Stonehill College

Exclusive 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 are 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 ARE 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
P.O. Box 9170
Watertown, Massachusetts 02471-9170

Hours: Monday through Thursday 8:00 am - 7:00 pm
Friday 8:00 am - 5:00 pm

IMPORTANT PHONE NUMBERS:

Emergency Care

For routine care, you should always call your *Primary Care Provider* (*PCP*) before seeking care. If you have an urgent medical need and cannot reach your *PCP* or your *PCP's Covering 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, assistance in choosing a *PCP*, 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 HP* 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, call711. 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. برای ترجمه رایگان فارسی به شماره تلفن مندرج در کارت شناسائی تان زنگ بزنید

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.

TDD Telecommunications Device for the Deaf
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 55063-000; ERISA Plan 502
***Tufts Health Plan* Effective Date**	This *Plan* became effective as of July 1, 2009.
***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.

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.

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Benefit Overview

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

COPAYMENTS

- *Emergency* Care:
  - Emergency room.....$250.

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.

- Other *Covered Services*:
  - *PCP* Office Visit or visit to an *Urgent Care Center*.....$20.
  - Specialist Office Visit.....$25.
  - *Inpatient* Services.....$300.
  - *Day Surgery*.....$200.

Note: For certain *Outpatient* services listed as "covered in full" in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. 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.* Please see the following Benefit Overview chart for more information. Also, please note that *Copayments* for *Urgent Care* services vary depending upon the location in which services are rendered (for example, *Provider's* office, *Limited Service Medical Center*, *Urgent Care Center*, or *Emergency* room).

OUT-OF-POCKET MAXIMUM

This *Description of Benefits* has an individual *Out-of-Pocket Maximum* of $3,000 per *Member* per *Benefit Year* for all *Covered Services*.

Your family (two or more *Members*) *Out-of-Pocket Maximum* is $3,000 per *Member* and $6,000 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*. However, no one family member will pay more than their $3,000 individual *Out-of-Pocket Maximum* towards the family *Out-of-Pocket Maximum* per *Benefit Year*.

The following amounts do not count towards your *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*.

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. 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 detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
Emergency Care	
Treatment in an Emergency room	Emergency room *Copayment*. (waived if admitted as an *Inpatient* or for *Day Surgery*) **Note:** Observation services will not take an *Emergency* room *Copayment*.
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* care is received. If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours. Note: A *Day Surgery Copayment* may apply if *Day Surgery* services are received.	

COVERED SERVICE	YOUR COST
***Outpatient* Care**	
Cardiac rehabilitation	Covered in full.
Chiropractic care **(BL)**	$25 *Copayment* per visit.
Diabetes self-management training and educational services	*PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.

(AR) – These services may require approval by an *Authorized Reviewer* .Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

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 detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	**YOUR COST**
***Outpatient* Care, continued**	
Early intervention services for a *Dependent Child* **(BL)**	Covered in full.
Family planning	*PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.
Hemodialysis	Covered in full.
Infertility services (Diagnostic procedures and tests provided in connection with an infertility evaluation)	*PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.
Maternity care Notes: *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*. Please note that in accordance with the ACA, routine laboratory tests associated with maternity care are covered in full.	**Routine maternity care:** Covered in full. **Non-Routine maternity care:** *PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.
Oral Health Services **(AR)**	***PCP* Office Visit:** $20 *Copayment* per visit. **Specialist Office Visit**: $25 *Copayment* per visit. **Emergency Room**: Emergency room *Copayment*. ***Inpatient* Services**: *Inpatient Copayment* per *Inpatient* admission. ***Day Surgery***: *Day Surgery Copayment* per *Day Surgery* admission.

(AR) – These services may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Outpatient medical care	
Allergy testing and treatment	Covered in full.
Allergy injections	Covered in full.
Chemotherapy	Covered in full.
Cytology examinations (Pap smears)	Routine annual cytology screenings: Covered in full. Diagnostic cytology examinations: Covered in full.
Diagnostic Imaging **(AR)** • General imaging (such as x-rays and ultrasounds) and • MRI / MRA, CT/CTA, PET and nuclear cardiology	**General imaging**: Covered in full. **MRI/MRA**: $100 *Copayment* per visit. **CT/CTA**: $100 *Copayment* per visit. **PET**: $100 *Copayment* per visit. **Nuclear cardiology**: $100 *Copayment* 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.
Diagnostic or preventive screening procedures (for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies) **(AR)**	**Screening for colon or colorectal cancer in the absence of symptoms, with or without surgery:** 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*.
Diagnostic testing **(AR)**	Covered in full.
Human leukocyte antigen (HLA) testing	Covered in full.
Immunizations and vaccinations	**Routine preventive immunizations:** Covered in full. **All other immunizations:** Covered in full.
Laboratory tests **(AR)** **Note:** In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full.	Covered in full.
Lead screenings	Covered in full.
Mammograms	**Routine mammograms:** Covered in full. **Diagnostic mammograms:** Covered in full.

(AR) – These services may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Outpatient medical care, continued	
Radiation therapy	Covered in full.
Respiratory therapy or pulmonary rehabilitation services	Covered in full.
Nutritional counseling **(BL)** Note: Nutritional services are covered in full 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.	*PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.
Office visits to diagnose and treat illness and injury **Note:** This includes consultation, and visits at a *Limited Services Medical Clinic.*	*PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.
Outpatient surgery in a *Provider's* office	*PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.
Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions	Covered in full.
Preventive health care for *Members* under age 6 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. Member* cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a preventive services visit. 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.	Covered in full.

(AR) – These services may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

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 detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Preventive health care for *Members* age 6 and older 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*. *Member* cost-sharing will also apply to diagnostic tests or laboratory tests when they are ordered as part of a preventive services visit or a 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.	Covered in full.
Rehabilitation services **(AR) (BL)**	Physical Therapy: $25 *Copayment* applies per visit. Occupational therapy: $25 *Copayment* applies per visit. Speech therapy: $25 *Copayment* applies per visit.
Smoking cessation counseling services	Covered in full.
Urgent Care in an *Urgent Care Center*	*PCP* Office Visit: $20 *Copayment* per visit. Specialist Office Visit: $25 *Copayment* per visit.
Vision care services	
Routine eye examination **(BL)**	$20 *Copayment* applies per visit.
Other vision care services	$25 *Copayment* applies per visit. Note: One pair of 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.

Day Surgery	YOUR COST
Day Surgery/facility fees **(AR)**	*Day Surgery Copayment*.
Physician/surgeon fees	Covered in full.

(AR) – These services may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

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 detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Inpatient* Care**	
Physician/surgeon fees	Covered in full.
Acute hospital services/facility fees **(AR)**	*Inpatient* Services *Copayment*.
Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants **(AR)**	*Inpatient* Services *Copayment*.
Extended care **(AR) (BL)**	Covered in full.
Maternity care	*Inpatient* Services *Copayment*.
Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions	*Inpatient* Services *Copayment*.
Reconstructive surgery and procedures **(AR)**	*Inpatient* Services *Copayment*.
Behavioral Health and Substance Use Disorder Services	
To contact the *Tufts Health Plan* Behavioral Health Department, call 1-800-208-9565. (See "Benefit Limits" and Chapter 3 for visit, day, and dollar limits)	
Outpatient services **(AR)**	$20 *Copayment* applies per office visit.
Inpatient services, including *Medically Necessary* treatment in a behavioral health residential treatment facility **(AR)**	*Inpatient* Services *Copayment*.
Intermediate care, including *Medically Necessary* treatment in a behavioral health residential treatment facility **(AR)**	Covered in full.

