TUFTS Health Plan

CareLink SM

CERTIFICATE OF INSURANCE
MASSACHUSETTS Large Group

Open Access Plan
Advantage PPO

Underwritten by Tufts Insurance Company

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

There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your EFFECTIVE DATE.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from TUFTS HEALTH PLAN.

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector*, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

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

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

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

***Note:** This includes health plans approved by the Massachusetts Health Insurance Connector as meeting its Minimum Creditable Coverage standards.

Address and Telephone Directory

TUFTS HEALTH PLAN
1 Wellness Way
Canton, MA 02021

Member Services Hours:
Monday through Thursday 8:00 a.m.-7:00 p.m. EST
Friday 10:00 a.m.-5:00p.m. EST

IMPORTANT PHONE NUMBERS:

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

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

Liability Recovery
Call the TUFTS HEALTH PLAN 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 8:00 a.m. - 5:00 p.m. Monday through Friday.

For questions related to subrogation, call a Member Representative at 1-866-352-9114. If you are uncertain which department can best address your questions, call Member Services.

Member Services Department

Call Member Services at 1-866-352-9114 for general questions, benefit questions, and information regarding eligibility for enrollment and billing. For help finding a Network Provider, call Member Services and follow the appropriate prompts. Our Member Services team can help you find a Provider who is appropriate for your age, condition and type of treatment.

For help finding a NETWORK PROVIDER call Member Services and follow the appropriate prompts. Our Member Services team can help you find a Provider who is appropriate for your age, condition and type of treatment.

Behavioral Health and Substance Use Disorder Services
If you need assistance locating a PROVIDER or in finding information about your behavioral health/substance use disorder benefits, please contact the Behavioral Health Department at 1-800-232-1164.

Prescription Drug Benefit: For questions about your Prescription Drug coverage, please contact CARELINK at 1-800-244-6224.

Services for Hearing Impaired MEMBERS
If you are hearing impaired, the following services are provided:

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

Massachusetts Relay (MassRelay)
711

Fraud and Abuse

You may have questions about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud or abuse, or if you have questions, please call Member Services, or email **fraudandabuse@tufts-health.com**. You can also call our confidential hotline any time at 877-824 7123 or send an anonymous letter to us at:

Tuf ts Health Plan
Attn: Fraud and Abuse
1 Wellness Way
Canton, MA 02021

IMPORTANT ADDRESSES:

Appeals and Grievances Department

If you need to call us about a concern or appeal, contact Member Services. To submit your appeal or grievance in writing, send your letter to the P.O. Box address below. Or you may fax it to us at 617-972-9509.

TUFTS HEALTH PLAN
Attn: Appeals and Grievances Department
P.O. Box 9193
Watertown MA 02472-9193

You may also submit your appeal or grievance in-person at this address:

TUFTS HEALTH PLAN

1 Wellness Way

Canton, MA 02021

Website

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 website.

COVID-19 Resource Center

For the most up-to-date information on policy changes related to COVID-19, please visit our website at **https://tuftshealthplan.com/covid-19/member/latest-updates**.

Treatment Cost Estimator

In compliance with Massachusetts law, TUFTS HEALTH PLAN offers a cost transparency estimator tool to help MEMBERS estimate the cost of COVERED SERVICES. In order to access this tool, you must register at **www.tuftshealthplan.com/members**. Once you have registered, enter the member portal to access the tool.

Examples of information you can find by using the treatment cost estimator include:

- the estimated or maximum ALLOWED COST f or a proposed admission, procedure or service; and
- the estimated amount you will be responsible for paying for admissions, procedures, or services that are COVERED SERVICES (including COST SHARING AMOUNTS), based on information available to TUFTS HEALTH PLAN at the time the request is made.

The cost estimates generated by the tool are binding to the extent required by Massachusetts law. The actual amount you may be responsible for paying may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

Translating Services

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

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 ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ສຽຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ດ້ານຫຼັງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo bą́ą́h ilíní da Diné k'ehjí álnéchgo, hodiilnih béésh bee haní'é bee néé ho'dílzingo nantinígíí bikáá'.

Persian. برای ترجمه رایگا 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.

Telecommunications Device for the Deaf (TDD).

Call 711

CERTIFICATE OF INSURANCE

THIS BOOKLET IS YOUR CERTIFICATE OF INSURANCE for health benefits underwritten by Tufts Insurance Company ("TIC"). As described in this CERTIFICATE, TIC has entered into an agreement with Tufts Benefit Administrators ("TBA") for TBA to administer the health benefits, make a network of PROVIDERS available in Massachusetts and Rhode Island, and perform behavioral health and substance use disorder utilization management for services received in Massachusetts and Rhode Island. TBA and TIC have entered into an agreement with Cigna, under which Cigna, on behalf of TIC, provides certain administrative services. This includes participating provider network contracting and maintenance outside of Massachusetts and Rhode Island, medical management, and behavioral health and substance use disorder utilization management for services received outside of Massachusetts and Rhode Island. Throughout this CERTIFICATE, your health insurance coverage provided in accordance with this agreement is referred to as CARELINK.

NETWORK PROVIDERS are hospitals, community-based physicians and other community-based health care professionals working in their own offices throughout the NETWORK CONTRACTING AREA. TUFTS HEALTH PLAN does not provide health care services to MEMBERS. NETWORK PROVIDERS provide health care services to MEMBERS. These PROVIDERS are independent contractors and are not the employees or agents of TUFTS HEALTH PLAN for any purposes.

This CERTIFICATE describes the benefits, exclusions, conditions and limitations provided under the GROUP CONTRACT to persons covered under the GROUP CONTRACT and replaces any CERTIFICATE previously issued to you. You should read this CERTIFICATE for a complete description of benefits and an understanding of how the preferred provider plan works.

CHANGES TO THIS CERTIFICATE OF COVERAGE

From time to time, certain sections in this CERTIFICATE may change. This may happen to comply with a state or federal law or regulation. Or, this may happen to reflect an enhancement to your plan with us during the year. To check to see whether this CERTIFICATE has been amended, please go to **https://tuftshealthplan.com/MA-2022-EOC-amendments** on the website.

Introduction

Welcome to TUFTS HEALTH PLAN. With TUFTS HEALTH PLAN, each time you need health care services, you may choose to obtain your health care from either a NETWORK PROVIDER (IN-NETWORK LEVEL OF BENEFITS) or any NON-NETWORK PROVIDER (OUT OF NETWORK LEVEL OF BENEFITS). Your choice will determine the level of benefits you receive for your health care services:

IN-NETWORK LEVEL OF BENEFITS: If your care is provided by a NETWORK PROVIDER, you will be covered at the IN-NETWORK LEVEL OF BENEFITS.

Please see the "Benefit Overview" and "Plan and Benefit Information" sections, and Chapter 3 for further details on your coverage and costs for medical services under this plan.

OUT OF NETWORK LEVEL OF BENEFITS: If your care is provided by a NON-NETWORK PROVIDER, you will be covered at the OUT OF NETWORK LEVEL OF BENEFITS.

COVERED SERVICES Outside of the 50 United States: EMERGENCY care services provided to you outside of the 50 United States qualify as COVERED SERVICES. Urgent care services while traveling outside of the 50 United States also qualify as COVERED SERVICES. However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan.

For additional information about these tiers of benefits and how to receive covered health care services, please see Chapter 1. If you have any questions, please call TUFTS HEALTH PLAN Member Services.

PLEASE READ THIS CERTIFICATE OF INSURANCE CAREFULLY.

This book will help you find answers to your questions about TUFTS HEALTH PLAN benefits. Italicized words are defined in the Glossary in Appendix A.

Your satisfaction with TUFTS HEALTH PLAN is important to Us. If at any time you have questions, please call a Member Services Representative and We will be happy to help you.

Tufts Insurance Company does business under the name TUFTS HEALTH PLAN.

Calls to Member Services

Our Member Services Department is committed to excellent service. All calls are recorded for training and quality purposes.

Contract and Benefit Information

This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COINSURANCE
COINSURANCE (IN-NETWORK LEVEL OF BENEFITS): Except as described in this Benefit Overview, we pay 90% of the applicable NETWORK fee schedule amount (or that same percentage of the REASONABLE CHARGE, if less) for certain COVERED SERVICES provided at the IN-NETWORK LEVEL OF BENEFITS by a NETWORK PROVIDER. The MEMBER pays the remaining 10%
COINSURANCE (OUT-OF-NETWORK LEVEL OF BENEFITS): Except as described in the COVERED SERVICES table below in this section, we pay 70% of the REASONABLE CHARGE for all COVERED SERVICES provided in the 50 United States by a NON-NETWORK PROVIDER. The MEMBER pays the remaining 30%. The MEMBER may also be responsible for any charges in excess of the REASONABLE CHARGE.

***Important Note:** COVERED SERVICES that are listed as "covered in full" or are subject to an Office Visit COPAYMENT at the IN-NETWORK LEVEL OF BENEFITS in this Benefit Overview are covered at 80% of the REASONABLE CHARGE when provided by a NON-NETWORK PROVIDER. The MEMBER pays the remaining 20% and is also responsible for any charges in excess of the REASONABLE CHARGE.

COPAYMENTS	
• **EMERGENCY Care (IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS):**	
• EMERGENCY room	$250.00 COPAYMENT applies per visit.
Note: • An EMERGENCY room COST SHARING AMOUNT may apply if you register in an EMERGENCY room but leave that facility without receiving care.	
• **Other COVERED SERVICES (IN-NETWORK LEVEL OF BENEFITS only)**	
• Office Visit (per visit)	$30.00 COPAYMENT.
Note: Applies to IN-NETWORK Office Visits for diagnostic cytological exams (Pap Smears), non-routine immunizations, behavioral health and substance use disorders; family planning services; diabetes self-management training and educational services; nutritional counseling; visits to a LIMITED SERVICE MEDICAL CLINIC; non-routine OUTPATIENT maternity care (pre-natal and post-partum), routine eye exam and other vision care.	
• Visits to a FREE-STANDING URGENT CARE CENTER (per visit)	$30.00 COPAYMENT.
• INPATIENT Services	DEDUCTIBLE then COINSURANCE.
• DAY SURGERY	DEDUCTIBLE then COINSURANCE.

Notes:

In accordance with the Affordable Care Act (ACA), preventive care services -- including women's preventive health care services, preventive care visits, 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. For more information on what services are now covered in full, please see **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services**. If you have any questions about whether specific services are considered preventive under the ACA, please call Member Services.

Diagnostic OUTPATIENT services rendered in conjunction with a routine physical examination (i.e., a preventive care visit) may be subject to COST SHARING AMOUNTS. For example, diagnostic testing and diagnostic laboratory tests provided during a preventive care visit are covered as described under "Diagnostic testing" and "Laboratory tests" below. For certain diagnostic OUTPATIENT services provided in conjunction with a preventive care visit, you may be charged an office visit COST SHARING AMOUNT.

For certain OUTPATIENT services, you may be billed both a facility fee and a separate physician fee for a single episode of care if the services are provided in a hospital setting. If the COST SHARING AMOUNTS for the OUTPATIENT service includes a DEDUCTIBLE or COINSURANCE charge, that charge will apply to both fees. If the COST SHARING AMOUNT is a COPAYMENT charge, only a singular COPAYMENT will apply unless otherwise specified in the "Benefit Overview."

COST SHARING AMOUNTS for URGENT CARE services vary depending on:

- location where services are provided (for example, PROVIDER's office, LIMITED SERVICE MEDICAL CLINIC, FREE-STANDING URGENT CARE CENTER, or EMERGENCY room); and
- any additional Diagnostic OUTPATIENT services provided during the visit. Such services including but are not limited to laboratory tests, x-rays, or DURABLE MEDICAL EQUIPMENT may be subject to separate COST SHARING AMOUNTS (see the "Benefit Overview"). For more information, please call Member Services.

DEDUCTIBLE- (IN-NETWORK):

The benefit schedule later in the section tells you what benefits are subject to the IN-NETWORK DEDUCTIBLE and other COST SHARING AMOUNTS you pay under this plan. Your DEDUCTIBLE applies to all COVERED SERVICES at the IN-NETWORK Level of Benefits except as listed in the benefit schedule. If your DEDUCTIBLE exceeds $2,700 per individual or $5,400 per family, your employer will be required to fund a Health Reimbursement Account for you in the amount that exceeds $2,700 per individual or $5,400 per family.

Individual DEDUCTIBLE: $500.00 per CONTRACT YEAR

An Individual DEDUCTIBLE of $500.00 applies to each MEMBER for COVERED SERVICES received at the IN-NETWORK LEVEL OF BENEFITS per CONTRACT YEAR.

Family DEDUCTIBLE: $500.00 per MEMBER and $1,500.00 per family each CONTRACT YEAR

NOTE: The Family DEDUCTIBLE is satisfied with any combination of DEDUCTIBLE payments for COVERED SERVICES for any enrolled MEMBERs. If any enrolled MEMBER in a family meets the Individual DEDUCTIBLE before the Family DEDUCTIBLE is met; then coverage will begin for that MEMBER; (1) subject to any other COST SHARING AMOUNTS that may apply, and (2) any such cost sharing will not count toward the Family DEDUCTIBLE.

The following amounts do not count towards your DEDUCTIBLE:

- Any amount you pay for services, supplies, or medications that are not COVERED SERVICES.
- Costs in excess of the REASONABLE CHARGE.
- The premium you pay for this plan.
- Any DEDUCTIBLE amount paid by the MEMBER for a COVERED SERVICE rendered during the last 3 months of a CONTRACT YEAR shall be carried forward to the next CONTRACT YEAR's DEDUCTIBLE. Any DEDUCTIBLE amount carried forward will be applied to the next CONTRACT YEAR OUT-OF POCKET MAXIMUM.

DEDUCTIBLE - (OUT-OF-NETWORK):
Individual DEDUCTIBLE: $1,000.00 per CONTRACT YEAR An Individual DEDUCTIBLE of $1,000.00 applies to each MEMBER for COVERED SERVICES per CONTRACT YEAR
Family DEDUCTIBLE: $1,000.00 per MEMBER and $3,000.00 per family each CONTRACT YEAR
NOTE: The Family DEDUCTIBLE is satisfied with any combination of DEDUCTIBLE payments for COVERED SERVICES for any enrolled MEMBERs. If any enrolled MEMBER in a family meets the Individual DEDUCTIBLE before the Family DEDUCTIBLE is met; then coverage will begin for that MEMBER; (1) subject to any other COST SHARING AMOUNTS that may apply, and (2) any such cost sharing will not count toward the Family DEDUCTIBLE. **Note**: • Any amount paid by the MEMBER for a COVERED SERVICE rendered during the last 3 months of a CONTRACT YEAR shall be carried forward to the next CONTRACT YEAR's DEDUCTIBLE. Any DEDUCTIBLE amount carried forward will be applied to the next CONTRACT YEAR OUT-OF POCKET MAXIMUM.

OUT-OF-POCKET MAXIMUM (IN-NETWORK):
Individual OUT-OF-POCKET MAXIMUM: $4,000.00
Family OUT-OF-POCKET MAXIMUM: $4,000.00 per MEMBER and $8,000.00 per family
Any DEDUCTIBLE, COPAYMENT, or COINSURANCE amount you pay for COVERED SERVICES under this plan counts towards your OUT-OF-POCKET MAXIMUM. Once you have satisfied your OUT-OF-POCKET MAXIMUM, you are no longer responsible for DEDUCTIBLES, COPAYMENTS, or COINSURANCE.
Note: Under a family plan, any combination of enrolled MEMBERS in a family can contribute toward meeting the Family OUT-OF POCKET MAXIMUM. Once the Family OUT-OF POCKET MAXIMUM is met during a Contract Year, we begin to pay for Covered Services for all enrolled Members in a family under the terms of this Certificate. If any enrolled Member in a family meets the Individual OUT-OF POCKET MAXIMUM before the Family OUT-OF POCKET MAXIMUM is met, then: (1) that Member has met his/her OUT-OF POCKET MAXIMUM requirement; and (2) we will begin to pay for his/her COVERED SERVICES, subject to the terms of this CERTIFICATE. **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. • The premium you pay for this plan.
OUT-OF-POCKET MAXIMUM - (OUT-OF-NETWORK):
Individual OUT-OF-POCKET MAXIMUM: $8,000.00
Family OUT-OF-POCKET MAXIMUM: $8,000.00 per MEMBER and $16,000.00 per family
Any DEDUCTIBLE, COPAYMENT, or COINSURANCE amount you pay for COVERED SERVICES under this plan counts towards your OUT-OF-POCKET MAXIMUM. Once you have satisfied your OUT-OF-POCKET MAXIMUM, you are no longer responsible for DEDUCTIBLES, COPAYMENTS, or COINSURANCE.
Note: Under a family plan, any combination of enrolled MEMBERS in a family can contribute toward meeting the Family OUT-OF POCKET MAXIMUM. Once the Family OUT-OF POCKET MAXIMUM is met during a Contract Year, we begin to pay for Covered Services for all enrolled Members in a family under the terms of this Certificate. If any enrolled Member in a family meets the Individual OUT-OF POCKET MAXIMUM before the Family OUT-OF POCKET MAXIMUM is met, then: (1) that Member has met his/her OUT-OF POCKET MAXIMUM requirement; and (2) we will begin to pay for his/her COVERED SERVICES, subject to the terms of this CERTIFICATE. **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. • The premium you pay for this plan.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your EFFECTIVE DATE.

Important Note about your coverage under the Affordable Care Act ("ACA"): Under the ACA, preventive care services -- including women's preventive health care services, preventive care visits, 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 our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services**.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
EMERGENCY Care		
Treatment in an EMERGENCY room	$250.00 COPAYMENT	Same as the IN-NETWORK LEVEL OF BENEFITS.
	Notes: • EMERGENCY room COPAYMENT waived if admitted as an INPATIENT or DAY SURGERY. • Observation services will take an EMERGENCY room COPAYMENT.	
Notes: • **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 in order to be covered at the IN-NETWORK LEVEL OF BENEFITS.** • **If you are admitted as an INPATIENT after receiving EMERGENCY care, please call TUFTS HEALTH PLAN in order to have your EMERGENCY room COPAYMENT waived.**		
Acupuncture services	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Allergy Injections	IN-NETWORK DEDUCTIBLE and then COINSURANCE per injection.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Allergy testing and treatment	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Ambulance services	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	Same as the IN-NETWORK LEVEL OF BENEFITS.
Notes: • Ground, sea, and air ambulance transportation for EMERGENCY care are COVERED SERVICES. • NON-EMERGENCY ambulance transportation is covered only when an AUTHORIZED REVIEWER determines in advance that such services are MEDICALLY NECESSARY.		

