay for all *Covered Services* you received between:

- your *Effective Date*; and
- your termination date, as chosen by the *Plan*. The *Plan* may retroactively terminate your coverage back to a date no earlier than your *Effective Date*.

The *Plan* may use any contributions to coverage you paid for a period after your termination date to pay for any *Covered Services* you received after your termination date.

If the contributions you paid are <u>not</u> enough to pay for that care, the *Plan*, at its option, may:

- pay the *Provider* for those services and ask you to pay the *Plan* back; or
- <u>not</u> pay for those services. In this case, you will have to pay the *Provider* for the services.

If the contribution to coverage is more than is needed to pay for *Covered Services* you received after your termination date, the *Plan* will refund the excess to your *Group*.

Termination of the *Group Contract*

End of *Tufts HP's* and *Group's* relationship

Coverage will terminate if the relationship between your *Group* and *Tufts HP* ends for any reason, including:

- your *Group's* contract with *Tufts HP* terminates;
- your *Group* fails to pay its obligation;
- *Tufts HP* stops operating; or
- your *Group* stops operating.

Chapter 5

Continuation of Coverage

Federal Continuation Coverage (COBRA)

Introduction

This topic contains an overview of continuation coverage under federal COBRA law. For more information, please contact your *Group* or the *Plan Administrator*.

Rules for federal COBRA continuation

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible to continue coverage after *Group* coverage ends if you were enrolled in the *Plan* through a *Group* which has 20 or more eligible employees and you experience a qualifying event (see list below) which would cause you to lose coverage under your *Group*.

Qualifying Events

A *Member's Group* coverage under the *Group Contract* may end because he or she experiences a qualifying event. A qualifying event is defined as:

- the *Subscriber's* death;
- termination of the *Subscriber's* employment for any reason other than gross misconduct;
- reduction in the *Subscriber's* work hours;
- the *Subscriber's* divorce or legal separation;
- the *Subscriber's* entitlement to Medicare; or
- the *Subscriber's* or *Spouse's* enrolled *Dependent* ceases to be a *Dependent Child*.

If a *Member* experiences a qualifying event, he or she may be eligible to continue *Group* coverage as a *Subscriber* or an enrolled *Dependent* under federal COBRA law as described below.

When federal COBRA coverage is effective

A *Member* who is eligible for federal COBRA continuation coverage is called a "qualified beneficiary." A qualified beneficiary must be given an election period of 60 days to choose whether to elect federal COBRA continuation coverage. This period is measured from the later of:

- the date the qualified beneficiary's coverage under the *Group Contract* ends (see the list of qualifying events described above); and
- the date the *Plan* provides the qualified beneficiary with a COBRA election notice.

A qualified beneficiary's federal COBRA continuation coverage becomes effective retroactive to the start of the election period, if he or she elects and pays for that coverage.

Cost of Coverage

In most cases, you are responsible for payment of 102% of the cost of coverage for the federal COBRA continuation coverage. (See "Important Note" in the "Duration of Coverage" table below for information about when you may be responsible for payment of more than 102% of the cost of COBRA coverage.) For more information, contact your *Group* or the *Plan Administrator*.

Duration of Coverage

Qualified beneficiaries are eligible for federal COBRA continuation coverage, in most cases, for a period of 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event. Generally, COBRA coverage is available for a maximum of 18 months for qualifying events due to employment termination or reduction of work hours. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive a maximum of 36 months of COBRA continuation coverage. For more information, see the "Duration of Coverage" table below.

Federal Continuation Coverage (COBRA), continued

FEDERAL COBRA - DURATION OF COVERAGE		
Qualifying Event(s)	**Qualified Beneficiaries**	**Maximum Period of Coverage**
• Termination of *Subscriber's* employment for any reason other than gross misconduct. • Reduction in the *Subscriber's* work hours.	*Subscriber, Spouse*, and *Dependent Children*	18 months*
Subscriber's divorce, legal separation, entitlement to Medicare, or death.	*Spouse* and *Dependent Children*	36 months
Subscriber's or *Spouse's* enrolled *Dependent* ceases to be a *Dependent Child*.	*Dependent Child*	36 months
*__Important Note:__ If a qualified beneficiary is determined under the federal Social Security Act to have been disabled within the first 60 days of federal COBRA continuation coverage for these qualifying events, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA coverage for up to an additional 11 months. You may be responsible for the payment of up to 150% of the cost of COBRA coverage for this additional period of up to 11 months.		

When coverage ends

Federal COBRA continuation coverage will end at the end of the maximum period of coverage, which in most cases is 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event. However, coverage may end earlier if:

- coverage costs are not paid on a timely basis.
- your Group ceases to maintain any group health plan.
- after the COBRA election, the qualified beneficiary obtains coverage with another employer group health plan that does not contain any exclusion or pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- after the COBRA election, the qualified beneficiary becomes entitled to federal Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Under USERRA:

- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed services, and (1) you ensure that your employer receives advance written or verbal notice of your service; (2) you have five years or less of cumulative service in the uniformed services while with that particular employer; (3) you return to work or apply for reemployment in a timely manner after conclusion of service; and (4) you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service, or, in some cases, a comparable job.
- If you are a past or present member of the uniformed services, have applied for membership in the uniformed services, or are obligated to serve in the uniformed services, then an employer may not deny you initial employment, reemployment, retention in employment, promotion, or any benefit of employment because of this status. In addition, an employer may not retaliate against any assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your *Dependents* for up to 24 months while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (for example, pre-existing condition exclusion) except for service-connected illnesses or injuries.
- Service members may be required to pay up to 102% of the premium for the health plan coverage. If coverage is for less than 31 days, the service member is only required to pay the employee share, if any, for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETSW process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact your *Group* or the *Plan Administrator.*

Coverage under an Individual Contract

If you live in Massachusetts:

If your *Group* coverage ends, you may be eligible to enroll in coverage under an individual contract offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority ("the Connector"). For more information, call *Tufts Health Plan* Member Services or contact the Connector either by phone (1-877-MA-ENROLL) or on its Web site (www.mahealthconnector.org).

If you live outside Massachusetts:

If your *Group* coverage ends, you are not eligible to enroll in coverage under an individual contract offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority. Please contact your state insurance department for information about coverage options that may be available to you in the state where you reside.

For more information

Please call the *Tufts Health Plan* Member Services Department.

Chapter 6

How to File a Claim and *Member* Satisfaction

How to File a Claim

Network Providers

When you obtain care from a *Network Provider*, you do not have to submit claim forms. The *Network Provider* will submit claim forms for you. *Tufts HP* will make payment directly to the *Network Provider*.

Non-Network Providers

As described below, when you obtain care from a *Non-Network Provider*, it may be necessary to file a claim form. Claim forms are available from your *Plan Administrator* or *Tufts HP* (see "To Obtain Claim Forms" below).

Hospital Admission or *Day Surgery*

When you receive care from a hospital that is a *Non-Network Provider*, have the hospital complete a claim form. The hospital should submit the claim form directly to *Tufts HP*. If you are responsible for any portion of the hospital bill, *Tufts HP* will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the *Non-Network Hospital*.

***Outpatient* Medical Expenses**

When you receive medical care from a *Non-Network Provider*, you are responsible for completing claim forms. (Check with the *Non-Network Provider* to determine if he or she will submit the claim form directly to *Tufts HP* for you or whether you will be required to submit the claim form directly to *Tufts HP* yourself.)

- If you sign the appropriate section on the claim form, *Tufts HP* will make payment directly to the *Non-Network Provider*. If you are responsible for any portion of the bill, *Tufts HP* will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe to the *Non-Network Provider*.
- If you do not sign the appropriate section on the claim form, *Tufts HP* will make the appropriate payment directly to you. If you have not already done so, you will be responsible to pay the *Non-Network Provider* for the services rendered. If you are responsible for paying any portion of the bill above what the *Plan* pays, an explanation of benefits statement will be sent to you. The explanation of benefits statement will tell you how much you owe to the *Non-Network Provider*.

To Obtain Claim Forms

Claim forms are available from your *Plan Administrator* or by calling the *Tufts HP* Member Services Department.