(AR) – These services may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

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 detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

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

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*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information
.

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.

Extended Care Services
Covered up to 100 days per *Benefit Year*.

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*.

Rehabilitation Services
The maximum benefit payable in each *Benefit Year* for physical therapy services is 2 evaluations and 60 visits.

The maximum benefit payable in each *Benefit Year* for occupational therapy services is 2 evaluations and 60 visits.

The maximum benefit payable in each *Benefit Year* for speech therapy is 2 evaluations and 60 visits.

Chapter 1

How Your Exclusive Provider Option Plan Works

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. Italicized words are defined in the Glossary in Appendix A.

How the *Plan* works
The *Group* has contracted with *Tufts Health Plan*. *Tufts Health Plan* is a preferred provider organization 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 *Tufts Health Plan Providers*.

The Exclusive Provider Option plan means that, except in an *Emergency*, all your health care must be provided or authorized by your *Tufts Health Plan Primary Care Provider* (*PCP*). Your *PCP* will provide primary care to you or will refer you to the appropriate specialist within the *Tufts Health Plan* network of *Providers*. If you choose on your own to receive care not provided or authorized by your *PCP*, no benefits will be paid by the *Plan* (except if the care was due to an *Emergency*).

About the *Tufts Health Plan* Network
The *Tufts Health Plan* network of preferred *Providers* consists of hospitals, community-based physicians and other health care professionals who work out of their private offices throughout the *Tufts Health Plan Service Area*.

Tufts Health Plan enters into arrangements with these *Providers*, and they, in turn, provide you with *Covered Services*. This means that *Tufts Health Plan* itself does not provide these services. *Tufts Health Plan Providers* are independent contractors and are not, for any purposes, employees or agents of the *Plan* or *Tufts Health Plan*.

With the Exclusive Provider Option plan, you must choose a *PCP* from the *Tufts Health Plan Directory of Health Care Providers*. Your *PCP* will manage your care by providing you with primary care and will arrange for appropriate specialty care when necessary. (In the event you require *Inpatient* behavioral health or *Inpatient* substance use disorder services, you may go to any *Designated Facility* without authorization from your *PCP*. See "*Inpatient* and intermediate behavioral health/substance use disorder services" later in this chapter for more information.) Specialty care will be provided within the network of *Tufts Health Plan Providers*. In the rare instance when the care you need is not available within the *Tufts Health Plan Provider* Network, your *PCP*, after obtaining approval from an *Authorized Reviewer*, will refer you to a *Provider* not affiliated with *Tufts Health Plan*.

Eligibility for Benefits
When you join the *Plan*, you agree to receive your care from *Tufts Health Plan Providers*. 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.

Calls to Member Services
The *Tufts Health Plan* Member Services Department is committed to excellent service.

All calls are recorded for training and quality purposes.

How the *Plan* Works

Primary Care Providers
Each *Member* must choose a *Primary Care Provider*. The *PCP* is responsible for providing or authorizing all of your health care services. If you do not choose a *PCP*, the *Plan* will not pay for any services or supplies except for *Emergency* care.

> **Note:** If you require non-emergency health care services, always call your *PCP*. Without authorization from your *PCP*, services will not be covered. Never wait until your condition becomes an *Emergency* to call.

***Medically Necessary* services and supplies**
The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*.

***Service Area* (see Appendix A)**
In most cases, you must receive your care in the *Tufts Health Plan Service Area*. (Please note that the *Service Area,* which is defined in Appendix A, includes both the Standard and Extended *Service Area*.) The exceptions are for an *Emergency*, or *Urgent Care* while traveling outside of the *Service Area.* See the *Tufts Health Plan Directory of Health Care Providers* for *Tufts Health Plan's Service Area*.

***Provider* network**
Tufts Health Plan offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*.

Although *Tufts Health Plan* works to ensure the continued availability of *Tufts Health Plan Providers*, the network of *Providers* may change during the year. This can happen for many reasons, including a *Provider's* retirement, moving out of the *Service Area*, or failure to continue to meet *Tufts Health Plan's* credentialing standards. In addition, because *Providers* are independent contractors who do not work for *Tufts Health Plan*, this can also happen if *Tufts Health Plan* and the *Provider* are unable to reach agreement on a contract.

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

Coverage
The table below tells you if coverage exists, depending on the type of care you receive and the place you receive care.

IF you…	AND you are…	THEN…
receive routine health care services, visit a specialist, or receive covered elective procedures	in the Standard or Extended *Service Area*	you are covered, if you receive care through your *PCP* or with *PCP* referral.
	outside the Standard or Extended *Service Area*	you are not covered.
are ill or injured	in the Standard or Extended *Service Area*	you are covered. A referral may be required if you seek these services from a *Tufts HP Provider* other than your *PCP,* or from a *Limited Service Medical Clinic* or *Urgent Care Center* that are not participating with *Tufts Health Plan.*
	outside the Standard or Extended *Service Area*	you are covered for *Urgent Care*.
have an *Emergency*	in the Standard or Extended *Service Area*	you are covered.
	outside the Standard or Extended *Service Area*	you are covered.

Care that could have been foreseen before leaving the Standard or Extended *Service Area* is not covered. This includes, but is not limited to:

- deliveries within one month of the due date, including postpartum care and care provided to the newborn *Child;* or
- long-term conditions that need ongoing medical care.

Emergency Care and *Urgent Care*

Emergency Care

Definition of *Emergency*: See Appendix A.

Follow these guidelines for receiving *Emergency* care

- 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.
- Go to the nearest emergency medical facility.
- You do not need approval from your *PCP* before receiving *Emergency* care.
- If you receive *Outpatient Emergency* care at an emergency facility, you or someone acting for you should call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. You are encouraged to contact your *Primary Care Provider* so your *PCP* can provide or arrange for any follow-up care that you may need.
- If you receive *Emergency Covered Services* from a non-*Tufts Health Plan 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 from the non-*Tufts Health Plan Provider*. If you receive a bill, please call Member Services or see "Bills from *Providers*" in Chapter 6 for more information on what to do if you receive a bill.

Urgent Care

Definition of *Urgent Care*: See Appendix A.

Follow these guidelines for receiving *Urgent Care*

If you are in the Standard or Extended *Service Area*

- You may seek *Urgent Care* in your *PCP's* office, in an Emergency room, or at a *Limited Services Medical Clinic* or an *Urgent Care Center* affiliated with *Tufts Health Plan.* A referral may be required if you seek *Urgent Care* from any *Tufts HP Provider* other than your *PCP*, or from a *Limited Service Medical Clinic* or *Urgent Care Center* that are not participating with *Tufts Health Plan.*

If you are outside the Standard or Extended *Service Area*

- You may seek *Urgent Care* in a *Provider's* office, an *Urgent Care Center*, an *Urgent Care Center*, or the Emergency room.
- You do not need the approval of your *PCP* before receiving *Urgent Care.*

Important Notes about *Emergency* Care and *Urgent Care*:

- If you are admitted as an *Inpatient* after receiving *Emergency* or *Urgent Care Covered Services*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. (Notification from the attending physician satisfies this requirement.)
- If you receive *Urgent Care* outside of the *Service Area*, you or someone acting for you must contact your *PCP* to arrange for any necessary follow-up care.
- *Emergency* or *Urgent Care* services are covered, whenever you need it, anywhere in the world. Continued services after the *Emergency* or *Urgent* condition has been treated and stabilized may not be covered if we determine, in coordination with the *Member's Providers*, that the *Member* is safe for transport back into the *Service Area* and it is appropriate and cost-effective to transport the *Member* back into the *Service Area.*
- If you receive care from a non-*Tufts Health Plan 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. Please call Member Services or see "Bills from *Providers*" in Chapter 6 for more information on what to do if you receive a bill.