(AR) - These services or certain services within this benefit category may require approval by the REVIEW ORGANIZATION. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for ensuring your PROVIDER obtains this approval. Please see "Pre-Authorization/Pre-Authorized" in Chapter 1 for more information.

(BL) - Benefit Limit applies. See "Benefit Limit" section following this section and "COVERED SERVICES" in Chapter 3.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Autism spectrum disorders - diagnosis and treatment **(AR)**	HABILITATIVE or rehabilitative care (including applied behavioral analysis): • When provided by a PARAPROFESSIONAL: $30.00 COPAYMENT. • When provided by a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA): $30.00 COPAYMENT. • When provided by a licensed physical or occupational therapist: $30.00 COPAYMENT. • When provided by a licensed speech-language therapist or audiologist: $30.00 COPAYMENT. **Prescription medications**: Covered as described under "Prescription Drug Benefit" in Chapter 3. **Psychiatric and psychological care:** Covered as described under "Behavioral Health/Substance Use Disorder Services". **Therapeutic care:** Covered as described under "Treatment of speech, hearing and language disorders" and "Physical and occupational therapy services".	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Behavioral Health and Substance Use Disorder Services To contact the Tuf ts Health Plan Behavioral Health Department, call 1-800-208-9565.		
OUTPATIENT services*	Individual Session - $30.00 COPAYMENT Group Sessions - $30.00 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

*Certain OUTPATIENT behavioral health and substance use disorder services may require approval by an AUTHORIZED REVIEWER. Please see "Behavioral Health and Substance Use Disorder Services" in Chapter 3 or contact the Behavioral Health Department for more information.

(AR) - These services or certain services within this benefit category may require approval by the REVIEW ORGANIZATION. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for ensuring your PROVIDER obtains this approval. Please see "Pre-Authorization/Pre-Authorized" in Chapter 1 for more information.

(BL) - Benefit Limit applies. See "Benefit Limit" section following this section and "COVERED SERVICES" in Chapter 3.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Medication assisted treatment, including methadone maintenance	Covered in full when provided by a medication assisted treatment clinic.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
INPATIENT services **(AR)**	**Facility Services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Professional Services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
MEDICALLY NECESSARY treatment in a behavioral health residential treatment facility **(AR)**	IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Intermediate care, including behavioral health services for children and adolescents **(AR)** Note: Prior approval by the REVIEW ORGANIZATION is only required for certain behavioral health services for children and adolescents. Please see Chapter 3 for more information about these services.	IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Cardiac rehabilitation services	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Chemotherapy administration **Note:** For information about your coverage for the medications used in chemotherapy, please see "Injectable, infused or inhaled medications" later in this "Benefit Overview".	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Chiropractic care See "Spinal manipulation"		
Cleft lip and cleft palate treatment and services for CHILDREN	**Medical or facial surgery:** DAY SURGERY: Covered as described under "DAY SURGERY". INPATIENT SERVICES: Covered as described under "Hospital Services (acute care)" or "Reconstructive Surgery and Procedures". **Oral surgery:** Covered as described under "Oral Health Services". **Dental surgery or orthodontic treatment and management:** Covered in full. **Preventive and restorative dentistry:** Covered in full (see "Cleft lip and cleft palate treatment and services for CHILDREN" in Chapter 3 for more information about what is covered under this benefit). **Speech therapy and audiology services:** Covered as described under "Treatment of speech, hearing and language disorders". **Nutrition services:** Covered as described under "Nutritional counseling".	**Dental surgery or orthodontic treatment and management:** Covered in full. **Preventive and restorative dentistry:** Covered in full. **All other services:** OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Colonoscopies See "Diagnostic or preventive screening procedures"		
DAY SURGERY	**FACILITY Services**: IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Physician, surgical & medical services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Diabetes self-management training and educational services	$30.00 COPAYMENT.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Diagnostic Imaging **(AR)** • General imaging (such as x-rays and ultrasounds); and • MRI / MRA, CT/ CTA, PET and nuclear cardiology.	**General imaging:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **MRI/MRA:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **CT/CTA:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **PET:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Nuclear cardiology:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Diagnostic or preventive screening procedures (for example, proctosigmoidoscopies, colonoscopies and sigmoidoscopies)	**Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention:** Covered in full. (not subject to DEDUCTIBLE) **Diagnostic procedure only (for example, colonoscopies associated with symptoms):** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Diagnostic procedure accompanied by treatment/ surgery (for example, polyp removal)**: IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Diagnostic testing **(AR)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
DURABLE MEDICAL EQUIPMENT **(AR)**	30% COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then 30% COINSURANCE.
Early intervention services for a DEPENDENT CHILD	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Extended Care **(AR) (BL)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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Benefit Overview, continued

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Family planning (procedures, services and contraceptives)	**Office Visit**: $30.00 COPAYMENT. **DAY SURGERY**: IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full at the IN-NETWORK LEVEL OF BENEFITS. To determine whether a specific family planning service is covered in full or subject to a COST SHARING AMOUNT, please see **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services,** or call Member Services.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Hearing aids	Hearing aids for CHILDREN age 21 and under: 30% COINSURANCE. Hearing aids for MEMBERS age 22 and over: 30% COINSURANCE.	Hearing aids for CHILDREN age 21 and under: OUT-OF NETWORK DEDUCTIBLE then COINSURANCE. Hearing aids for MEMBERS age 22 and over: OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Hemodialysis	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Home health care **(AR)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Hospice care services	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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Benefit Overview, continued

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Hospital INPATIENT care (acute care) **(AR)**	**FACILITY Services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Physician, surgical & medical services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Human leukocyte antigen testing or histocompatibility locus antigen testing	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Immunizations and vaccinations	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Infertility services Note: Prior approval by the REVIEW ORGANIZATION is only required for cryopreservation services; all other assisted reproductive technology procedures are covered without prior approval. Please see Chapter 3 for more information about these services.	IN-NETWORK DEDUCTIBLE and then COINSURANCE. Note: Approved Assisted Reproductive Technology services are subject to the IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Injectable, infused, or inhaled medications **(AR)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Laboratory tests **(AR)** **Note:** In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full at the IN-NETWORK LEVEL OF BENEFITS.	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Lead screenings	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Mammograms	**Routine mammograms:** Covered in full. **Diagnostic mammograms** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Maternity Care		
OUTPATIENT	**Routine maternity care:** Covered in full. **NOTES:** • Routine laboratory tests associated with maternity care are covered in full at the IN-NETWORK LEVEL OF BENEFITS, in accordance with the ACA. • At the IN-NETWORK LEVEL OF BENEFITS, MEMBER COST SHARING will apply to diagnostic tests or diagnostic laboratory tests when they are ordered during a routine maternity care visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services. **Non-Routine maternity care:** $30.00 COPAYMENT per visit. **All other services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
INPATIENT	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	
Medical Supplies	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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Benefit Overview, continued

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Nutritional counseling	**Preventive nutritional counseling:** Covered in full. **All other nutritional counseling services**: $30.00 COPAYMENT. **Note:** Nutritional counseling services are covered in full at the IN-NETWORK LEVEL OF BENEFITS when they are provided as preventive services, as defined by the U.S. Preventive Services Task Force. Please see "Nutritional Counseling" in Chapter 3 for more information.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Office visits to diagnose and treat illness and injury, including consultations	$30.00 COPAYMENT. **Note:** This includes visits to a LIMITED SERVICE MEDICAL CLINIC that participates with TUFTS HEALTH PLAN.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Oral health services **(AR)**	**EMERGENCY care in an EMERGENCY room**: $250.00 COPAYMENT. **Office visit:** Please see "Surgery – in a PROVIDER's office". **INPATIENT SERVICES**: IN-NETWORK DEDUCTIBLE and then COINSURANCE. **DAY SURGERY**: IN-NETWORK DEDUCTIBLE and then COINSURANCE.	**EMERGENCY care in an EMERGENCY room**: $250.00 COPAYMENT (not subject to DEDUCTIBLE). **All other services:** OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Pap smears	**Routine annual cytology screenings:** Covered in full. **Diagnostic cytology examinations:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Patient care services provided as part of a qualif ied clinical trial for the treatment of cancer or other lif e-threatening diseases or conditions (OUTPATIENT and INPATIENT)	**OUTPATIENT:** $30.00 COPAYMENT. **INPATIENT:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Preventive care for MEMBERS under age 6	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
	Note: • Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS. • 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.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	
Preventive care for MEMBERS age 6 and older	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
	Note: • Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS. • 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.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	
Prosthetic devices **(AR)**	20% COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Radiation therapy	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Rehabilitative and HABILITATIVE physical and occupational therapy services **(BL)** **Note:** Visit limits do not apply to the treatment of autism spectrum disorders.	$30.00 COPAYMENT.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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Benefit Overview, continued

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Treatment of speech, hearing and language disorders (AR)	$30.00 COPAYMENT. **Note:** COST SHARING AMOUNTS for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Respiratory therapy/pulmonary rehabilitation services	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Routine annual gynecological exam	Covered in full. **Notes:** • Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine annual gynecological exam is subject to an office visit COPAYMENT at the IN-NETWORK LEVEL OF BENEFITS. • MEMBER cost-sharing will also apply to diagnostic tests or 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.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Scalp hair prostheses or wigs for cancer or leukemia patients **(BL)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Smoking cessation counseling services	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

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Benefit Overview, continued

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Special medical formulas		
Low protein foods	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Nonprescription Enteral Formulas **(AR)**	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Special medical formulas **(AR)**	Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Spinal manipulation **(BL)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Surgery - Bone marrow transplants for breast cancer, hematopoietic stem cell transplants and human solid organ transplants **(AR)**	**Facility Services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Physician surgical & medical services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Surgery - in a PROVIDER's office	IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Surgery - Reconstructive surgery and procedures **(AR)**	**Facility Services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Physician surgical & medical services:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Telemedicine services obtained through TUFTS HEALTH PLAN'S designated telemedicine vendor (Also called "telehealth") Telemedicine services obtained through a TUFTS HEALTH PLAN NETWORK PROVIDER. **Note:** A telemedicine services visit with a NETWORK PROVIDER will apply the same COST SHARING AMOUNT that applies to an in-person office visit with that PROVIDER.	**General medicine/behavioral health services:** Covered in full. **Dermatology services:** Covered in full. **Office Visits:** $30.00 COPAYMENT. **Remote Patient Monitoring:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Remote medical data transfer/evaluation:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	Not applicable. Please see below for information about your COST SHARING AMOUNTS for telemedicine visits with NETWORK PROVIDERS. OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
URGENT CARE		
In a PROVIDER's office	$30.00 COPAYMENT.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
In a LIMITED SERVICE MEDICAL CLINIC	$30.00 COPAYMENT.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
In a hospital-based OUTPATIENT walk-in clinic	$30.00 COPAYMENT.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
In a FREE-STANDING URGENT CARE CENTER	$30.00 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

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COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Vision care services		
Routine eye examination **(BL)**	$30.00 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Other vision care services	Care provided by an optometrist: $30.00 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Note: MEMBER cost sharing will also apply to diagnostic tests or laboratory services when they are ordered during a visit for other vision care services. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services.		
	Care provided by an ophthalmologist: $30.00 COPAYMENT 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.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

TUFTS HEALTH PLAN MEMBER Discounts
For information on how you can take advantage of discounts on a variety of health products, services, and treatments, such as acupuncture, massage therapy, and wellness programs, see "TUFTS HEALTH PLAN MEMBER Discounts" in Chapter 3.

Prescription Drug Benefit
For information about your COPAYMENTS and/or COINSURANCE for covered prescription drugs, see the "Prescription Drug Benefit" section in Chapter 3.

(AR) - These services or certain services within this benefit category may require approval by the REVIEW ORGANIZATION. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for ensuring your PROVIDER obtains this approval. Please see "Pre-Authorization/Pre-Authorized" in Chapter 1 for more information.

(BL) - Benefit Limit applies. See "Benefit Limit" section following this section and "COVERED SERVICES" in Chapter 3.

Benefit Limits

Extended Care Services

Covered up to 100 days per CONTRACT YEAR (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of $350 per CONTRACT YEAR (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Rehabilitative and HABILITATIVE physical and occupational therapy
The maximum benefit payable per CONTRACT YEAR is 2 evaluations for short term occupational rehabilitation therapy services.

The maximum benefit payable per CONTRACT YEAR is 2 evaluations for short term occupational HABILITATIVE therapy services.

The maximum benefit payable per CONTRACT YEAR is 30 visits for short term occupational rehabilitation therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

The maximum benefit payable per CONTRACT YEAR is 30 visits for short term occupational HABILITATIVE therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

The maximum benefit payable per CONTRACT YEAR is 2 evaluations for short term physical rehabilitation therapy services.

The maximum benefit payable per CONTRACT YEAR is 2 evaluations for short term physical HABILITATIVE therapy services.

The maximum benefit payable per CALENDAR YEAR is 30 visits for short term physical rehabilitation therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

The maximum benefit payable per CALENDAR YEAR is 30 visits for short term physical HABILITATIVE therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Note: This benefit limit does not apply to the treatment of autism spectrum disorders or for physical or occupational therapy provided as part of home health care, as described in the "Home Health Care" benefit later in this document.

Spinal manipulation
The maximum benefit payable in each CONTRACT YEAR is 12 visits. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Eligibility for Benefits

When you need health care services, you may choose to obtain these services from either a NETWORK PROVIDER (IN-NETWORK LEVEL OF BENEFITS); or a NON-NETWORK PROVIDER (OUT-OF-NETWORK LEVEL OF BENEFITS). Your choice will determine the level of benefits you receive for your health care services. TUFTS HEALTH PLAN covers only the services and supplies described as COVERED SERVICES in Chapter 3.

Important Notes:

- 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.
- If you live outside of Massachusetts, your benefits under this plan may also include benefits required under applicable state law. For more information, please call Member Services.

IN-NETWORK LEVEL OF BENEFITS

If your care is provided by a NETWORK PROVIDER, or if you seek care at a LIMITED SERVICE MEDICAL CLINIC or a FREE-STANDING URGENT CARE CENTER that participates with TUFTS HEALTH PLAN, you are entitled to coverage for COVERED SERVICES at the IN-NETWORK LEVEL OF BENEFITS.

Note: Please see the "URGENT CARE" section later in this chapter for coverage information regarding URGENT CARE services with NETWORK PROVIDERs.

You pay a COPAYMENT for certain COVERED SERVICES you receive at the IN-NETWORK LEVEL OF BENEFITS. For more information about your MEMBER costs for medical services, see "Benefit Overview" at the front of this CERTIFICATE.

When a NETWORK PROVIDER provides your care, you do not have to submit any claim forms. The claim forms are submitted to TUFTS HEALTH PLAN by the NETWORK PROVIDER.

Selecting a PROVIDER

In order to receive coverage at the IN-NETWORK LEVEL OF BENEFITS, you must receive care from a NETWORK PROVIDER. You can find NETWORK PROVIDERs through our searchable directory on our website. You should choose a PROVIDER, who is in a location convenient to you. If you have difficulty or need assistance in finding a PROVIDER, call our Member Services Department.

Notes:

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

No PRECERTIFICATION by You

As long as your INPATIENT procedure is provided by a NETWORK PROVIDER, you are not responsible for PRECERTIFYING the procedure. Your NETWORK PROVIDER will PRECERTIFY the procedure for you. See "Preadmission Certification and Continued Stay Review (PAC.CSR)" later in this chapter for more information.

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

Changes to PROVIDER network

CARELINK offers MEMBERS access to an extensive network of physicians, hospitals, and other PROVIDERS throughout the NETWORK CONTRACTING AREA. NETWORK PROVIDERS may change during the year.

This can happen for many reasons, including a PROVIDER's retirement, moving out of the NETWORK CONTRACTING AREA, or failure to continue to meet credentialing standards. In addition, because PROVIDERS are independent contractors, this can also happen if the PROVIDER does not reach agreement on a network contract.

If you have any questions about the availability of a PROVIDER, please call Member Services.

OUT-OF-NETWORK LEVEL OF BENEFITS

OUT-OF-NETWORK LEVEL OF BENEFITS
If a NETWORK PROVIDER does not provide your care, you are entitled to coverage for COVERED SERVICES at the OUT-OF-NETWORK LEVEL OF BENEFITS. You pay a DEDUCTIBLE and COINSURANCE for certain COVERED SERVICES you receive at the OUT-OF-NETWORK LEVEL OF BENEFITS. For more information about your MEMBER costs for medical services, see "Benefit Overview" at the front of this document.

Note: Please see the "URGENT CARE" section later in this chapter for coverage information regarding URGENT CARE services with NON-NETWORK PROVIDERs.

Please note that you must submit a claim form for each service that is provided by a NON-NETWORK PROVIDER. For information on filing claim forms, see Chapter 6.

COVERED SERVICES Not Available from a NETWORK PROVIDER
If a COVERED SERVICE is not available from a NETWORK PROVIDER, as determined by TUFTS HEALTH PLAN, with our prior approval you may go to a NON-NETWORK PROVIDER and receive COVERED SERVICES at the IN-NETWORK LEVEL OF BENEFITS up to the REASONABLE CHARGE. You may be responsible for any costs in excess of the REASONABLE CHARGE, as well as any applicable COST SHARING AMOUNT. You may receive a bill for these services. If you receive a bill, please see "Bills from PROVIDERS" later in this CERTIFICATE or call Member Services for more information about what to do if you receive a bill.