Where to Medical Send Claim Forms

Send completed claim forms to:

Tufts Health Plan
Claims Department
P.O. Box 9185
Watertown, MA 02471-9185

Separate claim forms should be submitted for each family member.

Pharmacy Expenses

If you obtain a prescription at a non-designated or out-of-network pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a Member Specialist or through our Web site at **www.tuftshealthplan.com**.

Member Satisfaction Process

Process Summary

Tufts HP has a *Member* Satisfaction Process to address your concerns as expeditiously as possible. This process addresses:

- Internal Inquiry;
- *Member* Grievance Process; and
- appeals:
  - Internal *Member* Appeals; and
  - Expedited Appeals.

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to *Tufts HP's* Member Services at **1-800-462-0224**. Alternatively, you may submit your grievance or appeal at the address listed above.

Internal Inquiry

Call a *Tufts HP* Member Specialist to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell a Member Services Coordinator that you are not satisfied with the response you have received from *Tufts HP*, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Grievances

A grievance is a formal complaint about actions taken by *Tufts HP* or a *Network Provider*. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact *Tufts HP* as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. If you choose to file a grievance verbally, please call a *Tufts Health Plan* Member Specialist, who will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your *Tufts HP* Member ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names); and
- any supporting documentation.

Important Note: The *Member* Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "Internal *Member* Appeals" section below.

Administrative Grievances

An administrative grievance is a complaint about a *Tufts HP* employee, department, policy, or procedure, or about a billing issue.

Member Satisfaction Process, continued

Administrative Grievance Timeline

- If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- *Tufts HP* will review your grievance and will send you a letter regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and *Tufts HP*.

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. If you have concerns about your medical care, you should discuss them directly with your *Provider*. If you are not satisfied with your *Provider's* response or do not wish to address your concerns directly with your *Provider*, you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

Member Satisfaction Process, continued

Internal *Member* Appeals

Requests for coverage that was denied as specifically excluded in this *Description of Benefits* or for coverage that was denied based on medical necessity determinations are reviewed as appeals through the Internal Appeals Process. You may designate in writing someone to act on your behalf. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

You can submit a verbal appeal of a benefit coverage decision to a *Tufts HP* Member Services Coordinator, who will forward it to the Appeals and Grievances Department. Alternatively, you may submit your grievance or appeal at the address listed above.

You can also submit a written appeal to the address listed previously. *Tufts HP* encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- your complete name and address;
- your ID number and suffix;
- a detailed description of your concern; and
- copies of any supporting documentation.

Within forty-eight (48) hours of the receipt of your verbal or written appeal, you will be sent an acknowledgment of receipt, a summary of our understanding of your concerns, and if appropriate, a request for authorization for the release of medical and treatment information. The authorization for release of medical and treatment information gives permission to collect documents from your medical record related to your appeal. Your name will remain anonymous to your *Group* unless you explicitly request that your name remain in the case file. However, if your *Group* requests your name, we must provide it.

If your appeal involves an adverse determination (medical necessity determination), it will be reviewed by a medical director and/or a practitioner in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. The medical director and/ or practitioner will not have previously reviewed your case.

With respect to appeals for prospective or concurrent urgent care services, *Tufts HP* or its designee will conduct a full and fair review of the appeal and will send you a notice of the determination.

For non-emergent appeals not involving the medical necessity of services, *Tufts HP* will make a recommendation based upon this review and will forward the recommendation to your *Group* along with the appeal information. Your *Group*, fiduciary of the *Plan*, makes the final decision about these appeals.

For non-urgent appeals involving the medical necessity of services obtained from *Tufts HP Providers* or any *Provider* located in Massachusetts, New Hampshire, or Rhode Island, a *Tufts HP* medical director will make a recommendation based upon this review and will forward this recommendation to your *Group* along with the appeal information. Your *Group*, fiduciary of the *Plan*, makes the final decisions about medical necessity.

For appeals involving the medical necessity of services obtained from health care providers not contracted with *Tufts HP* and that are not located in Massachusetts, New Hampshire, or Rhode Island, *Tufts HP* or its designee will conduct a full and fair review of the appeal and will send you a notice of the determination.

You will have access to any medical information and records relevant to your appeal that are in the possession and control of *Tufts HP* or its designee. The time limits of this process may be waived or extended by mutual written agreement between you or your authorized representative and *Tufts HP* or its designee.

In the event that you do not sign and return the authorization for the release of medical and treatment information within thirty (30) calendar days of the day you requested a review of your case, a resolution of the appeal may be made without the review of some or all of your medical records.

You will be notified in writing of the decision on your appeal, within no more than thirty (30) calendar days of the receipt of your appeal. The decision letter will include the specific reasons for the decision and references to the pertinent plan provisions on which the decision is based.

Tufts HP or its designee maintains records of each inquiry made by a *Member* or by that *Member's* authorized representative.

Member Satisfaction Process, continued

Expedited Appeals

Tufts Health Plan recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard appeals process. *Tufts Health Plan* will expedite an appeal when your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner in the same or similar specialty that typically manages the medical condition, procedure or treatment under review. The Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner will not have previously reviewed your case.

Your review will generally be conducted within 2 business days, but no later than 72 hours (whichever is less) after *Tufts Health Plan's* receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.

If you have questions

If you have questions or need help submitting a grievance or an appeal, please call a *Tufts Health Plan* Member Services Coordinator for assistance.

External Review

For certain types of claims, you or your authorized representative has the right to request an independent, external review of our Appeals decision. Should you choose to do so, send your request within four months of your receipt of written notice of the denial of your appeal to:

Tufts Health Plan
Appeals & Grievances Department
705 Mt. Auburn Street
Watertown, MA 02471-9193

(fax) 617-972-9509

In some cases, *Members* may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. An urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the Appeal decision, the service or supply will be covered under the *Plan* within no more than 45 days after receipt of the request for standard external review. For expedited external review, the independent review organization will provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request.

Bills from *Providers*

Occasionally, you may receive a bill from a *Non-Network Provider* for *Covered Services*. Before paying the bill, contact the *Tufts HP* Member Services Department.

If you do pay the bill, you must send the following information to the Member Reimbursement Medical Claims Department:

- a completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the *Tufts HP* web site or by contacting the *Tufts HP* Member Services Department; and
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment.

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claim Form.

Please note: You must contact *Tufts Health Plan* regarding your bill(s) or send your bills to *Tufts HP* within twelve months from the date of service. If you do not, the bill cannot be considered for payment. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

If you receive *Covered Services* from a *Non-Network Provider*, the *Plan* will pay up to the *Reasonable Charge* for the services.

IMPORTANT NOTE:
Certain services you receive from non-*Network Providers* at an *In-Network* setting may be reimbursable. Some examples of these types of *Providers* include:

- radiologists, pathologists, and anesthesiologists who work in *Network Hospitals*; and
- *Emergency* room specialists.

The *Plan* reserves the right to be reimbursed by the *Member* for payments made in error.

Limitation on Actions

You cannot file a lawsuit against *Tufts Health Plan* for failing to pay or arrange for or administer *Covered Services* unless you have completed the *Tufts Health Plan* Member Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under this *Group Contract*, you must first complete the *Tufts Health Plan Member* Satisfaction Process, and then file your lawsuit within two years after the date you were first sent a notice of the denial. Going through the *Tufts Health Plan Member* Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage.

Chapter 7

Other *Plan* Provisions

Subrogation and Right of Recovery

The provisions of this section apply to all current and former plan participants and also to the parents, guardians, or other representatives of a *Dependent Child* who incurs claims and is or has been covered by the *Plan.* This *Plan's* right to recover (whether by subrogation or reimbursement) shall apply to the personal representative or administrator of your estate, your decedents, your heirs, your descendants, your beneficiaries, minors, and incompetent or disabled persons. These provisions will apply to all claims arising from your illness or injury, including, but not limited to, wrongful death, survival, or survivorship claims brought on your, your estate's, or your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" and "your" includes anyone on whose behalf the *Plan* pays benefits. No adult *Subscriber* hereunder may assign any rights that it may have to recover medical expenses from any person or entity responsible for causing your injury, illness, or condition or any other person or entity to any minor child or children of said adult *Subscriber* without the prior express written consent of the *Plan*.