Emergency Care and *Urgent Care,* continued

Urgent Care, continued

***Inpatient* Hospital Services**

- If you need *Inpatient* services, in most cases, you will be admitted to your *PCP's Tufts Health Plan Hospital.*
- Charges after the discharge hour: If you choose to stay as an *Inpatient* after a *Tufts Health Plan Provider* has scheduled your discharge or determined that further *Inpatient* services are no longer *Medically Necessary,* we will not pay for any costs incurred after that time.
- If you are admitted to a facility which is not the *Tufts Health Plan Hospital* in your *PCP's Provider Organization*, and your *PCP* determines that transfer is appropriate, you will be transferred to the *Tufts Health Plan Hospital* in your *PCP's Provider Organization* or another *Tufts Health Plan Hospital.* Important: We may not pay for *Inpatient* care provided in the facility to which you were first admitted after your *PCP* has decided that a transfer is appropriate and transfer arrangements have been made.

Behavioral Health/Substance Use Disorder Services

***Inpatient* and intermediate behavioral health/substance use disorders**

If you require *Inpatient* or intermediate behavioral health or substance use disorder services, you may go to any of *Tufts Health Plan's Designated Facilities*. There is no need to contact your *PCP* first. Simply call or go directly to any one of the *Designated Facilities*. Identify yourself as a *Tufts Health Plan Member*. The *Designated Facilities* are responsible for providing all *Inpatient* and intermediate behavioral health and use disorder abuse services. For more information, please call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565.

The *Designated Facilities*

Some *Designated Facilities* provide services only to adult *Members* (age 16 and over) and other *Designated Facilities* provide services only to children (under age 16).

***Outpatient* behavioral health/ substance use disorders services**

Your behavioral health and substance use disorder *Provider* must provide the necessary notification for *Outpatient* behavioral health/substance use disorder services by calling *Tufts Health Plan's Outpatient* Behavioral Health/Substance Use Disorder program at 1-800-208-9565. You or your *PCP* may also call *Tufts Health Plan's Outpatient* Behavioral Health/Substance Use Disorder program to provide notification.

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* 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 your *PCP* disenrolls, *Tufts Health Plan* will provide you with notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud, you may continue to see your *PCP* for up to 30 days after the disenrollment.

To choose a new *PCP*, call a Member Specialist. The Member Specialist will help you to select one from the *Tufts Health Plan Directory of Health Care Providers*. You can also visit the *Tufts Health Plan* Web site at **www.tuftshealthplan.com** to choose a *PCP*.

Continuity of Care, continued

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* for up to 30 days from your *Effective Date*.
- the *Provider* is your *PCP*. In this instance, you may continue to see your *PCP* 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* through your first postpartum visit;
- you are terminally ill. In this instance, you may continue to see your *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 Health Plan* 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 Health Plan*.

About Your *Primary Care Provider*

Importance of choosing a *PCP*
Each *Member* must choose a *PCP* when he or she enrolls. The *PCP* you choose will be associated with a specific *Tufts Health Plan Provider Organization*. This means that you will usually receive *Covered Services* from health care professionals and facilities associated with that *Tufts Health Plan Provider Organization*.

Once you have chosen a *PCP*, you are eligible for all *Covered Services*.

IMPORTANT NOTE: Until you have chosen a PCP, only Emergency care is covered.

What a *PCP* does
A *PCP* provides routine health care (including routine physical examinations), arranges for your care with other *Tufts Health Plan Providers*, and provides referrals for other health care services, except for behavioral health and substance use disorder services. See "*Inpatient* and intermediate behavioral health/substance use disorder services" and "*Outpatient* behavioral health/substance use disorder services" earlier in this chapter for more information about obtaining referrals for these services.

Your *PCP*, or a *Covering Provider*, is available 24 hours a day.

Your *PCP* will coordinate your care by treating you or referring you to specialty services.

About your *Primary Care Provider,* continued

Choosing a *PCP*
You must choose a *PCP* from the list of *PCPs* in the *Tufts Health Plan Directory of Health Care Providers*. If you already have a *Provider* who is listed as a *PCP*, in most instances you may choose him or her as your *PCP*. Once you have chosen a *PCP* who is part of the *Tufts Health Plan* network, you must inform *Tufts Health Plan* of your choice in order to be eligible for all *Covered Services.*

If you do not have a *PCP* or your *PCP* is not listed in the *Tufts Health Plan Directory of Health Care Providers*, call a Member Specialist for help in choosing a *PCP*. If you have difficulty choosing a *PCP*, please contact Member Services.

Notes:

- Under certain circumstances required by law, if your *Provide* is not in the *Tufts Health Plan* 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 20.
- For additional information about a *PCP* 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.**

Contacting your new *PCP*
If you have chosen a new *Provider* as your *PCP*, you should:

- contact your new *PCP* as soon as you join and identify yourself as a new *Tufts Health Plan Member*;
- ask your previous *Provider* to transfer your medical records to your new *PCP*; and
- make an appointment for a check-up or to meet your *PCP*.

If you can't reach your *PCP*
Sometimes you may not be able to reach your *PCP* by phone right away. If your *PCP* cannot take your call at once, always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call.

If you need medical services after hours, please contact your *PCP* or a *Covering Provider*. Your *PCP*, or a *Covering Provider*, is available 24 hours a day, 7 days a week. If you need *Inpatient* behavioral health or substance use disorder services after hours, please call 1-800-208-9565 for assistance.

Note: If you are experiencing a medical *Emergency*, you do not have to contact your *PCP* or a *Covering Provider*; instead, proceed to the nearest emergency medical facility for treatment (see "*Emergency* Care and *Urgent Care*" earlier in this chapter for more information).

Changing your *PCP*
You may change your *PCP* or, in certain instances, *Tufts Health Plan* may require you to do so. The new *Provider* will not be considered your *PCP* until:

- you choose a new *PCP* from the *Tufts Health Plan Directory of Health Care Providers*;
- you report your choice to a Member Specialist; and
- *Tufts Health Plan* approves the change in your *PCP*.

Note: You may not change your *PCP* while you are an *Inpatient* or in a partial hospitalization program, except when approved by *Tufts Health Plan* in limited circumstances.

Canceling appointments
If you must cancel an appointment with any *Provider*, always give as much notice to the *Provider* as possible (at least 24 hours). If your *Provider's* office charges for missed appointments that you did not cancel in advance, the *Plan* will not cover the charges.

About your *Primary Care Provider*, continued

Referrals for specialty services
Every *PCP* is associated with a specific *Provider Organization*. If you need to see a specialist (including a pediatric specialist), your *PCP* will select the specialist and make the referral. Usually, your *PCP* will select and refer you to another *Provider* in the same *Provider Organization* (as defined in Appendix A). Because the *PCP* and the specialists already have a working relationship, this helps to provide quality and continuity of care.

If you need specialty care that is not available within your *PCP's Provider Organization* (this is a rare event), your *PCP* will choose a specialist in another *Provider Organization* and make the referral. When selecting a specialist for you, your *PCP* will consider any long-standing relationships that you have with any *Tufts Health Plan Provider*, as well as your clinical needs. (As used in this section, a long-standing relationship means that you have recently been seen or been treated repeatedly by that *Tufts Health Plan* specialist.)