PRECERTIFICATION by You
If you receive INPATIENT services which are not provided by a NETWORK PROVIDER, you must ensure that the PROVIDER obtains a Precertification for these services or the services may not be covered. See "Preadmission Certification and Continued Stay Review (PAC.CSR)" later in this chapter for more information.

COVERED SERVICES Outside of the 50 United States

EMERGENCY care services provided to you outside of the 50 United States qualify as COVERED SERVICES. URGENT CARE services provided to you while you are traveling outside of the 50 United States also qualify as COVERED SERVICES. However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan.

Continuity of Care

If you are an existing MEMBER

If your PROVIDER is disenrolled from CARELINK for reasons other than quality or fraud, you may continue to see your PROVIDER for the following continuing care conditions for up to 90 days from the date we notify you of your PROVIDER'S termination, unless otherwise indicated below:

- If you are receiving treatment for a Serious or Complex Condition.
- If you are pregnant, you may continue to receive care from your PROVIDER through your first postpartum visit.
- If you are an INPATIENT.
- If you are scheduled to undergo urgent or emergent surgery, including postoperative.
- 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.

Note: Serious and Complex Condition means:

- an acute illness or condition that requires specialized medical treatment to avoid possibility of death or permanent harm; or
- a chronic illness or condition that (i) is life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.

Note: If you have a complex care need, you may continue to see your PROVIDER for up to 90 days to allow your care to be transitioned to a NETWORK PROVIDER. The "Conditions for coverage of continued treatment" section below does not apply to PROVIDERS treating MEMBERS with complex care needs.

If you are enrolling as a new MEMBER

When you enroll as a MEMBER, if none of the health plans offered by the GROUP at that time include your PROVIDER, you may continue to see your PROVIDER if:

- you are undergoing a course of treatment. In this instance, you may continue to see your PROVIDER and receive COVERED SERVICES at the IN-NETWORK LEVEL OF BENEFITS from that PROVIDER for up to 30 days from your EFFECTIVE DATE;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your PROVIDER and receive COVERED SERVICES at the IN-NETWORK LEVEL OF BENEFITS from that PROVIDER through your first postpartum visit; or
- you are terminally ill. In this instance, you may continue to see your PROVIDER and receive COVERED SERVICES at the IN-NETWORK LEVEL OF BENEFITS from that PROVIDER as long as necessary.

Conditions for coverage of continued treatment

TUFTS HEALTH PLAN may condition coverage of continued treatment upon the PROVIDER's agreement:

- to accept reimbursement from TUFTS HEALTH PLAN at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to a MEMBER in an amount that would exceed the cost sharing that could have been imposed if the PROVIDER has not been disenrolled;
- to adhere to the quality assurance standards of TUFTS HEALTH PLAN and to provide us 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.

INPATIENT Behavioral Health/Substance Use Disorder Services

IN -NETWORK LEVEL OF BENEFITS: If you require INPATIENT or intermediate behavioral health or substance use disorder services and wish to receive coverage for these services at the IN-NETWORK LEVEL OF BENEFITS, your INPATIENT or intermediate behavioral health or substance use disorder services must be provided by a NETWORK HOSPITAL. You may go to any NETWORK HOSPITAL and receive coverage at the IN-NETWORK LEVEL OF BENEFITS. There is no need to contact TUFTS HEALTH PLAN first. Simply call or go directly to any NETWORK HOSPITAL. Identify yourself as a TUFTS HEALTH PLAN MEMBER. The NETWORK HOSPITAL is responsible for providing all INPATIENT/intermediate behavioral health and substance use disorder services. You are not responsible for notifying TUFTS HEALTH PLAN of your admission at a NETWORK HOSPITAL.

OUT-OF-NETWORK LEVEL OF BENEFITS: If you wish to receive INPATIENT or intermediate behavioral health or substance use disorder services at a PROVIDER that is not a NETWORK HOSPITAL, your coverage will be at the OUT-OF-NETWORK LEVEL OF BENEFITS. Authorized review may be required for certain COVERED SERVICES. You are responsible for making sure your PROVIDER provides notification and obtains authorization from the REVIEW ORGANIZATION**.** If this notification is not provided and any required authorization is not obtained, you may be responsible for the full cost of these services. Please call 1-866-352-9114 for more information on how to receive this authorization.

EMERGENCY Admission to a NON-NETWORK HOSPITAL

If you are admitted in an EMERGENCY to a NON-NETWORK HOSPITAL, you will be covered at the IN-NETWORK LEVEL OF BENEFITS as long as your Provider contacts the Review Organization within 48 hours of the admission. Once it is determined that transfer to a NETWORK HOSPITAL is medically appropriate, you will be transferred to a NETWORK HOSPITAL. If you choose not to accept the transfer and to remain at the NON-NETWORK HOSPITAL, then your coverage as of that time will revert to the OUT-OF-NETWORK LEVEL OF BENEFITS.

EMERGENCY Care

To receive EMERGENCY care

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

OUTPATIENT EMERGENCY care

If you receive EMERGENCY services but are not admitted as an INPATIENT, you will be covered at the IN-NETWORK LEVEL OF BENEFITS. You will be required to pay a COST SHARING AMOUNT for each EMERGENCY room visit.

If you receive EMERGENCY COVERED SERVICES from a NON-NETWORK HOSPITAL, you pay the applicable COST SHARING AMOUNT. You may receive a bill for these services. Please see "Bills from PROVIDERS" in Chapter 6 or call Member Services for more information about what to do if you receive a bill.

INPATIENT EMERGENCY care

If you receive EMERGENCY services and are admitted as an INPATIENT, your PROVIDER should contact the REVIEW ORGANIZATION within 48 hours of the admission. (Notification from the attending physician satisfies this requirement.)

If you are admitted as an INPATIENT to a hospital that is a NON-NETWORK PROVIDER after receiving EMERGENCY care, an INPATIENT COPAYMENT will apply. In addition, you must ensure the PROVIDER contacts the REVIEW ORGANIZATION within 48 hours of the admission.

URGENT CARE

Definition of URGENT CARE:

URGENT CARE is defined as care provided when your health is not in serious danger, but you need immediate attention for a condition or unforeseen illness or injury, whether medical, physical, behavioral, related to a substance use disorder, or mental health. Examples 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.

Follow these guidelines for receiving URGENT CARE

Place of Service	NETWORK PROVIDER	Non-NETWORK PROVIDER located in the NETWORK CONTRACTING AREA	Non-NETWORK PROVIDER outside of the NETWORK CONTRACTING AREA
LIMITED SERVICE MEDICAL CLINIC or FREE-STANDING URGENT CARE Center	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the OUT-OF-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.
EMERGENCY room	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.
PROVIDER's office or hospital-based walk-in clinic	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the OUT-OF-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.
Behavioral health/substance use disorder PROVIDER's office	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the OUT-OF-NETWORK LEVEL OF BENEFITS.	You are covered for URGENT CARE at the IN-NETWORK LEVEL OF BENEFITS.

If you are in the NETWORK CONTRACTING AREA

You may seek URGENT CARE: in a PROVIDER's office; in an EMERGENCY room; in a hospital-based OUTPATIENT walk-in clinic; in a LIMITED SERVICE MEDICAL CLINIC or FREE-STANDING URGENT CARE Center

URGENT CARE services provided within the NETWORK CONTRACTING AREA by a NETWORK PROVIDER are covered at the IN-NETWORK LEVEL OF BENEFITS.

URGENT CARE services received within the NETWORK CONTRACTING AREA are covered at the OUT- OF-NETWORK LEVEL OF BENEFITS if provided in a Non-NETWORK PROVIDER's office, from a Non-NETWORK PROVIDER in a hospital-based OUTPATIENT walk-in clinic, or from a LIMITED SERVICE MEDICAL CLINIC or FREE-STANDING URGENT CARE Center that is not affiliated with TUFTS HEALTH PLAN.

If you are outside the NETWORK CONTRACTING AREA

You may seek URGENT CARE in a PROVIDER's office, a LIMITED SERVICE MEDICAL CLINIC, FREE-STANDING URGENT CARE Center, a hospital-based OUTPATIENT walk-in clinic, or the EMERGENCY room.

URGENT CARE services provided outside of the NETWORK CONTRACTING AREA are covered at the IN-NETWORK LEVEL OF BENEFITS.

Financial Arrangements between TUFTS HEALTH PLAN and NETWORK PROVIDERS

Methods of payment to NETWORK 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 our MEMBERS. TUFTS HEALTH PLAN uses a variety of mutually agreed upon methods to compensate NETWORK PROVIDERS.

The DIRECTORY OF HEALTH CARE PROVIDERS indicates the method of payment for each NETWORK PROVIDER with whom we contract. 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.

You should feel free to discuss specific questions about how he or she is paid with your PROVIDER.

Member Identification Card

Introduction

CARELINK 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 Representative.

Identifying yourself as a CARELINK MEMBER

Your Member ID card is important because it identifies you as a CARELINK 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 services.

When you receive services, you must tell the office staff that you are a CARELINK MEMBER.

IMPORTANT NOTE: If you do not identify yourself as a g MEMBER, then:

- we 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 a CARELINK Member Representative.

Utilization Review

The CARELINK utilization review program evaluates whether: (1) health care services proposed or provided to MEMBERS are MEDICALLY NECESSARY; and (2) are provided in the most appropriate and cost-effective manner.

This program sometimes includes prospective, concurrent, and retrospective review of health care services for MEDICAL NECESSITY (collectively, this comprises AUTHORIZED REVIEW) and is performed by the REVIEW ORGANIZATION. Prospective and concurrent reviews are ref erred to as Preadmission Certification/Preservice Review and Continued Stay Review (PAC/CSR) and are described in more detail below.

Prospective review is used to determine whether certain proposed treatments are MEDICALLY NECESSARY before that treatment begins. It is also referred to as "pre-service review".

Concurrent review is used to:

- monitor the course of treatment as they occur; and
- to determine when that treatment is no longer MEDICALLY NECESSARY.

Retrospective review is used to evaluate the MEDICAL NECESSITY of care after is has been provided. In certain circumstances, retrospective review is used to more accurately determine if a MEMBER'S health care services are appropriate. It is also referred to as Post-Service Review.

TIMEFRAMES TO REVIEW YOUR REQUEST FOR COVERAGE

Type of Review	Timeframe for Determinations*
Prospective (Pre-service) review (Non-Urgent)	Within 10 days of receiving all necessary information but no later than 15 days from receipt of the request.
Concurrent review	Within 1 working day of receiving all necessary information.
Retrospective (Post-service) review	30 days.

Utilization review helps MEMBERs in the following ways:

- Prospective and concurrent reviews let Members know if proposed health care services are MEDICALLY NECESSARY and covered under their plan. This allows MEMBERs to make informed decisions about their care.
- Utilization review can enhance the quality of care and convenience for the MEMBER by evaluating if treatment is MEDICALLY NECESSARY and the most appropriate for the MEMBER.
- By evaluating treatment cost effectiveness, MEMBER COST SHARING AMOUNTS may be reduced.
- Helping to control overall plan costs plays an important part in making sure health care plans continue to be af fordable.

*See Appendix B for 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 f or information on how to file an appeal.

Utilization reviews affect only coverage determinations under this CARELINK plan. You and your PROVIDER make all treatment decisions.

IMPORTANT NOTE: To determine the status or outcome of utilization review decisions, MEMBERS can call the following numbers:

- Behavioral health or substance use disorder utilization review decisions – 1-800-232-1164;
- All other utilization review decisions – 1-866-352-9114.

Care Management

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

If a MEMBER is identified by us as an appropriate candidate for care management or referred to the program, we may contact that MEMBER and his or her NETWORK PROVIDER to discuss a treatment plan and establish prioritized goals. A TUFTS HEALTH PLAN Complex Care Manager may suggest alternative services and supplies available to the MEMBER.

The MEMBER's treatment plan may be periodically reviewed. The MEMBER and the MEMBER's NETWORK PROVIDER will be contacted if alternatives to the MEMBER's current treatment plan are identified that qualify as COVERED SERVICES are cost effective and are appropriate for the MEMBER.

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

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

Preadmission Certification and Continued Stay Review

What is Preadmission Certification and Continued Stay Review (PAC/CSR)?
Preadmission Certification/Continued Stay Review is a program designed to help you and your Dependents choose the most appropriate setting for your medical care and to avoid expenses that will not be covered by your CARELINK plan. Any request for Precertification of coverage for a non-Emergency hospital stay must be approved by the Review Organization before you are admitted. As part of the Precertification process, the Review Organization will determine a Medically Necessary and appropriate length for your Inpatient hospital admission. If you choose to continue your hospital admission beyond this approved length of stay, your Provider must obtain an approval from the Review Organization. Remember, your Provider will handle PAC/CSR for you. If you use a non-Network Provider, you are responsible for ensuring your Provider has had your Inpatient hospital admission Precertified.

Who is Responsible for Obtaining PAC/CSR?
If you use a Network Provider, your Provider will initiate PAC/CSR by contacting the Review Organization. For services received from non-Network Providers, you must ensure your Provider initiates the review.

Pre-Admission Certification/Continued Stay Review for Hospital Confinement
Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the MEDICALNECESSITY and length of an INPATIENT hospital admission when you or your DEPENDENT require treatment in a Hospital:

- as a registered bed patient;
- for partial hospitalization for the treatment of behavioral health or substance use disorder;
- for behavioral health or substance abuse residential treatment services.

Your PROVIDER should request PAC prior to any non-EMERGENCY treatment in a hospital as described above. In the case of an EMERGENCY admission, your PROVIDER should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, your PROVIDER should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued hospital confinement.

Changes to Precertification Information
Precertification is valid only for the diagnosis, procedure, admission date and medical facility specified at the time of Precertification. Your PROVIDER must provide notification of any delays, changes or cancellations of your proposed admission. A separate Precertification must be obtained for a new admission date, readmission, hospitalization, transfer or surgery for conditions other than those designated during the initial Precertification.

PRIOR AUTHORIZATION/PRE-AUTHORIZED

The term "Prior Authorization" means the approval that a NETWORK PROVIDER must receive from the REVIEW ORGANIZATION, prior to services being rendered, in order for certain services and benefits to qualify as COVERED SERVICES under this plan.

- If you receive these services from a NETWORK PROVIDER, the PROVIDER is responsible for obtaining approval from the REVIEW ORGANIZATION.
- If your services are not provided by a NETWORK PROVIDER, you are responsible for ensuring that your PROVIDER obtains prior approval from the REVIEW ORGANIZATION. If prior approval is not received, TUFTS HP will not cover those services and supplies. If addition, if you received services that TUFTS HEALTH PLAN determines are not COVERED SERVICES, you will be responsible for the cost of those services.

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

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

  Services that require PRIOR AUTHORIZATION include, but are not limited to:

- DAY SURGERY services;
- Orthoses and prosthetic devices;
- DURABLE MEDICAL EQUIPMENT;
- Home health care services;
- advanced radiological imaging;
- Certain medical drugs;
- Transplant services;
- non-EMERGENCY ambulance; or
- Treatment of speech, hearing and language disorders.

Services that you receive in an EMERGENCY do not require PRIOR AUTHORIZATION.

Information Resources for MEMBERS

Obtaining information about TUFTS HEALTH PLAN

The following information about TUFTS HEALTH PLAN will be available from the Massachusetts Health Policy Commission's Office of Patient Protection:

- A list of sources of independently published information assessing MEMBER satisfaction and evaluating the quality of health care services offered by TUFTS HEALTH PLAN.
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with TUFTS HEALTH PLAN during the previous calendar year for which such data has been compiled. This information will contain the 3 most common reasons for voluntary and involuntary disenrollment of those PROVIDER'S.
- The percentage of PREMIUM revenue spent by TUFTS HEALTH PLAN for health care services provided to MEMBERS for the most recent year for which information is available.
- A report that details the following information for the previous calendar year:
  - the total numbers of filed appeals, appeals denied internally, and appeals withdrawn before resolution;and
  - the total number of external appeals pursued after exhausting the internal appeals process, as well as the resolution of all those external appeals.

How to obtain this information

You can obtain this information about TUFTS HEALTH PLAN by contacting the Massachusetts Health Policy Commission's Office of Patient Protection by calling 1-800-436-7757, sending a fax to 1-617-624-5046, sending an email to **HPC-OPP@state.ma.us**, going to **www.mass.gov/hpc/opp** or writing a letter to:

Health Policy Commission
Office of Patient Protection
50 Milk St., 8th Floor
Boston, MA 02109

Chapter 2 - Eligibility, Enrollment and Continuing Eligibility

Eligibility

SUBSCRIBERS

You are eligible as a SUBSCRIBER only if you are an employee of a GROUP and you:

- meet your GROUP's and TUFTS HEALTH PLAN's eligibility rules; and
- live, work or reside in the NETWORK CONTRACTING AREA.

DEPENDENTS

Your SPOUSE or your CHILD is eligible as a DEPENDENT only if you are a SUBSCIBER and that SPOUSE or CHILD:

- qualifies as a DEPENDENT, as defined in this CERTIFICATE; and
- meets your GROUP's and TUFTS HEALTH PLAN's eligibility rules; and
- lives, works or resides in the NETWORK CONTRACTING AREA.

Notes:

- In some instances, DEPENDENTS who live, work or reside outside of the NETWORK CONTRACTING AREA can be eligible for coverage under this plan. Please see "If you live, work or reside outside of the NETWORK CONTRACTING AREA" below for more information
- CHILDREN are not required to live, work or reside in the NETWORK CONTRACTING AREA.

If you do not live, work or reside in the NETWORK CONTRACTING AREA

If you do not live, work or reside in the NETWORK CONTRACTING AREA, you can be covered only if:

- you are a CHILD;
- you are a DEPENDENT subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced SPOUSE for whom TUFTS HEALTH PLAN is required to provide coverage

Proof of Eligibility

We may ask you for proof of your and your DEPENDENTS' eligibility or continuing eligibility. You must give us 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 ENROLLEMENT PERIOD; or
- within the 30 days of the date you or your DEPENDENT is first eligible for this coverage.

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

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

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

- your coverage under the other health coverage ends involuntarily;
- your marriage; or
- the birth, adoption, or placement for adoption of your DEPENDENT CHILD.