The *Plan's* right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness, or condition for which the *Plan* has paid medical claims (including, but not limited to, any disability award or settlement, premises or homeowners' medical payments coverage, premises or homeowners' insurance coverage, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interests are fully satisfied.

Subrogation

The right of subrogation means the *Plan* is entitled to pursue any claims that you may have in order to recover the benefits paid by the *Plan*. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the *Plan*. The *Plan* may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The *Plan* is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the *Plan* first from such payment for all amounts the *Plan* has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the plan are conditioned upon your agreement to reimburse the plan in full from any recovery you receive for your injury, illness, or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any *Provider*) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the *Plan.* No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the *Plan's* subrogation and reimbursement interest are fully satisfied.

Subrogation and Right of Recovery, continued

Lien Rights

Further, the *Plan* will automatically have a lien to the extent of benefits paid by the *Plan* for the treatment of illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury, or condition for which the *Plan* paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan,* including, but not limited to, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the *Plan*.

Subrogation Agent

Tufts Health Plan administers subrogation recoveries for the *Plan* and may contract with a third party to administer subrogation recoveries for the *Plan*. In such case, that subcontractor will act as *Tufts Health Plan's* agent.

Assignment

In order to secure the *Plan's* recovery rights, you agree to assign to the *Plan* any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the *Plan's* subrogation and reimbursement claims. This assignment allows the *Plan* to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the *Plan*, you acknowledge that the *Plan's* recovery rights are a first priority claim and are to be repaid to the *Plan* before you receive any recovery for your damages. The *Plan* shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the *Plan* will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The *Plan* is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical payments the *Plan* provided or purports to allocate any portion of such settlement or judgment to payments of expenses other than medical expenses. The *Plan* is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The *Plan's* claim will not be reduced due to your own negligence.

Subrogation and Right of Recovery, continued

Cooperation

You agree to cooperate fully with the *Plan's* efforts to recover benefits paid. It is your duty to notify the *Plan* within 30 days of the date when any notice given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the *Plan* or its representative's notices of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice information requested by the *Plan*, *Tufts Health Plan* or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the *Plan* may reasonably request and all documents related to or filed in personal injury protection. Failure to provide this information, failure to assist the *Plan* in pursuit of its subrogation rights or failure to reimburse the *Plan* from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits, or the institution of court proceedings against you.

You shall do nothing to prejudice the *Plan's* subrogation or recovery interest or prejudice the *Plan's* ability to enforce the terms of this *Plan* provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the *Plan* or disbursement of any settlement proceeds or other recovery prior to fully satisfying the *Plan's* subrogation and reimbursement interest.

You acknowledge that the *Plan* has the right to conduct an investigation regarding the injury, illness, or condition to identify potential sources of recovery. The *Plan* reserves the right to notify all parties and his/her agents of lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the *Plan* has notified you that it has the right pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the *Plan* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the *Plan*, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the *Plan* may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the *Plan* incurs in successful attempts to recover amounts the *Plan* is entitled to under this section.

Subrogation and Right of Recovery, continued

Workers' Compensation

Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The *Plan* will not provide coverage for any injury or illness for which it determines that the *Member* is entitled to benefits pursuant to any workers' compensation statute or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If the *Plan* pays for the costs of health care services or medications for any work-related illness or injury, the *Plan* has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider*. If your *Provider* bills services or medications to the *Plan* for any work-related illness or injury, please contact the *Tufts Health Plan* Liability to Recovery Department at 1-888-880-8699, x. 21098.

Future Benefits

If you fail to cooperate with and reimburse the *Plan*, the health plan may deny any future benefit payments on any other claim made by your until the plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Coordination of Benefits

Constructive Trust

By accepting benefits from the *Plan* (whether the payment of such benefits is made to you directly or made on your behalf, for example, to a *Provider*), you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness or condition, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the *Plan.*

Application and Purpose

The coordination of benefits (COB) program applies when you are also covered by other plans for hospital, medical, dental or other health care expenses. These plans include: personal injury insurance and medical benefits provisions of motor vehicle policies; group and non-group insurance contracts, health maintenance organization contracts (HMO), closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); student health insurance policies; medical care component of long-term care contracts, such as skilled nursing care; and Medicare or any other federal government plan, as permitted by law . The COB program prevents duplication of payments for the same health care services. *Tufts HP* will coordinate all benefits described in this *Description of Benefits* with other plans for the *Plan*, consistent with applicable law.

How COB works

The *Plan* will coordinate benefits by determining (a) which plan has the primary obligation to provide benefits to you when you make a claim (the primary plan); and (b) which plan has the secondary obligation to provide benefits (the secondary plan). These determinations will be made according to the following rules:

- **No COB Rule**
  A plan that does not contain COB rules that are consistent with the *Plan's* COB rules is always the primary plan.
- **COB Rule**
  When all plans which cover you have COB rules consistent with the *Plan's* COB rules, the rules listed below apply. Each plan determines the order of benefits using the first of the following rules that applies:
  - **Employee/Dependent Rule**
    The plan which covers the person as an employee, retiree, or *Subscriber* is primary to the plan which covers the person as a *Dependent*.

    Exception: If the person is a Medicare beneficiary and, under the Medicare Secondary Payer rules, Medicare is primary over the plan covering the person as an employee, retiree, or *Subscriber* and Medicare is secondary to the plan covering the person as a *Dependent,* then the order is reversed and the plan covering the person as a *Dependent* is primary and the plan covering the person as an employee, retiree, or *Subscriber* is secondary.
  - **Birthday Rule**
    If two or more plans cover a *Dependent Child* whose parents are not separated or divorced, the primary plan is that of the parent whose birth date (month and day only) occurs earlier in the *Benefit Year*. If both parents have the same birth date, the primary plan is that of the parent whose coverage has been in effect for the longest period of time.

Coordination of Benefits, continued

How COB works, continued

- **Children of Separated/Divorced Parents Rule**
  There may be a court decree which states that one of the parents is responsible for the health care expenses or insurance of the Child. If so, and the plan of the parent obligated to pay or provide benefits has actual knowledge of the terms of the court decree, that plan is primary only as of the time that that plan has such actual knowledge. If there is a court decree making both parents responsible for the health care expenses or insurance of the Child, the "Birthday Rule" applies. If there is a court decree granting joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the "Birthday Rule" applies.

  If two or more plans cover a *Dependent Child* whose parents are separated or divorced, and there is not a court decree addressing the responsibility for the health care expenses or insurance for the *Child,* the order of payment is:
  - the plan of the parent with custody of the *Child.*
  - the plan of the *Spouse* of the parent with custody of the *Child*.
  - the plan of the parent not having custody of the *Child*.
  - the plan of the *Spouse* of the parent not having custody of the *Child*.
- **Person Covered as a Child and Spouse Rule**
  For a person covered under one plan as a dependent child and another plan as a dependent spouse, the plan that has covered the person longer is primary.
- **COBRA Rule**
  The plan which covers the person pursuant to COBRA or a state continuation coverage law is secondary to a plan covering the person as an employee, retiree, or *Subscriber* (or that person's enrolled *Dependent*). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Active/Inactive Rule**
  The plan which covers an employee (or the employee's enrolled *Dependent*) who is neither laid off nor retired is primary to a plan that covers that person (or that person's enrolled *Dependent*) as a laid-off or retired employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Rule**
  If none of the above rules determine which plan is primary, the plan which has covered a person longer is primary. A person's length of coverage is measured from the person's first date of coverage under the plan. Two successive plans are treated as one if the covered person was eligible under the second plan within 24 hours after coverage under the first plan ended. The start of a new plan does not include a change in the amount or scope of benefits, a change in the entity that pays or administers benefits, or a change in the type of plan (such as, from a single employer plan to a multiple employer plan).