If you require specialty care which is not available through any *Tufts Health Plan Provider* (this is a rare event), your *PCP* may refer you, with the prior approval of an *Authorized Reviewer*, to a *Provider* not associated with *Tufts Health Plan*. 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. Please call Member Services or see "Bills from *Providers*" in Chapter 6 for information on what to do if you receive a bill.

Notes:

- A referral to a specialist must be obtained from your *PCP* **before** you receive any *Covered Services* from that specialist. If you do not obtain a referral **prior** to receiving services, you will be responsible for the cost of those services.
- *Covered Services* provided by non-*Tufts Health Plan Providers* are not paid for unless authorized in advance by your *PCP* and approved by an *Authorized Reviewer*.
- For behavioral health and substance use disorder services, you do not need a referral from your *PCP*; however, you may need authorization from a *Tufts Health Plan* Behavioral Health *Authorized Reviewer*. See "*Inpatient* and intermediate behavioral health/substance use disorder services" and "*Outpatient* behavioral health/substance use disorder services" earlier in this chapter for more information.

Referral forms for specialty services
Except as provided below, your *PCP* must complete a referral every time he or she refers you to a specialist. Sometimes your *PCP* will ask you to give a referral form to the specialist when you go for your appointment. Your *PCP* may refer you for one or more visits and for different types of services. Your *PCP* must approve any referrals that a specialist may make to other *Providers*. Make sure that your *PCP* has made a referral before you go to any other *Provider*. A *PCP* may authorize a standing referral for specialty health care provided by a *Tufts Health Plan Provider*.

***Authorized Reviewer* approval**
If the specialist refers you to a non-*Tufts Health Plan Provider*, the referral must be approved by your *PCP* and an *Authorized Reviewer*. In addition, certain *Covered Services* described in Chapter 3 must be authorized in advance by an *Authorized Reviewer*, or for behavioral health and substance use disorder services, from a *Tufts Health Plan* Behavioral Health *Authorized Reviewer*. If you do not obtain that authorization, the *Plan* will not cover those services and supplies.

About your *Primary Care Provider,* continued

When referrals are not required
The following *Covered Services* do not require a referral or prior authorization from your *Primary Care Provider.* Except as detailed earlier in this chapter, for *Urgent Care* outside of the *Tufts Health Plan Service Area*, or for *Emergency* care, you must obtain these services from a *Tufts Health Plan Provider*.

- *Emergency* care (Note: If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. Notification from the attending physician satisfies this requirement.)
- *Urgent Care* outside of the *Tufts Health Plan Service Area* (Note: You must contact your *PCP* after *Urgent Care Covered Services* are rendered for any follow-up care.)
- *Urgent Care* within the *Service Area*, when received from your *PCP,* or from a *Limited Service Medical Clinic* or *Urgent Care Center* that participates with *Tufts Health Plan.*
- Mammograms at the following intervals:
    - one baseline at 35-39 years of age;
    - one every year at age 40 and older; or
    - as otherwise *Medically Necessary*.
- Care in a *Limited Service Medical Clinic* (if available).
- Routine eye exam.
- Medical treatment provided by an optometrist.
- Oral Surgery
- Chiropractic Care.
- The following specialty care provided by a *Tufts Health Plan Provider* who is an obstetrician, gynecologist, certified nurse midwife or family practitioner:
    - Maternity care.
    - *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions.
    - Routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Financial Arrangements between *Tufts Health Plan* and *Tufts Health Plan Providers*

Methods of payment to *Tufts Health Plan Providers*
Tufts Health Plan's goal in compensation of *Providers* is to encourage preventive care and active management of illnesses. *Tufts Health Plan* 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 Health Plan* uses a variety of mutually agreed upon methods to compensate *Tufts Health Plan Providers*.

The *Tufts Health Plan Directory of Health Care Providers* indicates the method of payment for each *Provider*. Regardless of the method of payment, *Tufts Health Plan* 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*.

Tufts Health Plan reviews the quality of care provided to our *Members* through its Quality of Health Care Program. You should feel free to discuss with your *Provider* specific questions about how he or she is paid.

Member Identification Card

Introduction
Tufts Health Plan 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 Health Plan Member*
Your Member ID card is important because it identifies you as a *Tufts Health Plan 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 Health Plan Member*.

IMPORTANT NOTE: If you do not identify yourself as a *Tufts Health Plan Member*, then
- the *Plan* may not pay for the services provided, and
- you would be responsible for the costs.

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 Member Services.

Utilization Management

Introduction
This section describes *Tufts Health Plan's* utilization management program.

Utilization management
Tufts Health Plan has a utilization management program. 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. Under this program, *Tufts Health Plan* sometimes engages in prospective, concurrent, and retrospective review of health care services.

Tufts Health Plan uses prospective review to determine whether proposed treatment is *Medically Necessary* before that treatment begins. It is also referred to as "pre-service review".

Tufts Health Plan engages in concurrent review 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, *Tufts Health Plan* engages in retrospective review to more accurately determine the appropriateness of health care services provided to *Members*. Retrospective review is also referred to as "post-service review".

Utilization Management, continued

TIMEFRAMES FOR *TUFTS HEALTH PLAN* 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 Health Plan 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 or substance use disorder utilization review decisions: 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 *Tufts Health Plan's* case management program. Under this program, *Tufts Health Plan*:

- encourages the use of the most appropriate and cost-effective treatment; and
- supports the *Member's* treatment and progress.

If a *Member* is identified by us as an appropriate candidate for care management or referred to the program, we may contact that *Member* and his or her *Tufts Health Plan Provider* 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*.

Tufts Health Plan may periodically review the *Member's* treatment plan. *Tufts Health Plan* will contact the *Member* and the *Member's Tufts Health Plan Provider* if *Tufts Health Plan* identifies alternatives to the *Member's* current treatment plan 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 Health Plan* 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 type, level, and setting of health care services and supplies for the *Member*.

As a part of the ICM plan, *Tufts Health Plan* 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 Health Plan* 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 Reviewer* 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 Health Plan 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 Health Plan* may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan at our sole discretion. Please not 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 Reviewer 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 may require this approval are identified by **(AR)** in the "Benefit Overview".

If you receive these services from or authorized by your *Tufts HP PCP*, your *PCP* (or other *Tufts HP Provider*) is responsible for obtaining approval from the *Authorized Reviewer*.

For more information about *Authorized Reviewer* approval, please call Member Services.

If a request for coverage is denied, you have a right to appeal. Please see Chapter 7, "*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*.

Chapter 2

Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule
You are eligible as a *Subscriber* only if you are an employee of a *Group* and you:

- meet the *Plan's* eligibility rules (including the requirement for minimum hours described below); and
- live in the *Service Area**.

Your *Spouse* or your *Child* is eligible as a *Dependent* only if you are a *Subscriber* and that *Spouse* or *Child*:

- qualifies as a *Dependent*, as defined in this *Description of Benefits*; and
- meets the *Plan's* eligibility rules; and
- live, work, or reside in the *Service Area**

*Note: *Children* are not required to maintain live, work, or reside in the *Service Area.* However, care outside the *Service Area* is limited to *Emergency* or *Urgent Care* only.

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 an 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.

If you do not live, work, or reside in *Tufts Health Plan's Service Area*
If you do not live, work, or reside in *Tufts Health Plan's Service 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: Care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* services only. See "Coverage outside the *Service Area*" in Chapter 1 for more information.