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

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

EFFECTIVE DATE of coverage

If we accept your application and receive the needed PREMIUM, coverage starts on either the date chosen by your GROUP. Enrolled DEPENDENTS' coverage starts when the SUBSCRIBER's coverage starts, or at a later date if the DEPENDENT becomes eligible after the SUBSCRIBER became eligible for coverage. A DEPENDENT's coverage cannot start before the SUBSCRIBER's coverage starts.

If you or your enrolled DEPENDENT is an INPATIENT on your EFFECTIVE DATE, your coverage starts on the later of:

- the EFFECTIVE DATE, or
- the date we are notified and given the chance to manage your care.

Adding DEPENDENTS under FAMILY COVERAGE

When DEPENDENTS may be added

After you enroll, you may apply to add any DEPENDENTS who are not currently enrolled in TUFTS HEALTH PLAN only:

- during the OPEN ENROLLMENT PERIOD that applies to you; 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 NETWORK CONTRACTING AREA, or
  - if your GROUP has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add DEPENDENTS

If you have FAMILY COVERAGE, fill out either a group-approved form or TUFTS HEALTH PLAN form listing the DEPENDENTS. Give the form to your GROUP either during your OPEN ENROLLMENT PERIOD or within 30 days after the date of an event listed above, under "When DEPENDENTS may be added."

If you don't have FAMILY COVERAGE, ask your GROUP to change your INDIVIDUAL COVERAGE to FAMILY COVERAGE and then follow the procedure above.

EFFECTIVE DATE of DEPENDENTS' coverage

If we accept your application to add DEPENDENTS, we will send you a Member ID card for each DEPENDENT.

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: We will only pay for COVERED SERVICES which are provided on or after your EFFECTIVE DATE.

Newborn CHILDREN and ADOPTIVE CHILDREN

Importance of enrolling newborn CHILDREN and ADOPTIVE CHILDREN
You must enroll your newborn CHILD within 30 days after the CHILD's birth for the CHILD to be covered from birth. Otherwise, you must wait until the next OPEN ENROLLMENT PERIOD to enroll the CHILD.

You must enroll your ADOPTIVE CHILD within 30 days after the CHILD has been adopted or placed for adoption with you for that CHILD to be covered from the date of his or her adoption. Otherwise, you must wait until the next OPEN ENROLLMENT PERIOD to enroll the CHILD.

Continuing Eligibility for DEPENDENTS

When Coverage ends

DEPENDENT coverage for a CHILD ends on the last day of the month in which the CHILD's 26th birthday occurs.

Coverage after termination

When a CHILD loses coverage under this CERTIFICATE, he or she may be eligible for federal or state continuation or to enroll in INDIVIDUAL COVERAGE. See Chapter 5 for more information.

What the SUBSCRIBER must do to continue coverage for DISABLED DEPENDENTS

1 About 30 days before the CHILD no longer meets the definition of DEPENDENT, call Member Services.
2 Give proof, acceptable to us, 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 us proof of the DEPENDENT's continued disability.

Coverage after termination

The former DISABLED DEPENDENT may be eligible for federal or state continuation coverage or to enroll in coverage under an INDIVIDUAL CONTRACT. See Chapter 5 for more information.

Rule for former SPOUSES (Also see Chapter 5)

If you and your SPOUSE divorce or legally separate, your former SPOUSE may continue coverage as a DEPENDENT under your FAMILY COVERAGE in accordance with Massachusetts law.

Note: If you remarry, your former SPOUSE's coverage as a DEPENDENT under your FAMILY COVERAGE will end. However, your former SPOUSE may continue coverage under an Individual CONTRACT through your employer GROUP. If your former SPOUSE remarries, coverage will end unless continuation is still available under federal law.

How to continue coverage for former SPOUSES

Follow these steps to continue coverage for a former SPOUSE:

- Call a Member Representative within 30 days after the divorce decree is issued to tell us about your divorce.
- Send us proof of your divorce or separation when asked.

Keeping our records current

You must notify us 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 or the remarriage of your former SPOUSE, when the former SPOUSE is an enrolled DEPENDENT under your FAMILY COVERAGE;
- moving out of the NETWORK CONTRACTING AREA or temporarily residing out of the NETWORK CONTRACTING 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 GROUP or the CARELINK Member Services Department.

Chapter 3 - 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 state or federal law;
- consistent with the Cigna's MEDICAL NECESSITY Guidelines in effect at the time the services or supplies are provided. This information is available to you on our website at www.tuftshealthplan.com/provider/resource-center#///Commercial/carelink or by calling Member Services
- obtained within the 50 United States. The only exception to this rule is EMERGENCY care services and URGENT CARE services while traveling, which are COVERED SERVICES when provided outside of the 50 United States;
- provided to treat an injury, illness or pregnancy, except for preventive care; and
- approved by the REVIEW ORGANIZATION, in some cases.

Important Notes:

- the REVIEW ORGANIZATION approval: All claims for services (whether or not the services were provided by a NETWORK PROVIDER) are subject to retrospective review by the REVIEW ORGANIZATION. The REVIEW ORGANIZATION review claims to be sure that the claims are for COVERED SERVICES only. A COVERED SERVICE is one that is described in this chapter. We will only pay claims that are for COVERED SERVICES.
- Certain services require the prior approval of an AUTHORIZED REVIEWER at both the IN-NETWORK and OUT OF NETWORK LEVEL OF BENEFITS (see "Benefit Overview" to determine which services require this type of approval). Please see Chapter 1 for more information about how this prior approval is obtained at the IN-NETWORK LEVEL OF BENEFITS. If you wish to receive these services at the OUT OF NETWORK LEVEL OF BENEFITS, you are responsible for making sure authorization from the REVIEW ORGANIZATION is obtained by your PROVIDER when required for COVERED SERVICES. If this authorization is not obtained, you may be responsible for the full cost of those services.
- Please contact CARELINK Member Services for more information.
- Precertification: You must Precertify your OUT-OF-NETWORK INPATIENT services. Please see Chapter 1 –"Preadmission Certification and Continued Stay Review (PAC/CSR)" for more information.

COVERED SERVICES

Health care services and supplies only qualify as COVERED SERVICES if they meet the requirements shown above for "When health care services are COVERED SERVICES". The following section describes those services that qualify as COVERED SERVICES.

Notes:

- For information about your costs for the COVERED SERVICES listed below (for example, COPAYMENTS, DEDUCTIBLES and COINSURANCE), see the "Benefit Overview" section at the beginning of this document.
- Information about the day, dollar, and visit limits under this plan is listed in the "Benefit Limits" section at the front of this CERTIFICATE and in certain COVERED SERVICES listed below.
- For OUTPATIENT care: When you receive services from a PCP, your COST SHARE may be lower than for services from other PROVIDERS.

EMERGENCY CARE

Notes:

The EMERGENCY room COPAYMENT is waived if the EMERGENCY room visit results in immediate hospitalization or DAY SURGERY. If you are admitted as an INPATIENT after receiving EMERGENCY care, please call TUFTS HEALTH PLAN in order to have your EMERGENCY room COPAYMENT waived.

- If you receive EMERGENCY COVERED SERVICES from a NON-NETWORK PROVIDER, we will pay the PROVIDER up to the REASONABLE CHARGE. You will be responsible for any applicable COST SHARING AMOUNT. You may receive a bill for these services. If you receive a bill, please see "Bills from PROVIDERS" in Chapter 6 or call Member Services for more information about what to do if you receive a bill.
- An EMERGENCY room COST-SHARING AMOUNT may apply if you register in an EMERGENCY room but leave that facility without receiving care.
- Observation services will take an EMERGENCY room COPAYMENT.

In compliance with Massachusetts law, TUFTS HEALTH PLAN offers coverage for services and medications for pain management that are alternatives to opioids. Services include, but are not limited to:

- Spinal manipulation
- Acupuncture services
- Physical therapy
- Nutrition counseling

To find a PROVIDER for these services, please see our website. Click on "Find a Doctor or Hospital" to start your search. You may also call Member Services for help in finding a PROVIDER.

Please note that prior approval for these services may be required. Please see the "Benefit Overview" to determine if these services require prior approval.

Medications for pain management that are alternatives to opioids include, but are not limited to:

- Non-steroidal anti-inflammatory agents, such as ibuprofen
- Cyclooxygenase-2 (Cox-2) inhibitors, such as celecoxib

For information about medication alternatives to opioids, please call Member Services.

Acupuncture services

Acupuncture is covered when provided by a licensed acupuncturist (L.Ac.) or physician only.

The following acupuncture services are not covered:

- Adjunctive therapies, such as, but not limited to: moxibustion, herbs, oriental massage, etc.;
- Acupuncture when used as an anesthetic during a surgical procedure;
- Precious metal needles (e.g., gold, silver, etc).
- Acupuncture in lieu of anesthesia; and
- Any other service not specifically listed as a COVERED SERVICE.

Please see the "Benefit Overview" and "Benefit Limits" at the beginning of this document for COST SHARING AMOUNTS and visit limits.

Allergy testing and treatment

Allergy testing (including antigens) and treatment, and allergy injections. Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS.

Ambulance services

- Ground, sea, and air ambulance transportation for EMERGENCY care.
  - Air ambulance services means transportation by helicopter or fixed wing plane (for example, Medflight).
- Non-EMERGENCY ambulance transportation requires approval by the REVIEW ORGANIZATION at both the IN-NETWORK and OUT-OF- NETWORK LEVELS OF BENEFITS.
- Non-EMERGENCY ambulance transportation is covered only when the REVIEW ORGANIZATION determines in advance that such services are MEDICALLY NECESSARY.

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.

Autism spectrum disorders – diagnosis and treatment

Coverage is provided for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include:

- autistic disorder;
- Asperger's disorder;and
- pervasive developmental disorders not otherwise specified.

TUFTS HEALTH PLAN provides coverage for the following COVERED SERVICES:

- HABILITATIVE or rehabilitative care, which are professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA)* supervised by a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA). For more information about these programs, call the behavioral Health Department at 1-800-232-1164. Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS;
- prescription drugs, covered under your "Prescription Drug Benefit, described in Chapter 3;
- psychiatric and psychological care, covered under your "Behavioral Health and Substance Use Disorder Services" benef it, described later in this chapter;
- therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your "Rehabilitative and Habilitative physical and occupational therapy services" and "Treatment of speech, hearing and language disorders" benefits, described later in this chapter.

  *For the purposes for this benefit, ABA includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Behavioral Health and Substance Use Disorder Services (OUTPATIENT, INPATIENT, and Intermediate)

Note: Please see INPATIENT and Intermediate Behavioral Health and Substance Use Disorder Services in Chapter 1. Certain services may require approval by the REVIEW ORGANIZATION.

Note: Coverage of OUTPATIENT and intermediate behavioral health/substance use disorder services include those provided in a hospital setting, a PROVIDER's office, and in a MEMBER's home. These services must be provided by a professionally licensed behavioral health/substance use disorder PROVIDER or a person under the supervision of a professionally licensed behavioral health/substance use disorder PROVIDER.

OUTPATIENT behavioral health and substance use disorder services for BEHAVIORAL HEALTH DISORDERS
Services to diagnose and treat BEHAVIORAL HEALTH DISORDERS (including diagnosis, detoxification, and treatment of substance use disorders) given by the following PROVIDERS:

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

Notes: OUTPATIENT treatment of substance use disorders includes methadone maintenance or methadone treatment related to chemical dependency disorders. Psychological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury" as described earlier in this chapter.

INPATIENT and intermediate behavioral health and substance use disorder services for BEHAVIORAL DISORDERS

- INPATIENT behavioral health and substance use disorder services for BEHAVIORAL HEALTH DISORDERS in a facility that is licensed as a general hospital, a behavioral health hospital, or a substance use disorder 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;
  - intensive OUTPATIENT programs;
  - crisis stabilization;
  - partial hospital programs

Behavioral Health and Substance Use Disorder Services (OUTPATIENT, INPATIENT, and Intermediate), continued

INPATIENT and intermediate services for child-adolescent BEHAVIORAL HEALTH DISORDERS

In addition to the OUTPATIENT and INPATIENT and intermediate behavioral health and substance use disorder services listed above, the following services are available to children and adolescents until age 19, and their parents and/or appropriate caregiver, when MEDICALLY NECESSARY:

- **Intensive community based acute treatment (ICBAT)** is covered as INPATIENT behavioral health services. ICBAT provides the same services as CBAT (see below) for children and adolescents, but of higher intensity, including:
  - more frequent psychiatric and psychopharmacological evaluation and treatment; and
  - more intensive staffing and service delivery.

  ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to INPATIENT mental health services, but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to INPATIENT hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour hospital setting.

  These services require the prior approval of the REVIEW ORGANIZATION.

The following services are covered intermediate behavioral health services and require the prior approval of the Review Organization, except as designated below. Services may be provided by an appropriate health care professional under the supervision of a licensed behavioral health PROVIDER:

- **Community based acute treatment (CBAT)** – behavioral health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to:
  - daily medication monitoring;
  - psychiatric assessment;
  - nursing availability;
  - specialing (as needed);
  - individual, group and family therapy;
  - case management;
  - family assessment and consultation;
  - discharge planning; and
  - psychological testing, as needed.

  These services may be used as an alternative to or transition from INPATIENT services.

  These services require the prior approval of the REVIEW ORGANIZATION.

INPATIENT and intermediate services for child-adolescent BEHAVIORAL HEALTH DISORDERS, continued

- **Mobile crisis intervention** – A short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to:
  - identify, assess, treat and stabilize a situation;
  - reduce the immediate risk of danger to the child or others; and;
  - make referrals and linkages to all MEDICALLY NECESSARY behavioral health services and supports and the appropriate level of care.

The intervention shall be consistent with the child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. Mobile crisis intervention does not require the prior approval of the REVIEW ORGANIZATION.

- **In-home behavioral services** – A combination of MEDICALLY NECESSARY behavior management therapy and behavior management monitoring. These services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:
  - Behavior management monitoring: Monitoring of a child's behavior, the implementation of a behavior plan, and reinforcing implementation of a behavior plan by the child's parent or other caregiver.
  - Behavior management therapy: Therapy that addresses challenging behaviors that interfere with a child's successful functioning. "Behavior management therapy" shall include:
    - a functional behavioral assessment and observation of the youth in the home and/or community setting;
    - development of a behavior plan; and
    - supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy.

"Behavior management therapy" may include short-term counseling and assistance.

Behavioral Health and Substance Use Disorder Services (OUTPATIENT, INPATIENT, and Intermediate), continued

INPATIENT and intermediate services for child-adolescent BEHAVIORAL HEALTH DISORDERS, continued

- **In-home therapy services** – MEDICALLY NECESSARY therapeutic clinical intervention or ongoing training, as well as therapeutic support. The intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. The following services are covered intermediate behavioral health services:
  - Therapeutic clinical intervention: these services include a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's behavioral health needs. This may include improvement of the family's ability to provide effective support for the child and promote healthy functioning of the child within the family; the development of a treatment plan; and the use of established psychotherapeutic techniques, working with family members to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.
  - Ongoing therapeutic training and support: these services include those that support implementation of a treatment plan that involve therapeutic interventions that teach the child to understand, direct, interpret, and manage and control feelings and emotional responses to situations and assisting the family in supporting the child and addressing the child's emotional and behavioral health needs.

- **Intensive care coordination (ICC)** – A collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost effective outcomes. This service includes:
  - an assessment;
  - the development of an individualized care plan;
  - referrals to appropriate levels of care;
  - monitoring of goals, and
  - coordinating with other services and social supports and with state agencies, as indicated.

The service shall be based on a system of care philosophy. The individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate. Intensive care coordination of services do not require the prior approval of the REVIEW ORGANIZATION. You or your PROVIDER must notify TUFTS HEALTH PLAN within 3 days of your initial visit by calling the Behavioral Health Department at 1-800-232-1164. If you obtain these services from a NON-NETWORK PROVIDER, and you do not notify us within 3 days of your initial visit, these services will not be covered.

For more information about the services available under this benefit, please call the TUFTS HEALTH PLAN's CARELINK Behavioral Health Department at 1-800-232-1164. You may also see the MEDICALLY NECESSITY Guidelines on our website at **www.tuftshealthplan.com/provider/resource-center#//Commercial/carelink.**

INPATIENT and intermediate services for child-adolescent BEHAVIORAL HEALTH DISORDERS, continued

Family support and training* – **MEDICALLY NECESSARY services provided to a parent or other caregiver of a child to improve the capacity of the parent(s) or caregiver(s) to improve or resolve the child's emotional or behavioral needs.** This benefit is provided where the child resides, which may include the child's home, a foster home, a therapeutic foster home, or another community setting.

Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include:

- educating parent(s)/caregiver(s) about the youth's behavioral health needs and resiliency factors
- teaching parent(s)/caregiver(s) how to navigate services on behalf of the child
- identifying formal and informal services and supports in their communities, including parent support and self-help groups

- **Therapeutic mentoring services*** – MEDICALLY NECESSARY services provided to a child, designed to support age-appropriate social functioning or to improve deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment plan.

This benefit includes:

- supporting, coaching, and training the child in age-appropriate behaviors
- interpersonal communication, problem solving, conflict resolution
- relating appropriately to other children and adolescents and to adults.

Such services are provided, when indicated, where the child resides, which may include the child's home, a foster home, a therapeutic foster home, or another community setting to enable the youth to practice desired skills in appropriate settings.

*Prior authorization will not be required for these services; however, the member must be approved to receive services through a clinical hub provider (i.e., a provider for outpatient therapy, in-home therapy, or intensive care coordination). The clinical hub provider serves as the primary behavioral health care provider for the youth and will coordinate with other service providers to meet the child's clinical needs.

For more information about the services available under this benefit, please call the Behavioral Health Department at 1-800-208-9565. You may also see the Cigna MEDICAL NECESSITY Guidelines on our website at https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview.

Important Note: INPATIENT and Intermediate behavioral health and substance use disorder services must be obtained at a NETWORK HOSPITAL in order to receive benefits at the IN-NETWORK LEVEL OF BENEFITS. See "INPATIENT Behavioral Health and Substance Use Disorder Services" in Chapter 1 for more information.