This *Plan* always pays secondary to:
- Any medical payment, PIP, or No-Fault coverage under any automobile policy available to you.
- Any plan or program which is required by law.

All *Subscribers* should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

Coordination of Benefits, continued

Medicare

When a person has Medicare, the *Plan* pays primary over Medicare when required to do so by federal law. In all other cases, the plan is secondary to Medicare and will only pay claims after Medicare. If you are eligible for Medicare due to age, disability or ESRD, but do not have Medicare because you failed to apply for it or you dropped it, the *Plan* will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The *Plan* will not pay any amounts that would have been paid by Medicare if you had properly applied for it. This applies to both Parts A and B of Medicare. If you enter into a private contract with a provider who has opted out of Medicare, the *Plan* will also estimate Medicare benefits and pay secondary benefits only. Call *Tufts HP's* Liability and Recovery Department at 1-888-880-8699, x. 21098 for more information on Medicare COB.

Right to receive and release necessary information

When you enroll, you must include information on your member application about other health coverage you have. After you enroll, you must notify *Tufts HP* of new coverage or termination of other coverage. *Tufts HP* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with the *Plan's* COB program.

You hereby assign to the *Plan* benefits which you may be entitled to receive because a party other than the *Plan* may be responsible for all or a portion of the cost of health care services paid or to be paid by the *Plan*.

Right to recover overpayment

The *Plan* may recover, from you or any other person or entity, any payments it made that are greater than payments it should have made under the COB program. The *Plan* will recover only overpayments it actually made.

For more information

For more information about COB, contact the *Tufts HP* Liability and Recovery Department at 1-888-880-8699, x. 21098. You can also call a Member Services Coordinator and have your call transferred to the *Tufts HP* Liability and Recovery Department.

Medicare Eligibility

When a *Subscriber* or an enrolled *Dependent* reaches age 65, that person may become entitled to Medicare based on his or her age. That person may also become entitled to Medicare under age 65 due to disability or end stage renal disease.

The *Plan* will pay benefits **before** Medicare:

- for you or your enrolled *Spouse*, if you or your *Spouse* are age 65 or older, if you are actively working and if your employer has 20 or more employees;
- for you or your enrolled *Dependent,* for the first 30 months you or your *Dependent* are eligible for Medicare due to end stage renal disease; or
- for you or your enrolled *Dependent,* if you are actively working, you or your *Dependent* are eligible for Medicare under age 65 due to disability, and your employer has 100 or more employees.

The *Plan* will pay benefits **after** Medicare:

- if you are age 65 or older and are not actively working;
- if you are age 65 or older and your employer has fewer than 20 employees;
- after the first 30 months you are eligible for Medicare due to end stage renal disease; or
- if you are eligible for Medicare under age 65 due to disability, but are not actively working or are actively working for an employer with fewer than 100 employees.

Note: In any of the circumstances described above, you will receive benefits for *Covered Services* that Medicare does not cover.

Use and Disclosure of Medical Information

For information about how *Tufts HP* uses and discloses your medical information, please contact a Member Services Coordinator. Information is also available on the *Tufts HP* Web site at www.tuftshealthplan.com.

For information about how your employer uses and discloses your medical information, please contact your employer.

Relationships between *Tufts HP* and *Providers*

Tufts HP* and *Providers

Tufts HP is an administrator of health care services. *Tufts HP* does not provide health care services. *Tufts HP* has agreements with *Providers* practicing in their private offices throughout the *Network Contracting Area*. These *Providers* are independent. They are not *Tufts HP* employees, agents or representatives. *Providers* are not authorized to:

- modify the *Plan*; or
- change this *Description of Benefits*; or
- assume or create any obligation for the *Plan* or *Tufts HP*.

Neither the *Plan* nor *Tufts HP* is liable for acts, omissions, representations or other conduct of any *Provider*.

Circumstances Beyond *Tufts Health Plan's* Reasonable Control

Tufts HP shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of *Tufts HP*. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services. In doing so, *Tufts HP* will take into account the impact of the event and the availability of *Network Providers*.

Limited Role of the Group

The role of Stonehill College is limited under this arrangement. Neither the College nor any employee involved in Plan Administration, has any duty or responsibility with respect to the quality of medical care, or lack thereof, provided through this contract with *Tufts Health Plan*. The principal roles of the College are determination of eligibility for membership, funding of benefits, establishing the level of contributions and collecting them from *Members*, and the determination of the terms of the contract between it and *Tufts Health Plan* or any successor to *Tufts Health Plan.*

Group Contract

Acceptance of the terms of the *Plan*

By completing the member application form, employees apply for coverage under the *Plan* and agree, on behalf of themselves and their enrolled *Dependents*, to all the terms and conditions of the *Plan*, including this *Description of Benefits*.

Payments

The *Plan* under which you are covered is a self-funded plan. This means that your *Group* is responsible for funding *Covered Services* for *Members* in accordance with the terms of the *Plan*. Under an administrative services agreement between the *Group* and *Tufts HP*, *Tufts HP* processes claims, disburses *Plan* funds and provides other *Covered Services* only when the Group has forwarded adequate funds to *Tufts HP* to pay for *Covered Services*. This is the case even if the *Group* has charged you (for example, by withholding from your paycheck) for some or all of the cost of coverage under the *Plan*. If the *Group* fails to provide adequate funds for claims payment, *Tufts HP* has no responsibility to pay claims.

Revisions to the *Plan* and this *Description of Benefits*

The *Group* may revise the *Plan* and this *Description of Benefits* in accordance with the terms of the *Plan*. Revisions do not require the consent of *Members*. Notice of Tufts HP revisions will be sent to the *Group* and will include the effective date of the revision. The *Group* or *Plan Administrator* is responsible for notifying the *Members* of revisions. *Tufts HP* is not responsible if the *Group* does not so notify *Members*. Any revisions will apply to all *Members* covered under the *Plan* on the effective date of the revision.

Notice

Notice to *Members*: When *Tufts HP* sends a notice to you, it will be sent to your last address on file with *Tufts HP*.

Notice to *Tufts HP*: *Members* should address all correspondence to:

Tufts Health Plan
Member Services
P.O. Box 9166
Watertown, MA 02471-9166

Enforcement of terms

Tufts HP may choose to waive certain terms of the *Group Contract*, if applicable, including this *Description of Benefits*. This does not mean that *Tufts HP* gives up its rights to enforce those terms in the future.

Appendix A

Glossary of Terms

Terms and Definitions

Adoptive Child
A *Child* is an *Adoptive Child* as of the date he or she:

- is legally adopted by the *Subscriber*; or
- is placed for adoption with the *Subscriber*. This means that the *Subscriber* has assumed a legal obligation for the total or partial support of a *Child* in anticipation of adoption. If the legal obligation ceases, the *Child* is no longer considered placed for adoption.

Note: As required by applicable law, a foster child is considered an *Adoptive Child* as of the date that a petition to adopt was filed.

Annual Coverage Limitations
Annual dollar or time limitations on *Covered Services*.

Authorized Reviewer
Authorized Reviewers review and approve certain services and supplies to *Members*. They are:

- *Tufts HP's* Chief Medical Officer (or equivalent); or
- someone he or she names.

Behavioral Health Disorders
Psychiatric illnesses or diseases listed as behavioral health disorders in the latest edition, at the time treatment is provided, of the American Psychiatric Association's *Diagnostic and Statistical Manual: Behavioral Health Disorders.*

Benefit Year
The 12-month period of time in which benefit limits, *Out-of-Pocket Maximums*, and *Coinsurance* are calculated.

Child
The following individuals the last day of the month in which the *Child's* 26th birthday occurs:

- the *Subscriber's* or *Spouse's* natural child*,* stepchild*, or Adoptive* Child*;* or
- the *Child* of an enrolled child; or
- any other *Child* for whom the *Subscriber* has legal guardianship.

Coinsurance
The *Member's* share of costs for *Covered Services*.

- For services provided by a *Network Provider*, the *Member's* share is a percentage of
  - the applicable *Network* fee schedule amount for those services; or
  - the *Network Provider's* charges, whichever is less.