Proof of eligibility
Tufts Health Plan may ask you for proof of you and your *Dependents*' eligibility or continuing eligibility. You must give *Tufts Health Plan* proof when asked.

This may include proof of residence, marital status, birth or adoption of a *Child*, and legal responsibility for health care coverage.

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* is 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* becomes 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 *Dependen*t 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 *Dependen*t is an *Inpatient* on your *Effective Date*, your coverage starts on the later of:

- the *Effective Date*, or
- the date *Tufts Health Plan* 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,
  - a *Dependent* moves into the *Service Area*, or
  - if your *Group* has an IRS qualified cafeteria plan, any other qualifying event under that plan.

Adding *Dependents*, continued

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 form 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*

Introduction
This topic explains why it is very important to enroll and choose a *PCP* for newborn *Children* and *Adoptive Children*.

Importance of enrolling and choosing a *PCP* for 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*. Choose a *PCP* for the newborn *Child* before or within 48 hours after the newborn *Child's* birth. That way, the *PCP* can manage your *Child's* care from birth.

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*.

How to choose a *PCP* for newborn *Children* and *Adoptive Children*
Follow the steps in the table below to choose a *PCP* for a newborn *Child* or *Adoptive Child*.

Step	Action
1	Choose a *PCP* from the list of *PCPs* in the *Tufts Health Plan Directory of Health Care Providers* or call a Member Specialist for help.
2	Call the *Provider* and ask him or her to be the newborn or *Adoptive Child's PCP*.
3	If he or she agrees, call a Member Specialist to report your choice.

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 Health Plan*, of the *Child's* disability.

When coverage ends
Disabled Dependent coverage ends when:

- the *Dependent* no longer meets the definition of *Disabled Dependent*, or
- the *Subscriber* fails to give *Tufts Health Plan* 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 and supplies 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* Clinical Coverage 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;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your *PCP*, except in an *Emergency* or for *Urgent Care* (see "When You Need *Emergency* or *Urgent Care*" earlier in this *Description of Benefits* for more information);
- approved by an *Authorized Reviewer*, in some cases; and
- in the case of *Inpatient* or intermediate behavioral health/substance use disorder services, provided or authorized by a *Designated Facility*.

***Authorized Reviewer* approval:** Certain *Covered Services* described in this chapter must be authorized in advance by an *Authorized Reviewer*. If such authorization is not received, the *Plan* will not cover those services and supplies.

Emergency care (no *PCP* referral required)

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-*Tufts Health Plan 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. Please call Member Services or see "Bills from *Providers*" in Chapter 6 for more information on 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

Cardiac rehabilitation services

Services for *Outpatient* treatment of documented cardiovascular disease that are 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.

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.

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 when provided by a *Tufts Health Plan Provider* who is a certified diabetes health care provider.
- Medical nutritional therapy provided under this benefit is not subject to any visit limit described in the "Nutritional counseling" benefit later in this chapter.

Early intervention services for a *Dependent Child*

Services provided by early intervention programs. Early intervention services include, but are not limited to:

- occupational therapy;
- physical therapy;
- speech therapy;
- nursing care; and
- psychological counseling.

These services are available to *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

- *Outpatient* hemodialysis, including home hemodialysis; and
- *Outpatient* peritoneal dialysis, including home peritoneal dialysis.

Infertility services

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

*Infertility is defined as the condition of a presumably healthy *Member* who has been unable to conceive or produce conception during a period of one year.

Maternity care – Routine and Non-Routine

- 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, in accordance with the ACA. *Member* cost-sharing will apply 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,

Oral health services

- *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 or *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 the following criteria:
- the *Member* cannot safely and effectively receive oral health services in an office setting because of a specific and serious non-dental organic impairment (for example, hemophilia), AND
- the *Member* requires these services in order to maintain their health (and the services are not cosmetic or *Experimental*).

***Outpatient* medical care**

- Allergy testing (including antigens) and treatment, and allergy injections.
- chemotherapy;
- cytology examinations (Pap Smears) - one annual screening for women age 18 and older, or as otherwise *Medically Necessary*;
- diagnostic imaging, including general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA, and PET tests and nuclear cardiology (may require the approval of an *Authorized Reviewer*);
- diagnostic or preventive screening procedures (for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies) (requires the prior approval of an *Authorized Reviewer*);
- 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. Please call Member Services with questions about specific tests);
- human leukocyte antigen 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; or
  - any combination consistent with the rules and criteria established by the Department of Public Health;
- immunizations and vaccinations;
- laboratory tests, including, but not limited to, blood tests, urinalysis, throat cultures, glycosylated hemoglobin (HbA1c) tests, and urinary protein/microalbumin and lipid profiles. **Important Note:** 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*). In addition, in compliance with the ACA, laboratory tests associated with routine preventive care are covered in full;
- lead screenings;
- mammograms (no *PCP* referral required) at the following intervals:
  - one baseline at 35-39 years of age,
  - one every year at age 40 and older,
  - or as otherwise *Medically Necessary*;
- *Medically Necessary* diagnosis and treatment of speech, hearing and language disorders (services may require the approval of an *Authorized Reviewer*)
  Note: Short-term cognitive retraining or cognitive rehabilitation services are covered under this benefit only when provided to restore function lost or impaired as the result of an accidental injury or sickness. In order for these services to be covered, measurable improvement must be anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery Also, please note that *Cost Sharing Amounts* for the diagnosis of speech, hearing and language disorders vary depending the service provided (e.g., x-rays, diagnostic testing, office visits);

Outpatient **medical care,** continued

- Nutritional counseling. Coverage is provided for nutritional counseling when prescribed by a physician and performed by a registered dietician/nutritionist. Nutritional counseling visits are covered:
  - When *Medically Necessary*, for the purpose of treating an illness. Please see the "Nutritional Counseling" in the "Benefit Overview" for the applicable *Cost Sharing Amount*; or
  - As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, and behavior change and counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full. Note: Weight loss programs and clinics are not covered.

  Covered for an individual consultation and up to seven (7) follow-up visits with a registered dietician per *Benefit Year*.

  Note: This visit limit does not apply to *Outpatient* nutritional counseling provided as part of:
  - an approved home health care plan (see "Home health care" benefit later in this chapter); or
  - diabetes self-management training and educational services (see 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 (no *PCP* referral required), consultation, and visits to a *Limited Services Medical Clinic*.
- *Outpatient* surgery in a *Provider's* office.
- radiation therapy;
- respiratory therapy and pulmonary rehabilitation services.

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 health 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 *Tufts Health Plan 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. Member* cost-sharing will also apply 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 health care for *Members* age 6 and older

- routine physical examinations, including appropriate immunizations and lab tests as recommended by a *Tufts Health Plan Provider*;
- routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam (no *PCP* referral required), and hormone replacement therapy services; and
- hearing examinations and screenings.

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. Member* cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam or routine 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.

Rehabilitation services (Services may require the approval of an *Authorized Reviewer*)

Rehabilitative speech, physical and occupational therapy services, including cognitive rehabilitation or cognitive retraining, are covered. Services include up to 2 evaluations per *Benefit* Year. These services 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.

Note: Benefit limits do not apply to physical or occupational therapy provided in conjunction with a *Provider's* approved home health care plan.

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

(see "*Emergency* and *Urgent Care*" earlier in this document for more information about referrals for these services).