Cardiac rehabilitation services

OUTPATIENT treatment of documented cardiovascular disease that:

- meet the standards promulgated by the Massachusetts Commissioner of Public Health; and
- are initiated within 26 weeks after diagnosis of cardiovascular disease.

We cover 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: We do not cover the program phase that maintains rehabilitated cardiovascular health.

Chemotherapy administration

For information about coverage for the medications used in chemotherapy, please see "Injectable, infused or inhaled medications" later in this document.

Chiropractic care

See "Spinal manipulation".

Cleft lip or cleft palate treatment and services for CHILDREN

In accordance with Massachusetts law, the following services are covered for CHILDREN under the age of 18:

- **Medical and facial surgery**: Covered as described under "DAY SURGERY", "Hospital services (acute care)", and "Reconstructive surgery and procedures" earlier in this chapter. This includes surgical management and follow-up care by plastic surgeons (prior approval by an AUTHORIZED REVIEWER is required);
- **Oral surgery**: Covered as described under "Oral health services" earlier in this chapter. This includes surgical management and follow-up care by oral surgeons (prior approval by an AUTHORIZED REVIEWER is required);
- **Dental surgery or orthodontic treatment and management**;
- **Preventive and restorative dentistry** to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy;
- **Speech therapy and audiology services**: Covered as described under "Treatment of speech, hearing and language disorders" earlier in this chapter (prior approval by an AUTHORIZED REVIEWER is required);
- **Nutrition services**: Covered as described under "Nutritional counseling" earlier in this chapter.

Services must be prescribed by the treating physician or surgeon, and that PROVIDER must certify that the services are MEDICALLY NECESSARY and are required because of the cleft lip or cleft palate.

Colonoscopies

See “Diagnostic or preventive screening procedures” later in this chapter.

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.

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 Note: TUFTS HEALTH PLAN will only cover these services at the IN-NETWORK LEVEL OF BENEFITS when provided by a NETWORK PROVIDER who is a certified diabetes health care PROVIDER.

Diagnostic imaging

Includes:

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

Important Note: MRI/MRA, CT/CTA, and PET tests and nuclear cardiology require the approval of the REVIEW ORGANIZATION. This approval is required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval.

Diagnostic or preventive screening procedures

Includes, for example, proctosigmoidoscopies, colonoscopies and sigmoidoscopies.

Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS.

Diagnostic testing

Examples include, but are not limited to, ambulatory EKG testing, sleep studies (performed in the home or a sleep study facility), and diagnostic audiological testing. Prior approval by the REVIEW ORGANIZATION may be required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS. Please call Member Services with questions about specific tests.

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 the REVIEW ORGANIZATION approval. This prior approval is required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS. Please see "Important Notes" at the beginning of this chapter for more information about when you are responsible for obtaining this approval.

Important Note: You may be responsible for paying towards the cost of DURABLE MEDICAL EQUIPMENT covered under this plan. To determine whether your DURABLE MEDICAL EQUIPMENT benefit is subject to a DEDUCTIBLE or COINSURANCE, please see the "Benefit Overview" section at the front of this CERTIFICATE.

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

Below are examples of 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 at the IN-NETWORK LEVEL OF BENEFITS);
- cranial helmets;
- gradient stockings (up to three pairs every 365 days);
- 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,
- test strips for glucose monitors and/or visual reading (covered under your "Prescription Drug Benefit");
- insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar (covered under your "Prescription Drug Benefit" later in this chapter);
- therapeutic/molded shoes and shoe inserts for MEMBERS with severe diabetic foot disease,
- visual magnifying aids;
- oral appliances for the treatment of sleep apnea;
- oxygen concentrators (stationary and portable);
- prosthetic devices, except for arms, legs or breasts*; and
  ***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.
- power/motorized wheelchairs.

TUFTS HEALTH PLAN will decide whether to purchase or rent the equipment for you. At the IN-NETWORK LEVEL OF BENEFITS, this equipment must be purchased or rented from a DURABLE MEDICAL EQUIPMENT provider that has an agreement with us to provide such equipment.

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, mattress and pillow covers, including hypo-allergenic versions;
- bath and toilet aids, including, but not limited to: tub seats/benches/stools, raised toilet seats, commodes, and rails;
- bed-related items, including bed trays, bed pans, bed rails, bed cradles, over-the-bed tables, and bed wedges;
- car seats;
- car/van modifications;
- certain wearable devices (e.g. smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g. Fitbit, Biostamp, Embrace smartwatch, Smartmonitor smartwatch, Garmin Vivofit 4, Garmin Vivosmart 3, Samsung Galaxy Fit);
- comfort or convenience devices;
- dentures;
- ear plugs;
- emergency response systems (e.g., LifeAlert);
- exercise equipment and saunas;
- externally powered exoskeleton assistive devices and orthoses;
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts or stair climbers,
- foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a MEMBER with severe diabetic foot disease;
- heat and cold therapy devices, including, but not limited to: hot packs, cold packs and water pumps with or without compression wrap;
- heating pads, hot water bottles, paraffin bath units and cooling devices;
- 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;
- breast prostheses and prosthetic arms and legs. For more information about these covered devices, see "Prosthetic Devices" later in this chapter.
- wheelchair trays.

Early intervention services

Services provided by early intervention programs that meet standards established by the Massachusetts Department of Public Health. MEDICALLY NECESSARY early intervention services include, but are not limited to, occupational therapy, physical therapy, speech therapy, nursing care, and psychological counseling.

These services are available to MEMBERS from birth until their third birthday.

Extended care

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

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

Notes:

- CUSTODIAL CARE is excluded from coverage.
- Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval.

Family planning

Coverage is provided for OUTPATIENT contraceptive services, including consultations, examinations, procedures and medical services, which are related to the use of all contraceptive methods that have been approved by the United States Food and Drug Administration (FDA).

- Procedures:
  - sterilization; and
  - pregnancy terminations.
- Services:
  - medical examinations;
  - consultations;
  - birth control counseling; and
  - genetic counseling.
- Contraceptives:
  - cervical caps;
  - implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants).
  - intrauterine devices (IUDs);
  - Depo-Provera or its generic equivalent; and
  - any other MEDICALLY NECESSARY contraceptive device that has been approved by the United States Food and Drug Administration*.

***Notes:**

- Please note that we cover certain contraceptives, such as oral contraceptives, over-the-counter female contraceptives, and diaphragms, under your Prescription Drug Benefit. If those contraceptives are covered under that benef it, they are not covered here.
- In addition, please note that contraceptives and female sterilization procedures are covered in full. To determine whether a specific family planning service is covered in full or subject to a COST SHARING please see **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services.**

Hearing Aids

Coverage is provided for:

- hearing aids (one per ear per prescription change) for CHILDREN age 21 or younger, including hearing aid evaluations, the fitting and adjustment of hearing aids, and supplies, including ear molds, as required under Massachusetts law.
- hearing aids (one per ear per prescription change) for MEMBERS age 22 or older, including hearing aid evaluations, the fitting and adjustment of hearing aids, and supplies, including ear molds.

Hemodialysis

- OUTPATIENT hemodialysis, including home hemodialysis; and
- OUTPATIENT peritoneal dialysis, including home peritoneal dialysis.

Home health care

We will cover the following services for MEMBERS who are homebound*:

- home visits by a CARELINK 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; and
  - the services of a part-time home health aide.

*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.

Notes:

- Home health care services for physical 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 "Rehabilitative and HABILITATIVE physical and occupational therapy services" earlier in this Chapter 3. However, those home health care services are not subject to the 60-day period for significant improvement requirement for rehabilitative therapy services for "Rehabilitative and HABILITATIVE physical and occupational therapy services".
- Sleep studies performed in the home are not covered under this "Home Health Care" benefit. Instead, these sleep studies are covered as described under "Diagnostic testing" earlier in this chapter.
- Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS of BENEFITS.

Hospice care services

We 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

Hospital INPATIENT care (acute care)

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

*Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS.

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

Coverage is provided as recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (CDC), including travel vaccines.

Infertility services

Diagnosis and treatment of Infertility in accordance with Massachusetts law.

Infertility services include:

(I.) Diagnosis of Infertility: Diagnostic procedures and tests are covered when provided in connection with an infertility evaluation.

(II.) Treatment of Infertility: Infertility is defined as the condition of a MEMBER who has been unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35. Attempts at conception to satisfy the diagnosis of Infertility may be done naturally or through artificial insemination.

For purposes of meeting the criteria for infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period, as applicable.

The following procedures are COVERED SERVICES **for MEMBERS with a diagnosis of infertility** who also:

- are Massachusetts residents;
- meet our eligibility requirements, which are based on the MEMBER's medical history; and
- meet the eligibility requirements of our contracting Infertility Services PROVIDERS.

Note: With respect to non-MEMBER donors of sperm or eggs, procurement and processing of donor sperm or eggs will be considered COVERED SERVICES to the extent such costs are not covered by the donor's health care coverage, if any.

A. Assistive Reproductive Technology ("ART") procedures, including:

- In-vitro fertilization (IVF) and/or embryo transfer;
- Frozen embryo transfer (FET);
- Gamete intra-fallopian transfer (GIFT);
- Donor oocyte (DO/IVF);
- Donor embryo/frozen embryo transfer (DE/FET);
- Intracytoplasmic sperm injection (ICSI);
- Assisted hatching (AH);
- Cryopreservation of embryos/blastocysts;
- Cryopreservation of sperm;
- Cryopreservation of oocytes.

*NOTE: Prior approval by the REVIEW ORGANIZATION is only required for cryopreservation services. For further details on the cryopreservation services available to a MEMBER who meets the definition of infertility, please see Cigna's MEDICAL NECESSITY Guidelines for infertility services available at https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview, or call Member Services.

MEMBERS who meet the criteria for infertility who also have a documented medical contraindication to pregnancy, are using their own eggs, and are self-paying for a gestational carrier or surrogate, may be authorized for ovarian stimulation, egg retrieval and fertilization. For further details on what services are available to a MEMBER who meets the definition of infertility, please call Member Services.

B. Other related treatments, including:

- artif icial insemination (intrauterine or intracervical);
- gonadotropin medication (FSH);
- artif icial insemination (intrauterine or intracervical) used in conjunction with gonadotropin medication;
- procurement and processing of eggs or inseminated eggs or storage of inseminated eggs when associated with active infertility treatment.

Note: Donor sperm is only covered when the partner has a diagnosis of male factor infertility.

(III.) Preimplantation Genetic Diagnosis (PGD) testing with IVF:

PGD testing is covered when either of the partners is a known carrier for certain genetic disorders. In addition to the Inf ertility Services provided in connection with Massachusetts law (as described above), PGD testing with IVF may be covered **for MEMBERS who do not have a diagnosis of infertility** in certain circumstances when the fetus would be at risk f or an inherited genetic disorder associated with severe disability and/or premature death.

NOTE: Oral and injectable drug therapies used in the treatment of infertility, associated with the COVERED SERVICES above, are considered COVERED SERVICES only when the MEMBER is covered by a Prescription Drug Benefit. If applicable, see your Prescription Drug Benefit section for your COST SHARING AMOUNT.

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 nutritional therapy, chemotherapy, and antibiotics.

Notes:

- Prior approval 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 website for more information on these medications and PROVIDERS.
- Intravenous Immunoglobulin (IVIg) therapy is covered for the treatment of Pediatric Autoimmune Neuropsychiatric Disorders and Pediatric Acute-Onset Neuropsychiatric Syndromes under this benefit.
- Coverage includes the components required to administer these medications, including, but not limited to, hypodermic needles and syringes, DURABLE MEDICAL EQUIPMENT, supplies, pharmacy compounding, delivery of drugs and supplies.
- Medications that are listed on our website as covered under a TUFTS HEALTH PLAN pharmacy benefit are not covered under this "Injectable, infused, or inhaled medications" benefit. For more information, call Member Services or check our website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies.**

Laboratory tests

Including, but not limited to, blood tests, urinalysis, throat cultures, glycoslated hemoglobin (HbA1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles.

Important: Laboratory tests must be ordered by a licensed PROVIDER and be performed at a licensed laboratory.

Notes:

- Prior approval is required for some laboratory tests. An example of this is genetic testing. For a complete list of laboratory tests subject to prior authorization, see the MEDICAL NECESSITY Guidelines on our website**.**
- Please note that certain laboratory tests associated with routine preventive care are covered in full at the In-Network Level of Benefits when billed in accordance with our Preventive Services Payment Policy. An example of this is the colorectal cancer screening test Cologuard. If a laboratory test is not billed according to this policy, it will be subject to the MEMBER COST SHARING AMOUNT for "Laboratory tests" specified in the "Benefit Overview." For additional information on this policy, please see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services.**

Lead Screenings

Mammograms

Provided 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.

Maternity Care

Maternity Care - Routine and Non-Routine Care (OUTPATIENT)

- prenatal care, exams and tests; and
- postpartum care provided in a PROVIDERS office.

Notes:

- Routine laboratory tests associated with maternity care are covered in full at the IN-NETWORK LEVEL OF BENEFITS in accordance with the ACA.
- MEMBER cost-sharing will apply at the IN-NETWORK LEVEL OF BENEFITS to diagnostic tests or diagnostic laboratory tests when they are ordered as part of routine maternity care. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services.

Maternity Care (INPATIENT)

- hospital and delivery services, and
- well newborn CHILD care in hospital.

Includes INPATIENT care in hospital for mother and newborn CHILD for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

Notes:

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

(For inf ormation about notifying TUFTS HEALTH PLAN for a newborn CHILD, see Chapter 1.)

IMPORTANT NOTES - Benefits for Newborn CHILDREN at Time of Delivery:

1. MEMBER's Delivery is Performed by a NETWORK PROVIDER

If a mother is a MEMBER whose delivery was performed by a NETWORK PROVIDER, TUFTS HEALTH PLAN will pay for MEDICALLY NECESSARY care as follows:

When newborn CHILD is enrolled: If the newborn CHILD is enrolled under this CERTIFICATE as described under "Adding DEPENDENTS" in Chapter 2:

- TUFTS HEALTH PLAN will pay for ROUTINE NURSERY CARE at the IN-NETWORK LEVEL OF BENEFITS; and
- TUFTS HEALTH PLAN will pay for MEDICALLY NECESSARY care other than ROUTINE NURSERY CARE (1) at the IN-NETWORK LEVEL OF BENEFITS, if that care is provided by a NETWORK PROVIDER, and (2) at the OUT-OF- NETWORK LEVEL OF BENEFITS, if that care is not provided by a NETWORK PROVIDER (PRECERTIFICATION is required).

When newborn CHILD is not enrolled: If the newborn CHILD is not enrolled under this CERTIFICATE as described under "Adding DEPENDENTS" in Chapter 2, TUFTS HEALTH PLAN will pay (1) for ROUTINE NURSERY CARE at the IN-NETWORK LEVEL OF BENEFITS; and (2) will not pay for care other than ROUTINE NURSERY CARE.

2. Non-MEMBER's Delivery

Massachusetts law requires a newborn CHILD's ROUTINE NURSERY CARE to be covered under the maternity coverage benefits of the mother's health plan. If the mother is not a MEMBER under the CERTIFICATE and has no other maternity coverage benefits, TUFTS HEALTH PLAN will cover MEDICALLY NECESSARY care that the newborn CHILD may require (either ROUTINE NURSERY CARE or other care) if that newborn CHILD is enrolled under the CERTIFICATE.

When newborn CHILD is enrolled: If the newborn CHILD is enrolled under this CERTIFICATE as described under "Adding DEPENDENTS" in Chapter 2:

- TUFTS HEALTH PLAN will pay for ROUTINE NURSERY CARE (1) at the IN-NETWORK LEVEL OF BENEFITS, if that care is provided by a NETWORK PROVIDER, and (2) at the OUT-OF-NETWORK LEVEL OF BENEFITS, if that care is not provided by a NETWORK PROVIDER (PRECERTIFICATION is required); and
- TUFTS HEALTH PLAN will pay for MEDICALLY NECESSARY care other than ROUTINE NURSERY CARE (1) at the IN-NETWORK LEVEL OF BENEFITS, if that care is provided by a NETWORK PROVIDER, and (2) at the OUT- OF-NETWORK LEVEL OF BENEFITS, if that care is not provided by a NETWORK PROVIDER. (PRECERTIFICATION is required)

When newborn Child is not enrolled: If the newborn CHILD is not enrolled under this CERTIFICATE as described under "Adding DEPENDENTS" in Chapter 2, TUFTS HEALTH PLAN will not pay for any care for the newborn CHILD.

Medical supplies

TUFTS HEALTH PLAN covers the cost of certain types of medical supplies from an authorized vendor, including ostomy, tracheostomy, catheter, oxygen supplies, insulin pumps and related supplies.

Note:

- These medical supplies must be obtained from a vendor that has an agreement with us to provide such supplies.
- Contact a Member Representative with coverage questions.
- Prior approval by an AUTHORIZED REVIEWER is required for these supplies.

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 "Nutritional Counseling" in the "Benef it 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 at the IN-NETWORK LEVEL OF BENEFITS.

Note: Weight loss programs and clinics are not covered.

Office visits to diagnose and treat illness or injury

- MEDICALLY NECESSARY evaluations and related health care services for acute or EMERGENCY gynecological conditions.
- Office visits for evaluations and consultations. This includes visits to a LIMIITED SERVICE MEDICALCLINIC.

Note: Coverage for diagnostic laboratory tests and x-rays associated with these office visits is described in the "Diagnostic imaging" and "Diagnostic tests and laboratory services" benefits earlier in this chapter.

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.

- Non-EMERGENCY care
  The following services are covered, with the prior approval of a REVIEW ORGANIZATION, in an INPATIENT or DAY SURGERY setting, and include hospital/facility, PROVIDER, and surgical charges:
  - Extraction of seven or more permanent teeth during one visit
  - Surgical treatment of skeletal jaw deformities
  - Surgical repair related to Temporomandibular Joint Disorder

  In addition, surgical removal of impacted or unerupted teeth when embedded in bone is covered in an INPATIENT, DAY SURGERY, or office setting. COVERED SERVICES include hospital/facility, PROVIDER, and surgical charges. Prior approval by a Review Organization is only required if the services are received in an INPATIENT or DAY SURGERY setting.