For services provided by a *Non-Network Provider*, the *Member* pays a share of *Reasonable Charges*. The *Member* is responsible for costs in excess of the *Reasonable Charge.*

Note: The *Member's* share percentage is based on the *Tufts HP Provider* payment at the time the claim is paid, and does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.

See "Benefit Overview" at the front of this *Description of Benefits* for more information.

Copayment
The *Member's* payment for certain *Covered Services* provided by a *Network Provider*. The *Member* pays *Copayments* to the *Provider* at the time services are rendered, unless the *Provider* arranges otherwise. *Copayments* are not included in the *Deductible or Coinsurance* or *Out-of-Pocket Maximum.*.

Cost Sharing Amount
The cost you pay for certain *Covered Services*. This amount may consist of *Deductibles*, *Copayments*, and/or *Coinsurance*.

Covered Service
The services and supplies for which the *Plan* will pay. They must be:
- described in Chapter 3 of this *Description of Benefits* (subject to the "Exclusions from Benefits" section in Chapter 3);
- *Medically Necessary*; and
- in some cases, approved by an *Authorized Reviewer*.

These services include *Medically Necessary* coverage of pediatric specialty care, including behavioral health care, by *Providers* with recognized expertise in specialty pediatrics.

Note: *Covered Services* include any surcharges on the plan, such as the Massachusetts Health Safety Net Trust Fund or New York Health Care Reform Act surcharges, or later billed charges under provider network agreements, such as supplemental provider payments or access fee arrangements.

Covering *Provider*
A *Provider* designated by a *Tufts HP Provider* to provide or authorize services to *Members* in the *Tufts HP Provider's* absence.

Custodial Care
- Care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- care provided primarily for maintaining the Member's or anyone else's safety, when no other aspects of treatment require an acute hospital level of care;
- services that could be provided by people without professional skills or training;
- routine maintenance of colostomies, ileostomies, and urinary catheters; or
- adult and pediatric day care.

In cases of behavioral health care or substance use disorder care, *Inpatient* care or intermediate care provided primarily:
- for maintaining the *Member's* or anyone else's safety; or
- for the maintenance and monitoring of an established treatment program,

when no other aspects of treatment require an acute hospital level of care or intermediate care.

Note: *Custodial Care* is not covered by the *Plan*.

Day Surgery
Any surgical procedure(s) provided to a *Member* at a facility licensed by the state to perform surgery, and with an expected departure the same day, or in some instances, within twenty-four hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care".

Deductible
For each *Benefit Year*, the amount paid by the *Member* for *Covered Services* not provided by a *Network Provider* before any payments are made under this *Description of Benefits*. (Any amount paid by the *Member* for a *Covered Service* rendered during the last 6 months of a *Benefit Year* shall be carried forward to the next *Benefit Year's Deductible*. This amount carried does apply towards the next *Benefit Year*'s *Out-of-Pocket Maximum.*) *Copayments* do not count toward the *Deductible*. See "Benefit Overview" at the front of this *Description of Benefits* for more information.

Note: The amount credited towards the *Member's Deductible* is based on the *Network Provider* negotiated rate at the time the services are rendered and does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.

See "Benefit Overview" at the front of this *Description of Benefits* for more information.

Dependent
The *Subscriber's Spouse*, *Child*, or *Disabled Dependent*.

Description of Benefits
This document, and any future amendments, which describes the Preferred Provider Option you have selected under the *Plan*.

Developmental
Refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.

Directory of Health Care Providers
A separate booklet which lists *Network* physicians and their affiliated *Network Hospital(s)* and certain other *Network Providers*.

This directory is updated from time to time to reflect changes in *Network Providers*. For information about the *Providers* listed in the *Directory of Health Care Providers*, call Member Services or check *Tufts HP's* Web site at **www.tuftshealthplan.com**.

Disabled Dependent
The *Subscriber's Child* who:

- became permanently physically or mentally disabled before the last day of the month in which the *Child's* 26th birthday occurs;
- is incapable of supporting himself or herself due to disability;
- lives with the *Subscriber* or *Spouse*; and
- was covered under the *Subscriber's Family Coverage* immediately the last day of the month in which the *Child's* 26th birthday occurs; or has been covered by other group health coverage since the disability began.

Durable Medical Equipment
Devices or instruments of a durable nature that:

- are reasonable and necessary to sustain a minimum threshold of independent daily living;
- are made primarily to serve a medical purpose;
- are not useful in the absence of illness or injury;
- can withstand repeated use; and
- can be used in the home.

Effective Date
The date, according to the *Plan's* records, when you became a *Member* and were first eligible to receive *Covered Services* administered by *Tufts HP*.

Emergency

An illness or medical condition, whether physical, behavioral, related to behavioral health or substance use disorder , or behavioral health, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of prompt medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- serious jeopardy to the physical and/or behavioral health of a *Member* or another person (or with respect to a pregnant *Member,* the *Member's* or her unborn child's physical and/or behavioral health); or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another hospital before delivery, or a threat to the safety of the *Member* or her unborn child in the event of transfer to another hospital before delivery.

Some examples of illnesses or medical conditions requiring *Emergency* care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly getting much worse.

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered *Experimental or Investigative* and therefore, not *Medically Necessary*, if any of the following apply:

- the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished;
- the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval;
- reliable scientific evidence shows that the treatment: is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis;
- evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe;
- even if approved for lawful marketing by the U.S. Food and Drug Administration, reliable scientific evidence does not support that the treatment is effective in improving health outcomes or that appropriate patient selection has been determined;
- the peer- reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled or cohort studies, or there are few or no well-designed randomized, controlled trials; or
- there is no scientific or clinical evidence that the treatment is at least as beneficial as any established evidence-based alternatives.

This definition is fully explained in the corresponding Medical Necessity Guidelines

Family Coverage

Coverage for a *Subscriber* and his or her *Dependents*.

Group

The employer who sponsors the *Plan*, contracts with *Tufts HP* for the provision of certain services and the availability of Network Providers to the *Plan*, and who is responsible for funding all *Covered Services* under the *Plan* and described in this *Description of Benefits*.

A *Group* subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the plan sponsor under ERISA. The *Group* is your agent and is not *Tufts HP's* agent.

Group Contract
The agreement between *Tufts HP* and the *Group* under which *Tufts HP* agrees to provide certain administrative services, and the *Group* agrees to pay *Tufts HP* for these services.

The *Group Contract* includes this *Description of Benefits* and any amendments.

Individual Coverage
Coverage for a *Subscriber* only (no *Dependents*).

In-Network Level of Benefits
The level of benefits that a *Member* receives when *Covered Services* are provided by a *Network Provider*. See Chapter 1 for more information.

Inpatient
A patient who is admitted to a hospital or other facility licensed to provide continuous care; and classified as an *Inpatient* for all or a part of the day.

Inpatient Notification (formerly known as "Preregistration")
Tufts Health Plan's process of validating all information required for all *Inpatient* admissions and transfers. *Inpatient Notification* is not a guarantee of payment. See Chapter 1 for more information

Limited Service Medical Clinic
A walk-in medical clinic licensed to provide limited services, generally based in a retail store. Care is provided by a nurse practitioner or physician assistant. A *Limited Service Medical Clinic* offers an alternative to certain emergency room visits for a *Member* who requires less emergent care or who is not able to visit his or her *Primary Care Provider* in the time frame that is felt to be warranted by their condition or symptoms. Some examples of common illnesses a *Limited Service Medical Clinic* can treat include strep throat, or eye, ear, sinus, or bronchial infections. The services provided by a *Limited Service Medical Clinic* are only available to patients of ages 24 months or older. A *Limited Service Medical Clinic* does not provide *Emergency* or wound care, or treatment for injuries. It is not appropriate for people who need x-rays or stitches or who have life-threatening conditions. *Members* experiencing these conditions should go to an emergency room.

Medically Necessary
A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply:

- is the most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual;
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- for services and interventions not in widespread use, is based on scientific evidence.

In determining coverage for *Medically Necessary* services, *Tufts HP* uses *Medical Necessity* Guidelines which are:

- developed with input from practicing *Providers* in the *Network Contracting Area*;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- scientific evidence-based, if practicable.