Vision care services

- Annual routine eye examination: Coverage is provided for one routine eye examination per *Benefit Year* (no *PCP* referral required). **Note:** You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network in order to obtain coverage for these services. Please go to **www.tuftshealthplan.com** or contact Member Services for more information. Except as described below, in order to be covered for services to treat a medical condition of the eye, you must obtain a referral from your *PCP* for services from a *Tufts Health Plan Provider.*
- Other vision care services: Coverage is provided for eye examinations and necessary treatment of a medical condition (no *PCP* referral is required for medical treatment provided by an optometrist). 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: Certain *Day Surgeries* require the prior approval of an *Authorized Reviewer*. Please contact Member Services for information about which *Day Surgeries* require this approval.

Inpatient care

Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants
(must be approved by an *Authorized Reviewer*)

- Bone marrow transplants for *Members* diagnosed with breast cancer that has progressed to metastatic disease.
- Hematopoietic stem cell transplants and human solid organ transplants provided to *Members*. These services must be provided at a *Tufts Health Plan* designated transplant facility. The *Plan* covers charges incurred by the donor in donating the stem cells or solid organ to the *Member*, but only to the extent that charges are not covered by any other health care coverage. This includes:
  - evaluation and preparation of the donor, and
  - surgery and recovery services when those services relate directly to donating the stem cells or solid organ to the *Member.*

  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*.
  - The *Plan* covers a *Member's* human leukocyte antigen (HLA) testing. See "*Outpatient* medical care" earlier in this chapter for more information.

Extended care (Extended care services require prior approval by an *Authorized Reviewer*)
In an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

- skilled nursing services;
- chronic disease services; or
- rehabilitative services.

Hospital services (Acute care)

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

Maternity care – Routine and Non-Routine (no *PCP* referral required)

- 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 also 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).

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 (must be approved by an *Authorized Reviewer*);
- 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 auto-immune 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 authorized by your *PCP*).

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 *Tufts HP 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 authorization by a *Tufts HP* Behavioral Health *Authorized Reviewer* is required for psychological testing and neuropsychological assessment services.**
- ***Outpatient* behavioral health and substance use disorder services require notification within 30 days of the initial visit. Please see "*Outpatient* behavioral health/substance use disorder services" in Chapter 1 for more information.**

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

(Authorization is required for these services. See "*Inpatient* and intermediate behavioral health/substance use disorder services" in Chapter 1 for more information.)

- *Inpatient* behavioral health and substance use disorder services for *Behavioral Health Disorders* in:
  - 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.

Other Health Services

Ambulance services

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

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.

Other Health Services, (continued)

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.

Important Note: You may be responsible for paying towards the costs of *Durable Medical Equipment* covered under this plan. To determine whether your *Durable Medical Equipment* is subject a benefit limit, please see the "Benefit Overview" section at the front of this *Description of Benefits*.

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.

Below are 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 *Members*, when prescribed by a physician (Note: These breast pumps are covered in full);
- 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 food disease; and
  - visual magnifying aids;
- gradient stockings (up to three pairs per *Benefit Year*); oral appliances for the treatment of sleep apnea;
- oxygen concentrator (stationary and portable)
- prosthetic devices such as artificial legs, arms, eyes, 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);
- power/motorized wheelchairs;

Tufts Health Plan will decide whether to purchase or rent the equipment for you. This equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with *Tufts Health Plan* to provide such equipment.

(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;
- 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 (must be approved in advance by an *Authorized Reviewer*)

The Plan will cover the following services for *Members* who are homebound*:

- home visits by a *Tufts Health Plan Provider*;
- skilled nursing care and physical therapy; and
- the following services, if determined to be a *Medically Necessary* component of skilled nursing or physical therapy:
  - speech therapy;
  - occupational therapy;
  - medical/psychiatric social work;
  - nutritional consultation;
  - the use of *Durable Medical Equipment* (coverage is not subject to limits described in the "*Durable Medical Equipment*" benefit in this chapter); 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 (must be approved by an *Authorized Reviewer*)

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.

Other Health Services (continued)

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 limitations 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 medication, 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 Health Plan* Web site as covered under a *Tufts Health Plan* pharmacy benefit are not covered under the "Injectable, infused, or inhaled medications" benefit. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

Low protein foods

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

Medical supplies

The Plan covers the cost of certain types of medical supplies from an authorized vendor, including:

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

Notes:

- These medical supplies must be obtained from a vendor that has an agreement with *Tufts Health Plan* to provide such 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 Health Plan 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.

Other Health Services (continued)

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.

Scalp hair prostheses or wigs for cancer or leukemia patients

Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. Covered in full up to a maximum benefit of $350 per *Benefit Year*.

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

Special Medical Formulas (prior approval by an *Authorized Reviewer* may be required)

For the treatment of:

- phenylketonuria (PKU), tyrosinemia, homocystinuria, maple syrup urine disease, propionic academia, and methylmalonic acidemia; or
- when *Medically Necessary*, to protect the unborn fetuses of women with PKU.

Exclusions from Benefits

List of exclusions

There is no coverage for the following services, supplies, and 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 received outside the *Tufts Health Plan Service Area*, except as described under "How the *Plan* Works" in Chapter 1.
- 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.
- 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 a qualified clinical trial for the treatment of cancer or other life-threatening disease 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. Laboratory tests ordered by a *Member* (online or through the mail), even if performed at a licensed laboratory.
- The following exclusions apply to services provided by the relatives of a *Member*:
  - Services provided by a relative who is not a *Tufts Health Plan Provider,* whether or not the services are authorized by your *PCP*, are not covered.
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Tufts Health Plan Provider* and the services are authorized by your *PCP*, are not covered.
  - If you are a *Tufts Health Plan Provider*, you cannot provide or authorize services for yourself, be your own *PCP*, or be the *PCP*, of 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 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).
- Preventive dental care; periodontal treatment; orthodontia, even when it is an adjunct to other surgical or medical 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, or other 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.

Exclusions from Benefits, continued

- 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
- 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.
- The purchase of an electric hospital-grade breast pump;
- 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"; and
  - bereavement counseling services under "Hospice care services".

Exclusions from Benefits, continued

- 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.
- 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.
- 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.
- 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; or wilderness, camp, or ranch programs), even if performed or provided by licensed *Provider* (including, but not limited to, behavioral health professionals, nutritionists, nurses or physicians). Examples of services provided in a non-conventional setting that are excluded from coverage include, but are not limited to, psychotherapy, ABA services, and nutritional counseling.
- 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 disease), 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 purposes or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided under "Early intervention services for a *Dependent Child*" 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 under "*Durable Medical Equipment*" 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 cover contact lenses or contact lens fittings.
- Hearing aids.
- Private duty nursing (block or non-intermittent nursing).
- Methadone treatment or methadone maintenance related to substance abuse disorders.
- 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" earlier 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 States Food and Drug Administration (FDA);
- provided to treat an injury, illness, or pregnancy;
- *Medically Necessary;* and
- written by a *Tufts HP* participating *Provider*, except in cases of authorization referral or in *Emergencies*.

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. For a list of non-covered drugs, call Member Services.

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
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.

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" later in this Prescription Drug Benefit).
- 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 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.

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 Program" 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).

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 may be obtained at a specialty pharmacy. 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 plan), with some exception. Please call Member Services for more information about on which tier your medication is covered.
- 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. In cases of *Emergency*, please call the *Tufts Health Plan* Member Services Department at 1-800-462-0224 for instructions about submitting your prescription drug claims for reimbursement.