Important Notes:

- Please go to our website to view the complete guidelines for determining MEDICAL NECESSITY for these services in an Inpatient setting, entitled "Dental Procedures Requiring Hospitalization".
- Coverage does not apply to Non-EMERGENCY oral health services provided by a dentist. MEMBERS must receive these services from an oral surgeon.
- X-rays performed in association with Non-EMERGENCY oral health services are covered as described under "Diagnostic imaging."

Pap Smears

One annual screening for women age 18 and older, or as otherwise MEDICALLY NECESSARY.

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

To the extent required by Massachusetts and federal 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 or OUTPATIENT services would be covered if the MEMBER did not receive care in a qualified clinical trial.

Preventive care for MEMBERS under age 6

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

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

Coverage is also provided for:

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

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to a COST SHARING AMOUNT at the IN-NETWORK LEVEL OF BENEFITS. MEMBER cost-sharing will also apply at the IN-NETWORK LEVEL OF BENEFITS to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see the website at **https://tuftshealthplan.com/documents/providers/payments-policies/preventive-services** for more information about which laboratory services are considered preventive.

Preventive care for MEMBERS age 6 and older

- Routine physical examinations, including appropriate immunizations and lab tests as recommended by a PROVIDER; and
- hearing exams and screenings for MEMBERS under age 18.

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to a COST SHARING AMOUNT at the IN-NETWORK LEVEL OF BENEFITS. MEMBER cost-sharing will also apply at the IN-NETWORK LEVEL OF BENEFITS to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see the website at **https://tuftshealthplan.com/documents/providers/payments-policies/preventive-services** for more information about which laboratory services are considered preventive.

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 that adequately meets the MEMBER's needs. Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS of BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval*.

***Note:** Breast prostheses require prior authorization, except when provided in connection with a mastectomy.

Radiation therapy

Rehabilitative and HABILITATIVE physical and occupational therapy services

Rehabilitative physical and occupational therapy services, including cognitive rehabilitation or cognitive retraining, are covered. These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or illness and the MEMBER's condition is subject to significant improvement within a period of 60 days from the initial treatment as a direct result of these therapies.

HABILITATIVE physical and occupational therapy services are covered only when provided to keep, learn, or improve skills and functioning for daily living never learned or acquired due to a disabling condition.

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.

Respiratory therapy/pulmonary rehabilitation services

Routine annual gynecological exam

Includes any follow-up obstetric or gynecological care determined to be MEDICALLY NECESSARY as a result of that exam (no PCP referral required).

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of 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 gynecological exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see the website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more inf ormation about which laboratory services are considered preventive.

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. (Please also see "DURABLE MEDICAL EQUIPMENT" earlier in this Chapter.)

Smoking cessation counseling services

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 Patient Protection and Affordable Care Act.

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

Special formulas

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

Low protein foods:

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

Nonprescription enteral formulas: (prior approval by the REVIEW ORGANIZATION may be required)

- 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 for: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.

Note: Services may require prior approval by the REVIEW ORGANIZATION at both the IN-NETWORK and OUT-OF-NETWORK LEVELS of BENEFITS. Please see "Important Notes" at the beginning of this chapter for more information about when you are responsible for obtaining this approval.

Special medical formulas: (prior approval by the REVIEW ORGANIZATION may be required)

- for the treatment of phenylketonuria; tyrosinemia; homocystinuria; maple syrup urine disease; propionic acidemia; and methylmaloric acidemia; or
- when MEDICALLY NECESSARY to protect the unborn fetuses of women with PKU.

Note: Services may require prior approval by the REVIEW ORGANIZATION at both the IN-NETWORK and OUT-OF-NETWORK LEVELS of BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval.

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

REVIEW ORGANIZATION approval is required regardless of whether the procedure is provided by a NETWORK PROVIDER or a NON-NETWORK PROVIDER.

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

  Notes:
  - We do not cover donor charges of MEMBERS who donate stem cells or solid organs to non-MEMBERS.
  - We cover a MEMBER's donor search expenses for donors related by blood.
  - We cover the MEMBER's donor search expenses for donors not related by blood when MEDICALLY NECESSARY. These services are only covered to the extent that such services are not covered by any other plan of health benefits or health care coverage.
  - We cover a MEMBER's human leukocyte antigen (HLA) testing. See "OUTPATIENT medical care" earlier in this chapter for more information.
  - Prior approval by the REVIEW ORGANIZATION is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. See "Important Note" earlier in the chapter for more information about when you are responsible for obtaining this approval.

Surgery - in a PROVIDER's office

Surgery -- Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment

- services required to relieve pain or to restore a bodily function that is impaired as a result of a congenital defect (including treatment of cleft lip or cleft palate for CHILDREN under the age of 18, as required under Massachusetts law*),

  birth abnormality, traumatic injury or covered surgical procedure.
- the following services in connection with mastectomy:
  - reconstruction of the breast affected by the mastectomy;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses** and treatment of physical complications of all stages of mastectomy (including lymphedema).

*Prior authorization by the REVIEW ORGANIZATION is not required for the treatment of cleft lip or cleft palate for CHILDREN under the age of 18.

**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;
- 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 or with treatment of a cleft lip or cleft palate, the REVIEW ORGANIZATION approval is required before you receive any reconstructive surgery or procedure (regardless of whether the procedure is provided by a NETWORK PROVIDER or a NON-NETWORK PROVIDER). Please see "Important Notes" at the beginning of this chapter for more information about when you are responsible for obtaining this approval.

Spinal manipulation

Manual manipulation of the spine,

including unlimited evaluations per PROVIDER per CONTRACT YEAR.

Telemedicine services

We cover MEDICALLY NECESSARY telemedicine services for the purpose of diagnosis, consultation, or treatment in the same manner as an in-person consultation between you and your PROVIDER. Telemedicine services are provided through audio, video, or other electronic media communications and substitute for in-person consultation with PROVIDERS when determined to be medically appropriate. Telemedicine services are available for both medical and behavioral health/substance use disorder services.

Telemedicine services may be obtained from a NETWORK PROVIDER or through TUFTS HEALTH PLAN's designated telemedicine vendor. When received from the designated telemedicine vendor, these services are also referred to as "telehealth services". For additional information on the TUFTS HEALTH PLAN telemedicine vendor and how to access those services, including when certain services may be available when you are traveling outside of the 50 United States, please visit **https://tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth** or contact Member Services

When you obtain telemedicine services from a NETWORK PROVIDER, you will pay the same COST SHARING AMOUNT that applies to an office visit with that PROVIDER. When you access telemedicine services through the TUFTS HEALTH PLAN telemedicine vendor, you will pay the COST SHARING AMOUNT for telemedicine services listed in the "Benefit Overview".

Additionally, at your choice, audio-only consultation services are available to you. If you access such audio-only consultation services, the same COST SHARING AMOUNT as indicated for telemedicine services applies.

Coverage also applies to telemedicine services that are not considered telemedicine visits. This includes:

- Remote patient monitoring services to collect and interpret clinical data while the Member remains at a distant site. These services may occur in real-time or not; and
- Remote evaluation of transferred medical data recorded on an electronic device. The data must be used for the purpose of diagnostic and therapeutic assistance in the care of the MEMBER.

See the "Benefit Overview" for the COST SHARING AMOUNTS that apply to these additional telemedicine services.

Treatment of speech, hearing and language disorders

Diagnosis and treatment when MEDICALLY NECESSARY. 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. Please note that at the IN-NETWORK LEVEL OF BENEFITS, COST SHARING AMOUNTS for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits). Prior approval by an AUTHORIZED REVIEWER is required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS.

URGENT CARE

Services may be provided to you in a PROVIDER's office, a LIMITED SERVICES MEDICAL CLINIC, a hospital-based OUTPATIENT walk-in clinic, a FREE-STANDING URGENT CARE CENTER, or an emergency room.

Vision care services

- Routine eye examination : Coverage is provided for one routine eye examination every 24 months (IN-NETWORK and OUT-OF-NETWORK LEVELS combined) **Note:** You must receive routine eye examinations from a PROVIDER in the EyeMed Vision Care network in order to obtain coverage for these services at the IN-NETWORK LEVEL OF BENEFITS. Please go to our website or contact Member Services for more information.
- Other vision care services: Coverage is provided for eye examinations and necessary treatment of a medical condition. **Note:** One pair of eyeglass lenses and standard frames will be covered following a MEMBER's cataract surgery or other surgery to replace the natural lens of the eye, when the MEMBER does not receive an intraocular implant. See "Benefit Overview" earlier in this document to determine the COST SHARING AMOUNT applicable to these lenses and frames.

TUFTS HEALTH PLAN MEMBER Discounts

As a Member, you may take advantage of TUFTS HEALTH PLAN MEMBER Discounts. See Our website for the most current list. TUFTS HEALTH PLAN MEMBER Discounts include the fitness reimbursement and weight management program reimbursement. Go to Our website for further details and required reimbursement forms at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/discounts-perks/overview**.

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
- CARELINK Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered
Prescription drugs will be considered COVERED SERVICES only if they comply with the " CARELINK 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.

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 a higher level COST SHARING AMOUNT.

Notes:

- Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered in full for up to a 30-day supply.
- Smoking cessation agents (both prescription and generic over-the-counter agents when prescribed by a PROVIDER) are covered in full.
- Most generic drugs are covered on Tier 1 or Tier 2.
- In compliance with Massachusetts law, opioid medications listed as Schedule II or Schedule III controlled substances will be filled at a lesser quantity than prescribed if the MEMBER requests it. If the MEMBER requests the lesser quantity, no additional cost or penalty will be enforced on the MEMBER. If the MEMBER fills a lesser quantity than is prescribed of a Schedule II opioid controlled substance, and then decides to fill the remainder of the original prescription at the same pharmacy within 30 days of the original prescription date, no additional COPAYMENT or other cost sharing will be applied. Please see Appendix C, “Schedule II and III Opioid Medications”, for a list of these medications.
- Pursuant to Massachusetts law, naloxone (an opioid antagonist) is available without a prescription when obtained from a Massachusetts pharmacy. Whoever requests naloxone at a pharmacy will be billed for the medication, even if that person is picking up the medication for someone else.
- Certain drugs on our formulary are designated as part of our low-cost drug program. Your retail pharmacy Copayments for these low-cost drugs are $5 for up to a 30-day supply and $10 for a 31-90 day supply. Please see the website at https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies or call Member Services for more information.

Prescription Drug Coverage Table

DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs).	
TIER-1 drugs:	$10.00 COPAYMENT for up to a 30-day supply. $20.00 COPAYMENT for a 31-60-day supply. $30.00 COPAYMENT for a 61-90-day supply.
TIER-2 drugs:	$35.00 COPAYMENT for up to a 30-day supply. $70.00 COPAYMENT for a 31-60-day supply. $105.00 COPAYMENT for a 61-90-day supply.
TIER-3 drugs:	$60.00 COPAYMENT for up to a 30-day supply. $120.00 COPAYMENT for a 31-60-day supply. $180.00 COPAYMENT for a 61-90-day supply.
Important Note: If you choose to obtain a covered prescription drug at a retail pharmacy which is not a TUFTS HEALTH PLAN designated pharmacy, you will be required to pay for the entire cost of the drug up front. You will then need to contact TUFTS HEALTH PLAN in order to be reimbursed. You will be responsible only for the MEMBER COST SHARING AMOUNT listed above.	
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: • Coverage When Drugs Are Obtained Through a TUFTS HEALTH PLAN Designated Mail Services Pharmacy: Most maintenance medications, when mailed to you through a TUFTS HEALTH PLAN designated mail services pharmacy.	
TIER-1 drugs:	$20.00 COPAYMENT for up to a 90-day supply.
TIER-2 drugs:	$70.00 COPAYMENT for up to a 90-day supply.
TIER-3 drugs:	$120.00 COPAYMENT for up to a 90-day supply.
• Coverage When Drugs Are Not Obtained Through a TUFTS HEALTH PLAN Designated Mail Services Pharmacy: If you choose to obtain a covered prescription drug through a mail service pharmacy which is not a TUFTS HEALTH PLAN designated pharmacy, you pay 20% COINSURANCE for that drug. ***Note:** COINSURANCE is calculated based on TUFTS HEALTH PLAN's contracted rate at the time the prescription is filled and does not reflect any rebates that TUFTS HEALTH PLAN may receive at a later date. Rebates, if any, are reflected in your GROUP's PREMIUM.	

Notes:

- If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorized 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.
- You always pay the applicable COST SHARE AMOUNT, even if the cost of the drug is less than the COST SHARING AMOUNT.

What is Covered

We cover the following under this Prescription Drug Benefit. For a current list of covered drugs, please go to our website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies** or call Member Services.

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under "What is Not Covered" (see "Important Notes" below).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Generic and brand-name contraceptives, including oral contraceptives, diaphragms, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription and FDA-approved over-the-counter female contraceptives (e.g., female condoms or contraceptive spermicides) when prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription, are covered in full*. Certain brand-name contraceptives may be subject to prior authorization.*
  ***Note:** This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives (e.g., female condoms, contraceptive spermicides) when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription. See "Family planning" earlier in this chapter for information about other contraceptive drugs and devices that qualify as COVERED SERVICES.
- Fluoride for CHILDREN.
- Injectables and biological serum included on the list of covered drugs on our website. MEDICALLY NECESSARY hypodermic needles and syringes required to inject these medications are also covered. For more information, call Member Services or see our website.
- 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 at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies** or you can call Member Services for more information.
- Certain medications used for bowel preparation in colonoscopy procedures are covered in full at the IN-NETWORK LEVEL OF BENEFITS for MEMBERS ages 45 through 74. For more information, please call Member Services or see the formulary on the website.
- Prescription smoking cessation agents.

What is not Covered
We do not cover the following under this Prescription Drug Benefit:

- Acne medications unless MEDICALLY NECESSARY.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants, Depo-Provera or its generic equivalent (these are covered under your OUTPATIENT care benefit earlier in this Chapter)
- 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 website.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
- Drugs for asymptomatic onychomycosis, except for MEMBERS with diabetes, vascular compromise, or immune deficiency status.
- Drugs for the treatment of erectile dysfunction.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- 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.
- Immunization agents. These may be provided under "Preventive health care" earlier in this chapter.
- Homeopathic medications purchased with a prescription or over-the-counter.
- Medications for the treatment of idiopathic short stature.
- Oral non-sedating antihistamines.
- Over-the-counter medications if not included on the list of covered drugs on our website.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- oral non-sedating antihistamines.
- Prescription and over-the-counter homeopathic medications.
- 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 website.
- Prescription medications when packaged with non-prescription products.
- 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.
- Topical and oral fluorides for adults.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act and fluoride for CHILDREN).
- Medications packaged for institutional use may be excluded from the pharmacy benefit coverage unless otherwise noted in the formulary.

CARELINK Pharmacy Management Programs

In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, we have developed the following Pharmacy Management Programs:

Quantity Limitations Program

We limit the quantity of selected medications that MEMBERS can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:

We restrict 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 us 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 certain medical condition before a medication on a higher step is covered for that condition.

Designated Specialty Pharmacy Program (Mail Order):

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

New-To-Market Drug Evaluation Process:
New-To-Market drug products are reviewed for safety, clinical effectiveness, and cost by the TUFTS HEALTH PLAN's Pharmacy and Therapeutics Committee. We then make 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 CARELINK 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. We will approve the request if it meets our guidelines for coverage. For more information, call Member Services.
- If a request is made to cover medications that are part of the "New-to-Market Drug Evaluation Process" program or the "Non-Covered Drugs with Suggested Alternatives" program, and that request is approved by TUFTS HEALTH PLAN, the medications will generally be covered on the highest tier (e.g., Tier 3 on a 3-tier formulary, Tier-4 on a 4-tier formulary), with some exceptions. Please call Member Services for more information about on which tier your medication is covered.
- The TUFTS HEALTH PLAN website has a list of covered drugs with their tiers. We may change a drug's tier during the year. For example, if a brand drug's patent expires, we may change the drug's status by (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 website, or call a Member Representative.
- If are affected by a deletion to the formulary, TUFTS HEALTH PLAN will notify you at least 60 days before the change is made. Please be aware that advance notification will not be issued for prescription drugs deleted from the formulary that the Food and Drug Administration (FDA) have determined to be unsafe.

Filling Your Prescription

Where to Fill Prescriptions:
You can fill your prescriptions at any pharmacy; however, TUFTS HEALTH PLAN designated pharmacies will only charge you the MEMBER COST SHARING AMOUNT at the time you fill your prescription. If you choose to fill your prescription at a non-TUFTS HEALTH PLAN designated pharmacy, you will be responsible for paying the entire cost of the medication up front. Please see the Prescription Drug Coverage Table earlier in this chapter for more information. TUFTS HEALTH PLAN designated pharmacies include:

- for the majority of prescriptions, most 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 designated specialty pharmacy providers. (For more information about TUFTS HEALTH PLAN's designated specialty pharmacy program, see "CARELINK 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, call the TUFTS HEALTH PLAN Member Services Department.

Important: If you are filling a prescription at a non-TUFTS HEALTH PLAN designated pharmacy, please call the Member Services Department for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:

If you are required to take a maintenance medication, we offer 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 our Quantity Limitations program; or
- Medications that are part of our Special Designated Pharmacy program.

NOTE: Your COST SHARING AMOUNTS for covered prescription drugs are shown in the "Prescription Drug Coverage Table" above.

Exclusions from Benefits

This chapter lists services (and categories of services), supplies, and medications that are excluded (not covered) under this CERTIFICATE. **The following are not covered even if they are prescribed or recommended by a PROVIDER.** The exclusion headings used here are intended to group similar services, treatments, items or supplies together. Actual exclusions appear underneath each heading.