Member
An employee or *Dependent* who is covered under the *Plan* and therefore entitled to all benefits in accordance with the *Plan*. Also referred to as "you".

Network Contracting Area

The geographic area within which *Tufts HP* has developed or arranged for a network of *Providers* to afford *Members* with adequate access to *Covered Services*.

Note: For information about *Providers* in the *Network Contracting Area*, call *Tufts HP* Member Services or check *Tufts HP's* Web site at **www.tuftshealthplan.com**.

Network Hospital

A hospital which has an agreement either with *Tufts Health Plan* directly or with a provider network with whom *Tufts HP* has a contract to provide certain *Covered Services* to *Members*. *Network Hospitals* are independent. They are not owned by *Tufts Health Plan*. *Network Hospitals* are not *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees.

Network Hospitals are subject to change.

Network Provider

A *Provider* who has an agreement either with *Tufts Health Plan* directly or with a provider network with which *Tufts HP* has a contract to provide *Covered Services* to *Members*. *Network Providers* are located throughout the *Network Contracting Area*.

Non-Conventional Medicine

A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the *Tufts Health Plan* definition of *Medical Necessity* and are not covered. Providers of these non-covered services may be contracting or non-contracting traditional medical providers. These services may be offered in conjunction with a traditional office visit. Providers of *Non-Conventional Medicine* services often request payment up front because health insurance typically does not cover these services.

Common terminology used to refer to these types of services include, but are not limited to, "alternative medicine", "complementary medicine", "integrative medicine", "functional health medicine", and may be described as treating "the whole person", "the entire individual", or "the inner self", and may refer to re-balancing hormones or finding underlying causes that lead to bodily dysfunction. Examples of *Non-Conventional Medicine* and related services include, but are not limited to:

- holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields);
- manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi);
- mind-body medicine (e.g., hypnotherapy, meditation, stress management);
- whole medicine systems (e.g., naturopathy, homeopathy);
- biologically based practices (e.g., herbal medicine, dietary supplements, probiotics); and
- other related practices when provided in connection with *Non-Conventional Medicine* services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).

Non-Network Provider

A *Provider* who does not have an agreement either with *Tufts Health Plan* directly or with a provider network with which *Tufts HP* has a contract to provide *Covered Services* to *Members*.

Notification Penalty (formerly known as "Preregistration Penalty")

The amount a *Member* will be required to pay if he or she does not follow the *Inpatient Notification* guidelines described in Chapter 1. The *Notification Penalty* does not count toward *Coinsurance, Deductibles*, or the *Out-of-Pocket Maximum.* The *Notification Penalty* is shown in "Benefit Overview" at the front of this *Description of Benefits.*

Observation

The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within forty-eight (48) or a verified diagnosis and concurrent treatment plan. At times, an *Observation* stay may be followed by an *Inpatient* admission to treat a diagnosis revealed during the period of *Observation.*

Open Enrollment Period
If applicable to the *Plan*, the period of time each year when eligible employees are allowed to apply for or change coverage under the *Plan*.

Outpatient
A patient who receives care other than on an *Inpatient* basis. This includes services provided in a *Provider's* office; a *Day Surgery* or ambulatory care unit; and an Emergency room or *Outpatient* clinic.

Note: You are also an *Outpatient* when you are in a facility for observation.

Out-of-Network Level of Benefits
The level of benefits that a *Member* receives when care is not provided by a *Network Provider*. See "Benefit Overview" at the front of this *Description of Benefits* for more information.

Out-of-Pocket Maximum
The maximum amount of money paid by a *Member* during a *Benefit Year* for *Covered Services.* The *Out-of-Pocket Maximum* consists of *Copayments,* the *Deductible* and *Coinsurance*. It does not include *Notification Penalty,* costs in excess of the *Reasonable Charge* for *Covered Services* received at the *Out-of-Network Level of Benefits*, or costs for health care services that are not *Covered Services* under the *Plan*.

Note: Once you have met your *Out-of-Pocket Maximum* in a *Benefit Year*, you continue to pay for any costs in excess of the *Reasonable Charge.*

See "Benefit Overview" at the front of this *Description of Benefits* for more information.

Plan
The employee health benefits plan established and maintained by the *Group*. This *Description of Benefits* only describes one health benefits option under the *Plan*. For a description of other health benefit options under the *Plan*, see your *Plan Administrator*.

Plan Administrator
The person(s) or entity designated by the *Plan* as the *Plan Administrator* is Jeanne Finlayson .or, if not so designated, the *Group*. *Tufts HP* is not the *Plan Administrator*.

Provider
A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, *Limited Service Medical Clinics* (if available), *Urgent Care Centers* (if available), physicians, doctors of osteopathy, physician assistants, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed behavioral health counselors, licensed independent clinical social workers, licensed marriage and family therapists, and licensed psychiatric nurses who are certified as clinical specialists in psychiatric and behavioral health nursing, licensed speech-language pathologists and licensed audiologists.

The *Plan* will only cover services of a *Provider* if those services are listed as *Covered Services* and within the scope of the *Provider's* license.

Reasonable Charge
The lesser of the:
- amount charged by the *Non-Network Provider*; or
- amount that we determine to be reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to: Medicare fee schedules and allowed amounts, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.

Note: The amount the *Member* pays in excess of the *Reasonable Charge* is not included in the *Deductible*, *Coinsurance* or *Out-of-Pocket Maximum*.

Terms and Definitions, continued

Routine Nursery Care
Routine hospital care provided to a well newborn *Child* immediately following birth until discharge from the hospital.

Skilled
A type of care which is *Medically Necessary* and must be provided by, or under the direct supervision of, licensed medical personnel. *Skilled* care is provided to achieve a medically desired and realistically achievable outcome.

Spouse
The *Subscriber's* legal spouse, according to the law of the state in which you reside.

Subscriber
The person who is employed by the *Group* for at least the minimum number of hours specified in Chapter 2 and enrolls in *Tufts Health Plan* and signs the member application form on behalf of himself or herself and any *Dependents*.

Tufts Health Plan or Tufts HP
Tufts Benefit Administrators, Inc., a Massachusetts corporation d/b/a *Tufts Health Plan*. *Tufts Health Plan* enters into arrangements with *Groups* or payors underwriting health benefit plans to make available a network of *Providers* and to provide certain administrative services to the health benefit plans including, but not limited to, processing claims for benefits. *Tufts HP* is not the *Plan Administrator* and does not insure the *Plan*. Also referred to as “we”, “us”, and “our”.

Urgent Care
Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety, or symptoms of a urinary tract infection.

Note: Care that is rendered after the *Urgent* condition has been treated and stabilized and the *Member* is safe for transport is not considered *Urgent Care*.

Urgent Care Center
A medical facility (or clinic or medical practitioner office) that provides treatment for *Urgent Care* services (see definition of *Urgent Care*). An *Urgent Care Center* primarily treats patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. An *Urgent Care Center* offers an alternative to certain emergency room visits for a *Member* who is not able to visit his or her *Primary Care Provider* or health care *Provider* in the time frame that is felt to be warranted by their condition or symptoms. An *Urgent Care Center* does not provide *Emergency* care, and is not appropriate for people who have life-threatening conditions. *Members* experiencing these conditions should go to an emergency room. To find an *Urgent Care Center* in the *Tufts Health Plan* network, please visit the website at www.tuftshealthplan.com, and click on “Find a Doctor”.

You, Your
This term has the following meaning in this *Description of Benefits*, regardless of whether it is capitalized: the *Member*.

Appendix B - ERISA Information and other State and Federal Notices

ERISA RIGHTS

If your plan is an ERISA plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Most plans are ERISA plans, but not all. Please contact your plan administrator to determine if your plan is an ERISA plan.

ERISA provides that all plan participants shall be entitled to:

- receive information about their benefit overview;
- continue group health plan coverage; and
- prudent actions by plan fiduciaries.