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 Health Plan's* eligibility rules (including the requirement for minimum hours described in Chapter 1), or
  - are *Subscriber* or a *Spouse* and you no longer live, work, or reside in the *Service 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 Health Plan Member*, or
  - *Tufts Health Plan* or any *Tufts Health Plan* employee;
- you commit an act of misrepresentation or fraud; or
- your *Group's* contract with *Tufts Health Plan* 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 *Service Area*. However, care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only.

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 required medical care after your coverage ended.

Continuation

Once your coverage ends, you may be eligible to continue your coverage with your *Group* or to enroll in *Nongroup Coverage*. 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 or when the *Dependent* no longer meets the definition of *Dependent*, whichever occurs first.
- An enrolled *Dependent Child's* coverage ends when the *Child* reaches age 26 unless the *Child* is a *Disabled Dependent*. *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.

If you move out of *Tufts Health Plan's Service Area*

If you move out of the *Tufts Health Plan Service Area*, coverage ends as of the date you move.

Before you move, tell your *Group* or call a Member Specialist to notify *Tufts Health Plan* of the date you are moving. If you keep a residence in the *Service Area* but have been out of the *Service Area* for more than 90 days, coverage ends 90 days after the date you left the *Service Area*.

For more information about coverage available to you when you move out of the *Service Area*, contact a Member Specialist.

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

Your coverage may be terminated if you commit acts of physical or verbal abuse which:

- are unrelated to your physical or behavioral health condition;
- pose a threat to:
  - any *Provider*,
  - any *Tufts Health Plan Member*, or
  - *Tufts Health Plan* or any *Tufts Health Plan* 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 Health Plan* may not allow you to re-enroll for coverage with *Tufts Health Plan* 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 not 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
- not 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 Health Plan's* and *Group's* relationship

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

- your *Group's* contract with *Tufts Health Plan* terminates;
- your *Group* fails to pay its obligation;
- *Tufts Health Plan* 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. For more information, contact your *Group* or the *Plan Administrator*.

Duration of Coverage

In most cases, qualified beneficiaries are eligible for federal COBRA continuation coverage 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 CHART		
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.		

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 services 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 exclusions) except for service-connected illnesses or injuries.
- Service members may be required to pay up 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 VETS 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

Member Satisfaction

Overview

Introduction

This chapter contains information about:

- the *Member* Satisfaction Process, which addresses the *Member* Grievance Process and the Internal *Member* Appeals Process;
- concerns about quality of medical care;
- administrative concerns about *Tufts Health Plan*;
- bills from *Providers*; and
- limitation on actions.

Address and telephone number

If you write to *Tufts Health Plan*, send the letter to the Appeals and Grievances Department at this address:

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

If you need to call *Tufts Health Plan* about a concern or appeal, contact a Member Specialist at 1-800-462-0224.

Member Satisfaction Process

Process Summary

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

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

All grievances and appeals should be sent to *Tufts Health Plan* 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 Health Plan'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 Health Plan* 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 Specialist that you are not satisfied with the response you have received from *Tufts Health Plan*, 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.

Member Satisfaction Process, continued

Member Grievance Process

A grievance is a formal complaint about actions taken by *Tufts Health Plan* or a *Tufts Health Plan 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 Health Plan* 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 Health Plan* 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 Health Plan* employee, department, policy, or procedure, or about a billing issue.

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 Health Plan* 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 Health Plan*.

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 Health Plan 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.

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 Specialist, 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 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.

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 a 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 Specialist for assistance.

External Review

For certain types of claims, if you do not agree with the Appeals decision, you or your authorized representative have 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*

Medical Expenses

Occasionally, you may receive a bill from a *Provider* for *Covered Services*. Before paying the bill, contact the *Tufts Health Plan* 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 Health Plan* web site or by contacting the *Tufts Health Plan* 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 bill(s) to *Tufts Health Plan* 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. If you do not, the bill cannot be considered for payment.

If you receive *Covered Services* from a non-*Tufts Health Plan Provider*, the *Plan* will pay up to the *Reasonable Charge.*

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

IMPORTANT NOTE:
Certain services you receive from non-*Tufts Health Plan Providers* at an in-network setting may be reimbursable. Some examples of these types of non-*Tufts Health Plan Providers* include:

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

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.

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.

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 and Right of Recovery, continued

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.

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 representatives 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.

Subrogation and Right of Recovery, continued

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.

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

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 Health Plan* 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 making the 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:

(1) 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.

(2) 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 *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.

- ***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*.

Coordination of Benefits, continued

How COB works, continued

- **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.

- **Active/Inactive Rule**
  The plan which covers an employee (or an employee's enrolled *Dependent*) who is neither laid off nor retired is primary to a plan which 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.

- **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.

- **Longer/Shorter Rule**
  If none of the above rules determines 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 is 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 Non-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.

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 it 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 Health Plan's* Liability and Recovery Department at 1-888-880-8699, x. 21098 for more information on Medicare COB.

Coordination of Benefits, continued

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 Health Plan* of new coverage or termination of other coverage. *Tufts Health Plan* 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 they 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 made that are greater than payments it should have made under the COB program. The *Plan* will recover only overpayments actually made.

For more information

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

Medicare Eligibility

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.

Tufts Health 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.

Tufts Health 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 Health Plan* uses and discloses your medical information, please contact a Member Specialist. Information is also available on the *Tufts Health Plan* 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 Health Plan* and *Providers*

Tufts Health Plan* and *Providers

Tufts Health Plan is an administrator of health care services. *Tufts Health Plan* does not provide health care services. *Tufts Health Plan* has agreements with *Providers* practicing in their private offices throughout the *Tufts Health Plan Service Area*. These *Providers* are independent. They are not *Tufts Health Plan* employees, agents or representatives. *Providers* are not authorized to modify the *Plan*, change this *Description of Benefits*, or assume or create any obligation for the *Plan* or *Tufts Health Plan*.

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

Circumstances Beyond *Tufts Health Plan's* Reasonable Control

Circumstances beyond *Tufts Health Plan's* reasonable control

Tufts Health Plan 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 Health Plan*. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, *Tufts Health Plan* will make a good faith effort to arrange for the provision of services. In doing so, *Tufts Health Plan* will take into account the impact of the event and the availability of *Tufts Health Plan 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 your *Group* and *Tufts Health Plan*, *Tufts Health Plan* processes claims, disburses Plan funds and provides other *Covered Services* only when the *Group* has forwarded adequate funds to *Tufts Health Plan* to pay for *Covered Services*. This is the case even if your *Group* has charged you (for example, by withholding from your paycheck) for some or all of the cost of coverage under the *Plan*. If your Group fails to provide adequate funds for claims payment, *Tufts Health Plan* 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 Health Plan* 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 Health Plan* 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 Health Plan* sends a notice to you, it will be sent to your last address on file with *Tufts Health Plan.*

Notice to *Tufts Health Plan*: *Members* should address all correspondence to:
Tufts Health Plan, Member Services, P.O. Box 9166, Watertown, MA 02471-9166.

Enforcement of terms

Tufts Health Plan may choose to waive certain terms of the *Group Contract*, if applicable, including the *Description of Benefits*. This does not mean that *Tufts Health Plan* 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.

Notes:

- If any *Child* was under guardianship prior to age 18, the *Subscriber* may continue the *Child's* dependent coverage for two additional years (until age 20). If a petition for adoption is filed within that two-year period, the *Child* will be treated as an "*Adoptive Child*" until age 23. *Dependent* coverage would terminate for the *Child* at age 23 unless adoption proceedings are favorably finalized. If adoption proceedings are favorably finalized, the *Child* would be an *Adoptive Child* and the parent would have the same coverage rights for that *Child* (until age 26) as for other natural children. COBRA rights for the *Child* at the conclusion of these expanded rights to be covered as a *Dependent* would be available for 36 additional months.
- As required by applicable law, a foster child is considered an *Adoptive Child* as of the date that a petition to adopt was filed.