General Exclusions:

The following are excluded from coverage under this CERTIFICATE:

1. Any service, supply or medication is excluded:
   - That is not a COVERED SERVICE as defined in Appendix A and described in Chapter 3.
   - That is not MEDICALLY NECESSARY as defined in Appendix A and described in Chapter 3.
   - That is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
   - A service, supply, or medication that is obtained outside of the 50 United States. The only exception to this rule is for EMERGENCY care services, or URGENT CARE services while traveling which qualify as COVERED SERVICES when provided outside of the 50 United States.
   - That is related to non-COVERED SERVICE.
   - That is primarily for your, or another person's, personal comfort or convenience.
   - If there is a less intensive level of service, supply, or medication, or more cost-effective alternative, that can be safely and effectively provided.
   - If the service, supply or medication can be safely and effectively provided to you in a less intensive setting.
   - That is required by a third party that is not otherwise MEDICALLY NECESSARY (examples of a third party are an employer, an insurance company, school or court).
   - That you are not legally obligated to pay for; or you would not be charged for if you had no health plan.
   - That is provided to you by a relative who is a PROVIDER; or that is provided to you by an immediate family member (by blood or marriage), even if that relative is a PROVIDER. Please note: if you are a PROVIDER, you cannot provide or authorize services for yourself or for a member of your immediate family (by blood or marriage).
   - That is provided to a non-MEMBER, except as described in Chapter 3 for the following:
     - bereavement counseling services under **Hospice care services**;
     - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or banking donor sperm or inseminated eggs, under **Infertility services** (to the extent such costs are not covered by the donor's health coverage, if any);
     - organ donor charges under **Surgery - Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants.**

2. We do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including, but not limited to: therapeutic schools, camps, wilderness or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound. We will provide coverage for MEDICALLY NECESSARY OUTPATIENT or intermediate behavioral health services provided by licensed behavioral health PROVIDERS while the MEMBER is in a tuition-based program, subject to plan rules, including any network requirements or COSTSHARING.

3. Any additional fee a PROVIDER may charge as a condition of access, or any amenities that access fee is represented to cover is excluded. Please consult with your PROVIDER to see if he or she if charges such a fee.

4. Any care for conditions that (a) have benefits available under worker's compensation or other government programs (except Medicaid) or (b) must be treated in a public facility under state or local law.

5. Any drug, medicine, material or supply for use outside of the hospital or any other facility, except as described in Chapter 3.

6. Medications and other products that can be purchased over-the-counter except those listed as covered in Chapter 3.

7. Charges incurred when the Member, for his or her convenience, chooses to remain an Inpatient beyond the discharge hour.

8. Any examinations, evaluations or services for educational purposes or developmental purposes. This includes physical therapy, speech therapy, and occupational therapy, except as provided in Chapter 3. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities, and behavioral problems and developmental delays and services to treat speech, hearing and language disorders in a school-based setting. 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.

9. All Non-Conventional medicine services, (a) provided independently or together with conventional medicine, AND (b) all related testing, laboratory testing, services, supplies, procedures and supplements associated with this type of medicine, are excluded.

The following are not covered, even if they are prescribed or recommended by a PROVIDER. The exclusion headings used here are intended to group similar services, treatments, items, or supplies together. Actual exclusions appear underneath each heading.

Acupuncture services

- Acupuncture services are excluded except as described in Chapter 3. Excluded services include:
- Acupuncture in lieu of anesthesia
- Acupuncture when used as an anesthetic during a surgical procedure
- Adjunctive therapies, such as, but not limited to: moxibustion, herbs, oriental massage, etc.
- Precious metal needles (e.g., gold, silver, etc.)
- Any other service not specifically listed as a COVERED SERVICE.

Dental care

The following dental care services, treatments, and supplies are not covered unless (a) an exception is specifically stated in these exclusions or (b) such dental care services, treatments and supplies are described as a COVERED SERVICE in Chapter 3. These exclusions do not apply to the treatment of cleft lip or cleft palate for CHILDREN under the age of 18, as described under the **Cleft lip or cleft palate treatment and services for CHILDREN** benefit.

- Alteration of teeth
- Care related to deciduous (baby) teeth
- Dental supplies
- Dentures
- Orthodontia, even when it is an adjunct to other surgical or medical procedures
- Periodontal treatment
- Preventive dental care, in Chapter 3
- Restorative services including, but not limited to, crowns, fillings, root canals and bondings
- Skeletal jaw surgery, except as provided under **Oral health services** in Chapter 3
- Splints and oral appliances (except for sleep apnea, as stated under **Durable Medical Equipment** in Chapter 3
- Surgical removal or extraction of teeth, except as provided under **Oral health services** in Chapter 3
- TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies

Durable Medical Equipment (DME), orthoses or prosthetic devices

DME, orthoses and prosthetic devices are not covered except as described in Chapter 3. Exclusions include, but are not limited to, the following items. Call Member Services for questions about coverage of a specific item.

- air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers;
- articles of special clothing, mattress and pillow covers, including hypo-allergenic versions;
- bath and toilet aids, including, but not limited to: tub seats/benches/stools, raised toilet seats, commodes, and rails;
- bed-related items, including bed trays, bed pans, bed rails, bed cradles, over-the-bed tables, and bed wedges;
- car seats;
- car/van modifications;
- certain wearable devices (e.g. smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g. Fitbit, Biostamp, Embrace smartwatch, Smartmonitor smartwatch, Garmin Vivofit 4, Garmin Vivosmart 3, Samsung Galaxy Fit).
- comfort or convenience devices;
- dentures;
- ear plugs;
- emergency response systems (e.g., LifeAlert);
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts, or stair climbers;
- exercise equipment and saunas;
- externally powered exoskeleton assistive devices and orthoses;
- foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a Member with severe diabetic footdisease;
- heat and cold therapy devices, including, but not limited to: hot packs, cold packs and water pumps with or without compression wrap;
- heating pads, hot water bottles, paraffin bath units and cooling devices;
- 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® and Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered;
- wheelchair trays.

Experimental or Investigative

A drug, device or medical treatment or procedure (collectively, "treatment") that is EXPERIMENTAL or INVESTIGATIVE is not covered. If a treatment is Experimental or Investigative, we will not pay for any related treatments provided to the member for the purpose of furnishing the EXPERIMENTAL or INVESTIGATIVE treatment.

In accordance with requirements of Massachusetts and federal law, this exclusion does not apply to the following:

- long-term antibiotic treatment of chronic Lyme disease
- bone marrow transplants for breast cancer
- patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions
- off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS, if you have a Prescription Drug Benefit

Family planning or maternity care

- Costs associated with home births or with services provided by a doula
- Over-the-counter contraceptive agents, except as described under **Family planning** in Chapter 3
- Purchase of an electric hospital-grade breast pump; donor breast milk

Infertility services

Inf ertility services are not covered except as described in Chapter 3. Specifically, such services are excluded for MEMBERs who do not meet the definition of infertility provided under **Infertility services** in Chapter 3, except for COVERED SERVICES described under section (III.), Preimplantation Genetic Diagnosis (PGD) testing with IVF. Other exclusions include:

- Costs associated with donor recruitment and compensation
- Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the MEMBER is the sole recipient of the donor's eggs
- Experimental infertility procedures
- Infertility services necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
- Long-term (more than 90 days) sperm or embryo cryopreservation unless the MEMBER is in active infertility treatment. We may approve short-term (less than 90 days) cryopreservation of sperm, oocytes, or embryos for certain medical conditions that may impact a MEMBER's future fertility.
- Reversal of voluntary sterilization
- The costs of surrogacy, which means 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: (1) use of donor egg and a gestational carrier; (2) costs for drugs necessary to achieve implantation in a surrogate, embryo transfer, and cryo-preservation and embryos; 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.

Prescription drugs

Prescription drugs are covered as described in Chapter 3. We do not cover the following under this prescription drug benef it:

- Acne medications, unless MEDICALLY NECESSARY.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent (these are covered under your OUTPATIENT care benef it earlier in this Chapter)
- 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 website.
- Drugs for asymptomatic onychomycosis, except for MEMBERs with diabetes, vascular compromise, or immune def iciency status.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above
- Drugs which are dispensed in an amount or dosage that exceeds our established quantity limitations.
- 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.
- Homeopathic medications purchased with a prescription or over-the-counter.
- Immunization agents. These may be provided under "Preventive health care" earlier in this chapter.
- Medications for the treatment of idiopathic short stature.
- Oral non-sedating antihistamines.
- Over-the-counter medications if not included on the list of covered drugs on our website.
- 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 website.
- Prescription medications when co-packaged with non-prescription products.
- Prescriptions filled at pharmacies other than TUFTS HEALTH PLAN designated pharmacies, except for EMERGENCY care.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescriptions written by Providers who do not participate in TUFTS HEALTH PLAN, except in cases of authorized ref erral or Emergency care.
- 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.
- Topical and oral fluorides for adults.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, and fluoride for CHILDREN).
- Medications packaged for institutional use may be excluded from the pharmacy benef it coverage unless otherwise noted in the formulary.

Surgery

Surgery services are covered as described in Chapter 3. Excluded surgery services include:

- Circumcisions performed in any setting other than a hospital, DAY SURGERY or a PROVDER's office.
- Cosmetic (to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under **Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity and impairment** in Chapter 3.
- Hair removal (for example, electrolysis, laser hair removal), except when MEDICALLY NECESSARY (1) to treat an underlying skin condition or (2) for skin preparation for transgender genital surgery that has been approved by the REVIEW ORGANIZATION.
- Liposuction or brachioplasty
- Removal of tattoos
- Reversal of gender reassignment surgery
- Rhinoplasty, except as provided under **Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity and impairment** in Chapter 3
- Treatment of spider veins; removal or destruction of skin tags

Therapies

Therapy services are covered as described in Chapter 3. Excluded services include:

- Biofeedback, except for the treatment of urinary incontinence
- Hypnotherapy
- Massage therapies, cognitive rehabilitation programs and cognitive retraining programs, except as described under **Rehabilitative and Habilitative physical and occupational therapy services.**
- Neuromuscular stimulators and related supplies
- Diagnostic services related to any of the above procedures or programs
- Psychoanalysis
- With respect to child-adolescent mental health intermediate care and OUTPATIENT services, TUFTS HEALTH PLAN will not pay for the following programs:
- Programs in which the patient has a pre-defined duration of care without TUFTS HEALTH PLAN's ability to conduct concurrent determinations of continued medical necessity for an individual.
- Programs that only provide meetings or activities that are not based on individualized treatment planning.
- Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific mental health disorders.

Transplants

Transplants are not covered except as described in Chapter 3

Transportation

Transportation services are not covered except as described under **Ambulance services** in Chapter 3. Excluded transportation services include, but are not limited to, transportation by chair car, wheelchair van, or taxi, except as described.

Vision care

The following vision services, treatments, and supplies are not covered except as described under **Vision care services** and **Durable Medical Equipment** in Chapter 3.

- Eyeglasses (lenses or frames), contact lenses, or contact lens fittings
- Refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery

Other exclusions under the plan

- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products are not covered, except for the following:
  - Blood processing
  - Blood administration
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency) and von Willebrand disease. Prior approval by the REVIEW ORGANIZATION is required for these services at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS.
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (Prior approval by the REVIEW ORGANIZATION is required for these services at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS)
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually provided and/or able to be validated)
- Custodial Care
- Facility charges or related services if the procedure being performed is not a COVERED SERVICE, except as provided under **Oral health services** in Chapter 3
- Hearing aids, except as described in Chapter 3
- INPATIENT and OUTPATIENT weight-loss programs and clinics; relaxation therapies; services by a personal trainer; and exercise classes (diagnostic services related to any of these excluded programs or procedures are also excluded
- Laboratory tests ordered by a MEMBER (online or through the mail), even if they are performed at a licensed laboratory.
- Lodging related to receiving any medical service, including lodging related to obtaining gender reassignment surgery or related 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.
- Nutritional counseling, except as described under **Nutritional counseling** in Chapter 3
- Private duty nursing (block or non-intermittent nursing
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics and fittings; or casting and other services related to foot orthotics or other support devices for the feet.

Note: This exclusion 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.

This exclusion also does not apply to routine foot care for MEMBERS diagnosed with diabetes.

- Service or therapy animals and related supplies.
- Snoring reduction devices and procedures, including, but not limited to: laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

Chapter 4 - When Coverage Ends

Reasons coverage ends

This coverage is guaranteed renewable to the extent required by federal law (45 C.F.R. 148.122), and may only non-renew or cancel coverage under the plan for the following reasons, when applicable: non-payment of premiums, fraud, market exit, movement outside of the NETWORK CONTRACTING AREA, or cessation of bona fide association membership. Specifically, your coverage (including federal COBRA coverage and Massachusetts continuation coverage) ends when any of the following occurs:

- you lose eligibility because you:
    - enrolled under a GROUP CONTRACT and no longer meet your GROUP's or TUFTS HEALTH PLAN's eligibility rules; or
- you are a SUBSCRIBER or a SPOUSE and you no longer live, work or reside in the NETWORK CONTRACTING AREA*;
- you choose to drop coverage;
- you commit an act of physical or verbal abuse unrelated to your physical or behavioral condition which poses a threat to any PROVIDER, any TUFTS HEALTH PLAN MEMBER, TUFTS HEALTH PLAN or any TUFTS HEALTH PLAN employee;
- you commit an act of misrepresentation or fraud; or
- your GROUP CONTRACT with us ends. (For more information, see "Termination of a GROUP CONTRACT and Notice" later in this chapter.)

*Note: CHILDREN are not required to live, work or reside in the NETWORK CONTRACTING. In addition, there are a few exceptions in which DEPENDENTS are still eligible for coverage even if they do not live, work or reside in the NETWORK CONTRACTING AREA. Please see "If you do not live, work or reside in the NETWORK CONTRACTING AREA" in Chapter 2 for more information.

Benefits after termination

TUFTS HEALTH PLAN will <u>not</u> pay for services you receive after your coverage ends even if:

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

Continuation

Once your coverage ends, you may be eligible to continue your coverage with your GROUP or to enroll in coverage under an INDIVIDUAL CONTRACT. See Chapter 5 for more information.

When a Member is No Longer Eligible

Loss of eligibility
Your coverage ends on the date you no longer meet your GROUP's or TUFTS HEALTH PLAN's eligibility rules.

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

If you no longer live, work, or reside in the Network Contracting Area
If you are a SUBSCRIBER or a SPOUSE and you no longer live, work, or reside in the NETWORK CONTRACTING AREA, coverage ends as of the date you no longer live, work, or reside there*. CHILDREN are not required to live, work, or reside in the NETWORK CONTRACTING AREA. However, care outside of the NETWORK CONTRACTING AREA is only available at the OUT-OF-NETWORK LEVEL OF BENEFITS.

Before you no longer live, work, or reside in the NETWORK CONTRACTING AREA, tell your GROUP or call a Member Representative before you no longer live, work, or reside there. For more information about coverage available to you when you no longer live, work, or reside in the NETWORK CONTRACTING AREA, contact a Member Representative.

*Note: There are a few other exceptions in which DEPENDENTS are still eligible for coverage even if they do not live, work, or reside in NETWORK CONTRACTING AREA. Please see "If you do not live, work, or reside in the NETWORK CONTRACTING AREA" in Chapter 2 for more information.

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. Coverage of any CHILD of an enrolled DEPENDENT CHILD ends when the enrolled DEPENDENT CHILD's coverage ends.

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 PREMIUMS up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse
TUFTS HEALTH PLAN may terminate your coverage if you commit acts of physical or verbal abuse which:

- are unrelated to your physical or behavioral 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
TUFTS HEALTH PLAN may terminate your coverage 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 application;
- enrolling as a SPOUSE someone who is not your SPOUSE;
- receiving benefits for which you are not eligible;
- keeping for yourself payments made by TUFTS HEALTH PLAN that were intended to be used to pay a PROVIDER;
- abuse of the benefits under this plan, including the resale or transfer of supplies, medications, or equipment provided to you as COVERED SERVICES;
- allowing someone else to use your Member ID;
- submission of any false paperwork, forms, or claims information.

Date of termination
If TUFTS HEALTH PLAN terminates your coverage for misrepresentation or fraud, your coverage will end as of your EFFECTIVE DATE or a later date chosen by TUFTS HEALTH PLAN.

Payment of claims
TUFTS HEALTH PLAN will pay for all COVERED SERVICES you received between:

- your EFFECTIVE DATE; and
- your termination date, as chosen by TUFTS HEALTH PLAN. TUFTS HEALTH PLAN may retroactively terminate your coverage back to a date no earlier than your EFFECTIVE DATE.

TUFTS HEALTH PLAN will use any PREMIUM you paid for a period after your termination date to pay for any COVERED SERVICES you received after your termination date.

If the PREMIUM is not enough to pay for that care, TUFTS HEALTH PLAN, at its option, may:

- pay the PROVIDER for those services and ask you to pay TUFTS HEALTH PLAN back; or
- not pay for those services. In this case, you will have to pay the PROVIDER for the services.

If the PREMIUM is more than is needed to pay for COVERED SERVICES you received after your termination date, TUFTS HEALTH PLAN will refund the excess to your GROUP.

Termination of a GROUP CONTRACT and Notice

End of TUFTS HEALTH PLAN and GROUP's relationship

If you enrolled under a GROUP CONTRACT, 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 PREMIUMS on time;
- TUFTS HEALTH PLAN stops operating; or
- your GROUP stops operating.

Notice of termination

The GROUP CONTRACT will terminate if your GROUP fails to pay PREMIUMS on time. If this happens, TUFTS HEALTH PLAN will notify you of the termination in writing within 60 days after the effective date of termination. The notice will tell you that you can elect to continue your coverage under Temporary Continuation of Coverage (TCC) and coverage under an INDIVIDUAL CONTRACT, as well as how to elect that coverage. If you elect Temporary Continuation of Coverage and pay the required PREMIUM, TCC coverage is available to you during the period between:

- the effective date of termination of your GROUP coverage; and
- the date TUFTS HEALTH PLAN sends you a written notice of termination.

The benefits available under Temporary Continuation of Coverage will be identical to those in your GROUP COVERAGE.