Receiving Information About Your Benefit Overview

ERISA provides that all plan participants shall be entitled to:

- examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuing Group Health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

- continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.
- review your summary plan description and the documents governing the plan for the rules governing your continuation coverage rights under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit

ERISA Rights, continued

in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone director, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PROCESSING OF CLAIMS FOR PLAN BENEFITS

The Department of Labor's (DOL) Employee Benefits Security Administration has published benefit determination procedure regulations for employee benefit plans governed under ERISA. The regulations set forth requirements with respect to the processing of claims for plan benefits, including urgent care claims, pre-service claims, post-service claims and review of claims denials.

Who can submit a claim?

The DOL Regulations apply to claims submitted by ERISA participants or their beneficiaries. In accordance with the regulations, Tufts Health Plan permits an authorized representative (referred to here as the "authorized claimant") to act on your behalf in submitting a claim or obtaining a review of a claim decision. An authorized claimant can be any individual (including, for example, a family member, an attorney, etc.) whom you designate to act on your behalf with respect to a claim for benefits.

How do I designate an Authorized Claimant?

An authorized claimant can be designated at any point in the claims process – at the pre-service, post service or appeal level. Please contact a Tufts Health Plan Member Services Coordinator at 1-800-462-0224 for the specifics on how to appoint an authorized claimant.

Types of claims

There are several different types of claims you may submit for review. Tufts HP's procedures for reviewing claims depends upon the type of claim submitted (urgent care claims, pre-service claims, post-service claims, and concurrent care decisions).

Urgent care claim: An "urgent care claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon our provider's determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested. For urgent care claims, Tufts HP will respond to you within 72 hours after receipt of the claim. If Tufts HP determines that additional information is needed to review your claim, we will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hours after that time to provide the requested information. Tufts HP will evaluate your claim within 48 hours after the earlier of our receipt of the requested information, or the end of the extension period given to you to provide the requested information.

PROCESSING OF CLAIMS FOR PLAN BENEFITS, continued

Types of claims, continued

Concurrent care decision: A "concurrent care decision" is a determination relating to the continuation/reduction of an ongoing course of treatment. If Tufts HP has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, Tufts HP will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the decision and obtain a determination before the treatment is reduced or terminated. If you request to extend an ongoing course of treatment that involves urgent care, Tufts HP will respond to you within 24 hours after receipt of the request (provided that you make the request at least 24 hours prior to the expiration of the ongoing course of treatment). If you reach the end of a pre-approved course of treatment before requesting additional services, the "pre-service" and "post-service" time limits will apply.

Pre-service claim: A "pre-service claim" is a claim that requires approval of the benefit in advance of obtaining the care. For pre-service claims, Tufts HP will respond to you within 15 days after receipt of the claim. If Tufts HP determines that an extension is necessary due to matters beyond our control, we will notify you within 15 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a pre-service claim, but do not submit enough information for Tufts HP to make a determination, we will notify you within 15 days and describe the information that you need to provide to Tufts HP. You will have no less than 45 days from the date you receive the notice to provide the requested information.

Post-service claim: A "post-service claim" is a claim for payment for a particular service after the service has been provided. For post-service claims, Tufts HP will respond to you within 30 days after receipt of the claim. If Tufts HP determines than an extension is necessary due to matters beyond our control, we will notify you within 30 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a post-service claim, but do not submit enough information for Tufts HP to make a determination, we will notify you within 30 days and describe the information that you need to provide to Tufts HP. You will have no less than 45 days from the date you receive the notice to provide the requested information.

If your request for coverage is denied, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans or issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay or up to 48 hours (or 96 hours). However, to use certain providers or facilities, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Note: The Family and Medical Leave Act only applies to groups with 50 or more employees.

Under the Family and Medical Leave Act of 1993 (FMLA), if an employee meets the eligibility requirements, that employee is legally allowed to take up to 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- for the birth and care of the newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the employee is unable to work because of a serious health condition.

The FMLA was amended to add two new leave rights related to military service, effective January 16, 2009:

- Qualifying Exigency Leave: Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. Effective October 28, 2009, deployment to a foreign country was added as a requirement for exigency leave.
- Military Caregiver Leave: An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in single 12-month period to care for the service member. The employee is entitled to a combined total of 26 weeks for all types of FMLA leave in the single 12-month period. Effective March 8, 2013, the definition of "covered service member" was expanded to include certain veterans.

In order to be eligible, the employee must have worked for his or her employer for a total of 12 months and worked at least 1,250 hours over the previous 12 months.

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance contributions while on leave. In some instances, the employer may recover contributions it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

An employee should contact his or her employer for details about FMLA and to make payment arrangements, if applicable. Additional information is also available from the U.S. Department of Labor: 1-866-487-9243, TTY: 1-877-899-5627 or www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf.

PATIENT PROTECTION DISCLOSURE

This plan generally requires the designation of a *Primary Care Provider*. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a *Primary Care Provider,* and for a list of the participating *Primary Care Providers,* contact Member Services or see our Web site at www.tuftshealthplan.com.

For *Children*, you may designate a pediatrician as the *Primary Care Provider.*

You do not need prior authorization from *Tufts Health Plan* or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or see our Web site at www.tuftshealthplan.com

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Tufts Health Plan is committed to safeguarding the privacy of our members' protected health information ("PHI"). PHI is information which:

- identifies you (or can reasonably be used to identify you); and
- relates to your physical or mental/behavioral health or condition, the provision of health care to you or the payment for that care.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use, and disclose your PHI, and your rights concerning your PHI. This Notice applies to all members of Tufts Health Plan's insured health benefit plans (including HMO plans; Tufts Health Plan Medicare Preferred plans; and insured POS and PPO plans. It also applies to all members of health plans insured by Tufts Insurance Company (a Tufts Health Plan affiliate)). Unless your employer has notified you otherwise, this Notice of Privacy Practices also applies to all members of self-insured group health plans that are administered by a Tufts Health Plan entity.

How We Obtain PHI

As a managed care plan, we engage in routine activities that result in our being given PHI from sources other than you. For example, health care providers – such as physicians and hospitals – submit claim forms containing PHI to enable us to pay them for the covered health care services they have provided to you.

How We Use and Disclose Your PHI

We use and disclose PHI in a number of ways to carry out our responsibilities as a managed care plan. The following describes the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

- **Treatment:** We may use and disclose your PHI to health care providers to help them treat you. For example, our care managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from a hospital.
- **Payment Purposes:** We use and disclose your PHI for payment purposes, such as paying doctors and hospitals for covered services. Payment purposes also include activities such as: determining eligibility for benefits; reviewing services for medical necessity; performing utilization review; obtaining premiums; coordinating benefits; subrogation; and collection activities.
- **Health Care Operations:** We use and disclose your PHI for health care operations. For example, this includes coordinating/managing care; assessing and improving the quality of health care services; reviewing the qualifications and performance of providers; reviewing health plan performance; conducting medical reviews; and resolving grievances. It also includes business activities such as: underwriting; rating; placing or replacing coverage; determining coverage policies; business planning; obtaining reinsurance; arranging for legal and auditing services (including fraud and abuse detection programs); and obtaining accreditations and licenses. We do not use or disclose PHI that is genetic information for underwriting purposes.
- **Health and Wellness Information:** We may use your PHI to contact you with information about: appointment reminders; treatment alternatives; therapies; health care providers; settings of care; or other health-related benefits, services and products that may be of interest to you. For example, we might send you information about smoking cessation programs, or we might send a mailing to subscribers approaching Medicare eligible age with materials describing our senior products and an application form.
- **Organizations That Assist Us:** In connection with treatment, payment and health care operations, we may share your PHI with our affiliates and third party "business associates" that perform activities for us or on our behalf, for example, our pharmacy benefit manager. We will obtain assurances from our business associates that they will appropriately safeguard your information.