Age

Birthday and not insurance age.

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 Health Plan'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 until 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 percentage of costs you must pay for certain *Covered Services*. For services provided by a non-*Tufts Health Plan Provider*, your share is a percentage of the *Reasonable Charge* for those services. For services provided by a *Tufts Health Plan Provider*, your share is a percentage of:

- the applicable *Tufts Health Plan* fee schedule amount for those services; or
- the *Tufts Health Plan Provider's* actual charges for those services, whichever is less.

Note: The *Member's* share percentage is based on the *Tufts Health Plan 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.

Copayment
Fees you pay for *Covered Services*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. *Copayments* are not included in the *Out-of-Pocket Maximum*. See "Benefit Overview" at the front of this *Description of Benefits* for more information.

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

Covered Services
The services and supplies that the *Plan* will cover. They must be:
- described in Chapter 3 (subject to the "Exclusions from Benefits" section in Chapter 3;
- *Medically Necessary*; and
- provided or authorized by your *PCP* 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
The *Provider* named by your *PCP* to provide or authorize services in your *PCP'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 a covered benefit under 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."

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

Description of Benefits
This document, and any future amendments, which describes the EXCLUSIVE PROVIDER OPTION plan you have selected under the *Plan*.

Designated Facility
A facility licensed to treat *Behavioral Health Disorders* and/or substance use disorder (alcohol and drug). This facility has an agreement with *Tufts Health Plan* to provide *Inpatient* or partial hospitalization services to *Members* assigned to the facility.

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 *Tufts Health Plan PCPs* and their affiliated *Tufts Health Plan Hospitals* and certain other *Tufts Health Plan Providers*.

Note: This booklet is updated from time to time to show changes in *Providers* affiliated with *Tufts Health Plan*. For information about the *Providers* listed in the *Directory of Health Care Providers*, you can call *Tufts Health Plan* Member Services or check *Tufts Health Plan'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 before reaching 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 began receiving *Covered Services* administered by *Tufts Health Plan*.

Emergency
An illness or medical condition, whether physical, behavioral, related to substance use disorder, or behavioral health, that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent lay person, 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 Health Plan* for the provision of certain services and the availability of a preferred provider network 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 Health Plan's* agent.

Group Contract

The agreement between *Tufts Health Plan* and the *Group* under which *Tufts Health Plan* agrees to provide certain administrative services and the *Group* agrees to pay *Tufts Health Plan* for these services. The *Group Contract* includes this *Description of Benefits* and any amendments.

Individual Coverage

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

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.

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 Health Plan* uses *Medical Necessity* Guidelines which are:

- developed with input from practicing *Providers* in the *Tufts Health Plan Service 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".

Non-Conventional Medicine

A group of diverse medicine 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 connection 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).

Observation

The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within forty-eight (48) hours 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*.

Out-of-Pocket Maximum

The maximum amount of money paid by a *Member* during a *Benefit Year* for certain *Covered Services*. The *Out-of-Pocket Maximum* consists of *Copayments*. It does not include:

- costs for health care services that are not *Covered Services* under the *Group Contract*.

Once you have met your *Out-of-Pocket Maximum* in a *Benefit Year*, you no longer pay for *Copayments* in that *Benefit Year*.

See "Benefit Overview" at the front of this Description of Benefits for detailed information about your *Out-of-Pocket Maximum*.

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.

Provider Organization

A *Provider Organization* is comprised of doctors and other health care *Providers* who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care.

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. *Tufts Health Plan* is not the *Plan Administrator*.

Primary Care Provider (PCP)
The *Tufts Health Plan* physician, physician assistant, or nurse practitioner you have chosen from the *Tufts Health Plan Directory of Health Care Providers* who has an agreement with *Tufts Health Plan* to provide primary care and to coordinate, arrange, and authorize the provision of *Covered Services*.

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, 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; or
- amount that we determine to be reasonable, based on 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.

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

Service Area
The *Service Area* (sometimes referred to as the "Enrollment Service Area") is the geographical area within which *Tufts Health Plan* has developed a network of *Providers* to afford *Members* adequate access to *Covered Services*. The Enrollment *Service Area* consists of the Standard Service Area and the Extended Service Area.

The Standard *Service Area* is comprised of:
- all of Massachusetts, New Hampshire and Rhode Island.

The Extended Service Area includes certain towns in Connecticut, Maine New York, and Vermont which:
- surround the Standard Service Area; and
- are within a reasonable from *Tufts Health Plan's PCPs* and specialists who provide the most-often used services such as behavioral health practitioners and *Providers* who are surgeons or OB/GYNs.

Note: For a list of cities and towns in the *Service Area*, call *Tufts Health Plan* Member Services or check the Web site at **www.tuftshealthplan.com**.

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 an employee of the *Group*; and
- enrolls in *Tufts Health Plan* and signs the member application form on behalf of himself or herself and any *Dependents*.

Tufts Health Plan
Total Health Plan, Inc. ("THP"), a Massachusetts corporation d/b/a *Tufts Health Plan*. *THP* enters into arrangements with *Groups* or payors underwriting health benefit plans to make available a network of preferred providers and to provide certain services to the health benefit plans including, but not limited to, processing claims for benefits and enrollment. *THP* is not the *Plan Administrator* and does not insure the *Plan*. Also referred to as "*Tufts Health Plan*".

Tufts Health Plan Hospital
A hospital which has an agreement with *Tufts Health Plan* to provide certain *Covered Services* to *Members*. *Tufts Health Plan Hospitals* are independent. They are not owned by *Tufts Health Plan*. *Tufts Health Plan Hospitals* are not *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees.

Tufts Health Plan Provider
A *Provider* with which *Tufts Health Plan* has an agreement to provide *Covered Services* to *Members*. *Providers* are not *Tufts Health Plan's* employees, agents or representatives.

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, sudden extreme anxiety, a cut that needs stitches but is not actively bleeding, 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 when used in this *Description of Benefits*, regardless of whether or not 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 plan and benefits;
- continue group health plan coverage; and
- prudent actions by plan fiduciaries.

Receiving Information About Your Plan and Benefits

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, 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 on 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 or in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

ERISA RIGHTS, continued

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 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 directory 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 Specialist 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 that you may submit for review. Tufts Health Plan'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 your 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 Health Plan will respond to you within 72 hours after receipt of the claim. If Tufts Health Plan 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 Health Plan 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 Health Plan has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, Tufts Health Plan 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 Health Plan 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" or "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 Health Plan will respond to you within 15 days after receipt of the claim. If Tufts Health Plan 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 Health Plan to make a determination, we will notify you within 15 days and describe the information that you need to provide to Tufts Health Plan. 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 Health Plan will respond to you within 30 days after receipt of the claim. If Tufts Health Plan determines that 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 Health Plan to make a determination, we will notify you within 30 days and describe the information that you need to provide to Tufts Health Plan. 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 of 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.
- 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 a single 12-month period to care for the service member. The employee is entitled to a combined total of 26 weeks of all types of FMLA leave in the single 12-month period.

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 **http://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.

NOTICE OF PRIVACY PRACTICES, continued

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.

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 **www.mass.gov/ocabr/docs/doi/consumer/css-complaint-form.pdf.**

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