How We Use and Disclose Your PHI – continued

- **Plan Sponsors:** If you are enrolled in Tufts Health Plan through your current or former place of work, you are enrolled in a group health plan. We may disclose PHI to the group health plan's sponsor – usually your employer – for plan administration purposes. A plan sponsor of an insured health benefit plan must certify that it will protect the PHI in accordance with law.
- **Public Health and Safety; Health Oversight:** We may disclose your PHI: to a public health authority for public health activities, such as responding to public health investigations; when authorized by law, to appropriate authorities, if we reasonably believe you are a victim of abuse, neglect or domestic violence; when we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to your or others' health or safety; or to health oversight agencies for certain activities such as: audits; disciplinary actions; and licensure activity.
- **Legal Process; Law Enforcement; Specialized Government Activities:** We may disclose your PHI in the course of legal proceedings; in certain cases, in response to a subpoena, discovery request or other lawful process; to law enforcement officials for such purposes as responding to a warrant or subpoena; or for specialized governmental activities such as national security.
- **Research; Death; Organ Donation:** We may disclose your PHI to researchers, provided that certain established measures are taken to protect your privacy. We may disclose PHI, in certain instances, to coroners, medical examiners and in connection with organ donation.
- **Workers' Compensation:** We may disclose your PHI when authorized by workers' compensation laws.
- **Family and Friends:** We may disclose PHI to a family member, relative, or friend – or anyone else you identify – as follows: (i) when you are present prior to the use of disclosure and you agree; or (ii) when you are not present (or you are incapacitated or in an emergency situation) if, in the exercise of our professional judgment and in our experience with common practice, we determine that the disclosure is in your best interests. In these cases, we will only disclose the PHI that is directly relevant to the person's involvement in your health care or payment related to your health care.
- **Personal Representatives:** Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or health care benefits. For example, an individual named in a durable power of attorney or a parent or guardian of an unemancipated minor are personal representatives.
- **Communications:** We will communicate information containing your PHI to the address or telephone number we have on record for the subscriber of your health benefits plan. Also, we may mail information containing your PHI to the subscriber. For example, communication regarding member requests for reimbursement may be addressed to the subscriber. We will not make separate mailings for enrolled dependents at different addresses, unless we are requested to do so and agree to the request. See below "Right to Receive Confidential Communications: for more information on how to make such a request.
- **Required by Law:** We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

If one of the above reasons does not apply, we will not use or disclose your PHI without your written permission ("authorization"). You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may later change your mind and revoke your authorization in writing. However, your written revocation will not affect actions we've already taken in reliance on your authorization. Where state or other federal laws offer you greater privacy protections, we will follow those more stringent requirements. For example, under certain circumstances, records that contain information about: alcohol abuse treatment; drug abuse prevention or treatment; AIDS-related testing or treatment; or certain privileged communications, may not be disclosed without your written authorization. In addition, when applicable, we must have your written authorization before using or disclosing medical or treatment information for a member appeal. See below "Who to Contact for Questions or Complaints" if you would like more information.

How We Protect PHI Within Our Organization

Tufts Health Plan protects oral, written and electronic PHI throughout our organization. We do not sell PHI to anyone. We have many internal policies and procedures designed to control and protect the internal security of your PHI. These policies and procedures address, for example, use of PHI by our employees. In addition, we train all employees about these policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws.

Your Individual Rights

The following is a summary of your rights with respect to your PHI:

- **Right of Access to PHI:** You have the right to inspect and get a copy of most PHI Tufts Health Plan has about you, or a summary explanation of PHI if agreed to in advance by you. Requests must be made in writing and reasonably describe the information you would like to inspect or copy. If your PHI is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable cost-based fee for paper or electronic copies as established by state or federal law. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice of denial describing the basis of our denial. You may request that we send a copy of your PHI directly to another person that you designate. Your request must be in writing, signed by you, and clearly identify the person and the address where the PHI should be sent.
- **Right to Request Restrictions:** You have the right to ask that we restrict uses or disclosures of your PHI to carry out treatment, payment and health care operations, and disclosures to family members or friends. We will consider the request. However, we are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made verbally or in writing to Tufts Health Plan.
- **Right to Receive Confidential Communications:** You have the right to ask us to send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the subscriber's address. We will accommodate your request if: you state that disclosure of your PHI through our usual means could endanger you; your request is reasonable; it specifies the alternative means or location; and it contains information as to how payment, if any, will be handled. Requests may be made verbally or in writing to Tufts Health Plan.
- **Right to Amend PHI:** You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to Tufts Health Plan and must include a reason to support the requested amendment.
- **Right to Receive an Accounting of Disclosures:** You have the right to a written accounting of the disclosures of your PHI that we made in the last six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to: (i) disclosures we made for treatment, payment or health care operations; (ii) disclosures made to you or people you have designated; (iii) disclosures you or your personal representative have authorized; (iv) disclosures made before April 14, 2003; and (v) certain other disclosures, such as disclosures for national security purposes. IF you request an accounting more than once in a 12-month period, we may charge you a reasonable fee. All requests for an accounting of disclosures must be made in writing to Tufts Health Plan.
- **Right to authorize other use and disclosure:** You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- **Right to receive a privacy breach notice:** You have the right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.
- **Right to this notice:** You have a right to receive a paper copy of this Notice from us on request.

Your Individual Rights – continued

- **How to Exercise Your Rights:** To exercise any of the individual rights described above or for more information, please call a Member Services Coordinator at 1-800-462-0224 (TDD: 1-800-815-8580) or write to:

  Compliance Department
  Tufts Health Plan
  705 Mount Auburn Street
  Watertown, MA 02472-1508

Effective Date of Notice

This Notice takes effect August 1, 2013. We must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to privacy of your medical information.

Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that we maintain – whether created or received before or after the effective date for the new Notice. Whenever we make an important change, we will publish the updated Notice on our Web site at www.tuftshealthplan.com. In addition, we will use one of our periodic mailings to inform subscribers about the updated Notice.

Who to Contact for Questions or Complaints

If you would like more information or a paper copy of this Notice, please contact a Member Services Coordinator at the number listed above. You can also download a copy from our Web site at www.tuftshealthplan.com. If you believe your privacy rights may have been violated, you have a right to complain to Tufts Health Plan by calling the Privacy Officer at 1-800-208-9549 or writing to:

Privacy Officer
Compliance Department
Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508

You also have a right to complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Tufts Associated Health Maintenance Organization, Inc., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., and Tufts Insurance Company do business as Tufts Health Plan. Tufts Health Plan is a registered trademark of Tufts Associated Health Maintenance Organization, Inc.

Massachusetts Mental Health Parity Laws and The Federal Mental Health Parity and Addiction Equity Act (MHPAEA)

This is to inform you about your Tufts Health Plan benefits for mental/behavioral health and substance use disorder services.

Under both Massachusetts laws and federal laws, benefits for mental/behavioral health services and substance use disorder services must be comparable to benefits for medical/surgical services. This means that copays, coinsurance and deductibles for mental/behavioral health and substance use disorder services must be at the same level as those for medical/surgical services. Also, Tufts Health Plan's review and authorization of mental/behavioral health or substance use disorder services must be handled in a way that is comparable to the review and authorization of medical/surgical services.

If Tufts Health Plan makes a decision to deny or reduce authorization of a service, you will receive a letter explaining the reasons for the denial or reduction. At your request, Tufts Health Plan will send you or your provider a copy of the criteria used to make this decision.

If you think that Tufts Health Plan is not handling your benefits in accordance with this notification, you may file a complaint with the Division of Insurance (DOI) Consumer Services Section.

You may file a written complaint using the DOI's Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI's webpage at http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html.

You may also submit a complaint by phone by calling 877-563-4467 or 617-521-7794. If you submit a complaint by phone, you must follow up in writing and include your name and address, the nature of your complaint, and your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an appeal under your Tufts Health Plan coverage. You must also file an appeal with Tufts Health Plan in order to have a denial or reduction of coverage of a service reviewed. This may be necessary to protect your right to continued coverage of treatment while you wait for an appeal decision. Follow the appeal procedures outlined in your Tufts Health Plan benefit document for more information about filing an appeal.

ANTI-DISCRIMINATION NOTICE

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

Tufts Health Plan:

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

If you need these services, contact Tufts Health Plan at 800.462.0224.

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

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, TTY number — 800.439.2370 or 711
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

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

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

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

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

tuftshealthplan.com | 800.462.0224