TUFTS HEALTH PLAN may terminate your coverage back to the date the GROUP CONTRACT terminated, if:

- TUFTS HEALTH PLAN sends you a written notice of termination;
- TUFTS HEALTH PLAN offers you the opportunity to elect Temporary Continuation of Coverage and coverage under an INDIVIDUAL CONTRACT; and
- you do not elect that coverage within the time period specified in the notice.

Upon termination of TCC, you may elect coverage under an INDIVIDUAL CONTRACT. For more information about this coverage, see "Coverage Under an INDIVIDUAL CONTRACT" at the end of Chapter 5.

If the GROUP CONTRACT terminates for any reason other than your GROUP's failure to pay PREMIUMS, TUFTS HEALTH PLAN will send a notice of termination to your GROUP with the effective date of termination. Your GROUP is responsible for notifying you of the termination. TUFTS HEALTH PLAN is not responsible if your GROUP does not notify you.

Transfer to Other GROUP Health Plans

Conditions for transfer

If you enrolled under a GROUP CONTRACT, you may transfer from TUFTS HEALTH PLAN to any other health plan offered by your GROUP only during your GROUP's OPEN ENROLLMENT PERIOD within 30 days after moving out of the NETWORK CONTRACTING AREA, or as of the date your GROUP no longer offers TUFTS HEALTH PLAN.

Note: Both your GROUP and the other health plan must agree.

Chapter 5 - Continuation of GROUP CONTRACT Coverage

31-Day Continuation Coverage When MEMBER Leaves GROUP

Under Massachusetts law, a MEMBER who leaves a GROUP shall be able to continue his or her coverage under the GROUP CONTRACT for a period of 31 days. If that MEMBER becomes entitled to other health insurance coverage during that 31-day period, this continuation coverage shall end as of the date he or she becomes entitled to the other health insurance coverage. For more information about this continuation coverage, please call your GROUP or Member Services.

Federal Continuation Coverage (COBRA)

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 TUFTS HEALTH 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) or the date the plan provides the qualified beneficiary with a COBRA election notice.

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

Cost of Coverage

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

Duration of Coverage

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

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

When coverage ends

Federal COBRA continuation coverage will end at the end of the maximum period of coverage. 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.

39-Week Continuation Coverage

Under Massachusetts law, when a MEMBER becomes ineligible for coverage under the GROUP CONTRACT because of involuntary layoff or death, that person may continue his or her coverage under the GROUP CONTRACT until the earlier of:

- a period of up to 39 weeks from the date of such ineligibility; or
- the date that MEMBER becomes eligible for benefits under another GROUP plan.

The GROUP is responsible for notifying the involuntarily laid-off SUBSCRIBER, the surviving SPOUSE of a deceased SUBSCRIBER, and other DEPENDENTS of their eligibility for this continuation coverage. Such MEMBER(s) may elect to this continuation coverage by providing at least 30 days written notice of that election to the GROUP. The MEMBER(s) shall then be responsible for the payment of the whole PREMIUM due for this continuation coverage. Please call your GROUP or Member Services for more information about this continuation coverage.

Plant Closing

Description of continuation available under a GROUP CONTRACT

Under Massachusetts law, SUBSCRIBERS whose employment is terminated due to a state-certified plant closing or covered partial closing may be eligible, along with their enrolled DEPENDENTS, for continuation of coverage for a period of 90 days. The GROUP is responsible for notifying SUBSCRIBERS of their eligibility. Contact your GROUP or Member Services for more information.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Under USERRA:

- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed services, and (1) you ensure that your employer receives advance written or verbal notice of your service; (2) you have five years or less of cumulative service in the uniformed services while with that particular employer; (3) you return to work or apply for reemployment in a timely manner after conclusion of service; and (4) you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you have 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 to 102% of the premium for the health plan coverage. If coverage is for less than 31 days, the service member is only required to pay the employee share, if any, for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website 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.

Coverage under an INDIVIDUAL CONTRACT

If GROUP coverage ends, the MEMBER 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"). Please note that coverage under an INDIVIDUAL CONTRACT may differ from group coverage. For more information, call TUFTS HEALTH PLAN Member Services or contact the Connector either by phone (1-877-MA-ENROLL) or on its website (www.mahealthconnector.org).

Chapter 6 - How to File a Claim and MEMBER Satisfaction

How to File a Claim

NETWORK Providers

When you obtain care f rom a NETWORK PROVIDER, you do not have to submit claim forms. The NETWORK PROVIDER will submit claim forms to CARELINK for you. CARELINK will make payment directly to the NETWORK PROVIDER.

NON-NETWORK Providers

As described below, when you obtain care from a NON-NETWORK PROVIDER, it may be necessary to file a claim form. Claim forms are available from the GROUP or CARELINK (see "To Obtain Claim Forms" below).

Hospital Admission or DAY SURGERY

When you receive care from a hospital that is a NON-NETWORK PROVIDER, have the hospital complete a claim form. The hospital should submit the claim form directly to CARELINK. If you are responsible for any portion of the hospital bill, CARELINK will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the NON-NETWORK HOSPITAL.

OUTPATIENT Medical Expenses

When you receive care from a NON-NETWORK PROVIDER, you are responsible for completing claim forms. (Check with the NON-NETWORK PROVIDER to determine if he or she will submit the claim directly to CARELINK for you or whether you will be required to submit the claim form directly to CARELINK yourself.)

If you sign the appropriate section on the claim form, CARELINK will make payment directly to the NON-NETWORK PROVIDER. If you are responsible for any portion of the bill, CARELINK will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the NON-NETWORK PROVIDER.

If you do not sign the appropriate section on the claim form, CARELINK will make the appropriate payment directly to you. If you have not already done so, you will be responsible for paying the NON-NETWORK PROVIDER for the services rendered. If you are responsible for any portion of the bill above what CARELINK pays, CARELINK will send you an explanation of benefits statement. The explanation of benefits statement will tell you how much you owe the NON-NETWORK PROVIDER.

To Obtain Claim Forms

Claim forms are available from the GROUP or by calling CARELINK Member Services.

Where to Forward Medical Claim Forms

Send completed claim forms to:

TUFTS HEALTH PLAN
Claims Department
P.O. Box 9185
Watertown, MA 02472-9185

Separate claim forms should be submitted for each family member.

Pharmacy Expenses

If you obtain a prescription at a non-designated or OUT-OF-NETWORK pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a CARELINK Member Representative or through our website.

MEMBER Satisfaction Process

CARELINK has a multi-level MEMBER Satisfaction Process including:

- Internal Inquiry;
- Member Grievance Process;
- Internal Member Appeals; and
- External Review by the Office of Patient Protection.

All calls should be directed to Our CARELINK Member Services Department at 1-866-352-9114. To submit your appeal or grievance in writing, send your letter to the P.O. Box address below. Or you may fax it to us at 617-972-9509.

TUFTS HEALTH PLAN
Attn: Appeals and Grievances Department
P.O. Box 9193
Watertown, MA 02472-9193

You may also submit your appeal or grievance in-person at this address:

TUFTS HEALTH PLAN
1 Wellness Way
Canton, MA 02021

Internal Inquiry

Call a CARELINK Member Representative to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be explained or resolved within three (3) business days or if you tell a Member Representative that you are not satisfied with the response you have received from CARELINK, 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.

CARELINK maintains records of each inquiry made by a MEMBER or by that MEMBER's authorized representative. The records of these inquiries and the response provided by CARELINK are subject to inspection by the Massachusetts Commissioner of Insurance and the Massachusetts Health Policy Commission.

MEMBER Grievance Process

A grievance is a formal complaint about actions taken by TUFTS HEALTH PLAN or a NETWORK PROVIDER. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact CARELINK 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 CARELINK Member Representative, who will document your concern and forward it to an Appeals and Grievances Specialist 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 P.O. Box address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your CARELINK 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 CARELINK employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline
- If you file your grievance verbally or 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 Specialist coordinating the review of your grievance.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify CARELINK that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your PROVIDERS to release medical information relevant to your grievance to CARELINK. You must sign and return the form before we can begin the review process. If you do not sign and return the form to CARELINK within thirty (30) business days of the date you filed, we may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance that are in the possession and control of CARELINK.
- We 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 CARELINK.

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 verbally or 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 Specialist coordinating the review of your grievance.

CARELINK 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

An appeal is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by CARELINK based on MEDICAL NECESSITY (an adverse determination) or a denial of coverage for a specifically excluded service or supply. The CARELINK Appeals and Grievances Department will review all of the information submitted upon appeal, taking into consideration your benefits as detailed in this CERTIFICATE OF INSURANCE.

It is important that you contact CARELINK as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal. Appeals may be filed either verbally or in writing. If you would like to file a verbal appeal, call a CARELINK Member Representative who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your appeal in writing and send it to the P.O. Box address provided at the beginning of this section.

Your explanation should include:

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

Appeals Timeline

- If you file your appeal verbally or in writing, we will notify you in writing, within forty-eight (48) hours after receiving your written or verbal appeal, that your appeal has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your appeal and our understanding of your concerns.
- If your request for review was first addressed through the Internal Inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify CARELINK that you are not satisfied with the response you received during the Internal Inquiry process.
- CARELINK will review your appeal and, make a decision. TUFTS HEALTH PLAN will send you a decision letter 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 verbal or written agreement between you or your authorized representative and CARELINK.

This extension may be necessary if we are waiting for medical records that are necessary for the review of your appeal and have not received them. The Appeals and Grievances Specialist handling your case will notify you in advance if an extension may be needed. In addition, a letter will be sent to you confirming the extension.

Note: If you need help, the Consumer Assistance Resource Program in Massachusetts can help you file your appeal. Contact:

Office of Patient Protection

450 Milk Street, 8th Floor

Boston, MA 02109

(800) 436-7757

https://www.mass.gov/hpc.opp

When Medical Records are Necessary

If your appeal requires the review of medical records, you will receive a form that you will need to sign that authorizes your PROVIDERS to release to CARELINK medical information relevant to your appeal. You must sign and return the form before CARELINK can begin the review process. If you do not sign and return the form to CARELINK within thirty (30) calendar days of the date you filed your appeal, CARELINK may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal that are in the possession and control of CARELINK.

Who Reviews Appeals?
If the appeal involves a medical necessity determination, an actively practicing health care professional in the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment that is under review, and who did not participate in any of the prior decisions on the case, will take part in the review. In addition, a committee made up of managers and clinicians from various TUFTS HEALTH PLAN departments will review your appeal. A committee within the Appeals and Grievances Department will review appeals involving non-COVERED SERVICES.

Appeal Response Letters
The letter you receive from us will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on MEDICAL NECESSITY) will include: the specific information upon which the adverse determination was based; CARELINK's understanding of your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; notification of the steps for requesting external review by the Office for Patient Protection; and the titles and credentials of the individuals who reviewed the case; and the availability of translation services and consumer assistance programs. Please note that requests for coverage of services that are specifically excluded in your CERTIFICATE are not eligible for external review.

An appeal not properly acted on by CARELINK within the time limits of Massachusetts law and regulations, including any extensions made by mutual written agreement between you or your authorized representative and CARELINK, shall be deemed resolved in your favor.

Expedited Appeals
CARELINK recognizes that there are circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. CARELINK will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending PROVIDER should contact the Member Services Department. Under these circumstances, you will be notified of the decision within 2 business days, but no later than seventy-two (72) hours (whichever is less) after the review is initiated. If your treating PROVIDER (the practitioner responsible for the treatment or proposed treatment) certifies that the service being requested is MEDICALLY NECESSARY; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal appeal process, you will be notified of the decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for DURABLE MEDICAL EQUIPMENT (DME) that was determined not to be MEDICALLY NECESSARY, you will be notified of the decision within less than forty-eight (48) hours of the receipt of certification. If you are an INPATIENT in a hospital, CARELINK will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at CARELINK's expense through the completion of the Internal Appeals Process. Only those services which were originally authorized by CARELINK and which were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

If you have a terminal illness, we will notify you of the decision within five (5) days of receiving your appeal. If the decision is to deny coverage, you may request a conference. We will schedule the conference within 10 days (or within 5 business days if your PROVIDER determines, after talking with a CARELINK Medical Affairs Department Physician or Psychological Testing Reviewer, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date). You may bring another person with you to the conference. At the conference, you and/or your authorized representative, if any, and a representative of CARELINK who has authority to determine the disposition of the appeal, shall review the information provided.

If the appeal is denied, the decision will include the specific medical and scientific reasons for denying the coverage, and a description of any alternative treatment, services or supplies that would be covered. If your request meets the criteria for an expedited review, you may also file a request for a simultaneous external appeal as described below.

If You are Not Satisfied with the Appeals Decision
"Reconsideration"
In circumstances where relevant medical information (1) was received too late to review within the thirty (30) calendar day time limit; or (2) was not received but is expected to become available within a reasonable time period following the written resolution, you may choose to request a reconsideration. CARELINK may allow the opportunity for reconsideration of a final adverse determination. If you request a reconsideration, you must agree in writing to a new time period for review. The time period will be no greater than thirty (30) calendar days from the agreement to reconsider the appeal.

External Review by the Office of Patient Protection
The Massachusetts Office of Patient Protection, which is not connected in any way with CARELINK, administers an independent external review process for final coverage determinations based on medical necessity (final adverse determination). Appeals for coverage of services specifically excluded in your CERTFICATE and payment disputes are not eligible for external review.

To request an external review by the Office of Patient Protection, you must file your request in writing with the Office of Patient Protection within four (4) months of your receipt of written notice of the denial of your appeal by CARELINK. The letter from CARELINK notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection. The review panel will make a decision within forty-five (45) calendar days for standard reviews and within seventy-two (72) hours for expedited reviews.

Note: Payment disputes are not eligible for external review, except when the appeal is filed to determine if surprise billing protections are applicable.

You or your authorized representative may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a PROVIDER, that delay in providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review.

Your cost for an external review by the Office of Patient Protection is $25.00. This payment should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that the payment of the fee would result in an extreme financial hardship to you and shall refund the fee to the insured if the adverse determination is reversed in its entirety. CARELINK will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill CARELINK the amount established pursuant to contract between the Massachusetts Health Policy Commission and the assigned external review agency minus the $25 fee which is your responsibility. You will not be required to pay more than $75 per plan year, regardless of the number of external review requests submitted.

You or your authorized representative will have access to any medical information and records relating to your appeal in the possession of the CARELINK or under its control.

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. The review panel may order the continuation of coverage where it determines that substantial harm to your health may result absent such continuation or for such other good cause as the review panel shall determine. Any such continuation of coverage will be at CARELINK's expense regardless of the final external review determination.

The decision of the review panel will be binding on CARELINK. If the external review agency overturns the decision in whole or in part, CARELINK will send you a written notice within five (5) business days of receipt of the written decision from the review agency. This notice will:

- include an acknowledgement of the decision of the review agency;
- advise you of any additional procedures that you need to take in order to obtain the requested coverage or services;
- advise you of the date by which the payment will be made or the authorization for services will be issued by CARELINK; and
- include the name and phone number of the person at CARELINK who will assist you with final resolution of the appeal.

Please note: If you are not satisfied with CARELINK's MEMBER Satisfaction process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care at 617-521-7777 or the Health Policy Commission's Office of Patient Protection at:

Health Policy Commission
Office of Patient Protection
50 Milk St., 8th Floor
Boston, MA 02109
Phone: 1-800-436-7372
Fax: 1-617-624-5046
Internet: www.mass.gov/hpc/opp

Email: HPC-OPP@state.ma.us

Bills from Providers

Bills from PROVIDERS

Occasionally, you may receive a bill from a NON-NETWORK PROVIDER for COVERED SERVICES. Before paying the bill, contact the CARELINK 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 CARELINK website or by contacting the CARELINK 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 Claims 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 may take longer. Reimbursements will be sent to the SUBSCRIBER at the address TUFTS HEALTH PLAN has on file.

Except as described earlier in this CERTIFICATE, if you receive COVERED SERVICES from a NON-NETWORK PROVIDER, CARELINK will pay up to the REASONABLE CHARGE.

IMPORTANT NOTE

Certain services you receive from NON-NETWORK PROVIDERS within our NETWORK CONTRACTING AREA may be reimbursable at the IN-NETWORK LEVEL OF BENEFITS. Some examples of these types of NON-NETWORK PROVIDERS include:

- radiologists, pathologists, and anesthesiologists who work in hospitals; and
- EMERGENCY room specialists.

You may receive a bill from a PROVIDER who is not a TUFTS HEALTH PLAN PROVIDER. If this happens, please follow the member reimbursement process described above.

We reserve the right to be reimbursed by the MEMBER for payments made due to our error.

Notice to Michigan Residents

A complete and proper claim for COVERED SERVICES made by a MEMBER will be promptly processed by CARELINK. However, in the event there are delays in processing claims, the MEMBER shall have no greater rights to interest or other remedies against TUFTS HEALTH PLAN's third party administrator, Tufts Benefit Administrators, Inc., than as otherwise afforded to him or her by law.

Limitation on Actions

You cannot file a lawsuit against TUFTS HEALTH PLAN for failing to pay or arrange for COVERED SERVICES unless you have completed the CARELINK 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 our 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 CARELINK MEMBER Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage. However, if you choose to pursue external review by the Office of Patient Protection, the days from the date your request is received by the Office of Patient Protection until the date you receive the response are not counted toward the two-year limit.

Subrogation

TUFTS HEALTH PLAN's right of subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else (a "Third Party"). "Third Party" means any person or company that is, could be, or is claimed to be responsible for the costs of injuries or illness to you. This includes such costs to any DEPENDENT covered under this plan.

TUFTS HEALTH PLAN may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or rewards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- no-fault, personal injury protection ("PIP"), or medical payments coverage ("MedPay") under any automobile policy to the extent permissible by law;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you for Third Party injuries.

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether:

- all or part of the recovery is for medical expenses; or
- the recovery is less than the amount needed to reimburse you fully for the illness or injury.

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. TUFTS HEALTH 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 TUFTS HEALTH PLAN pays for the costs of health care services or medications for any work-related illness or injury, TUFTS HEALTH 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 TUFTS HEALTH PLAN for any work-related illness or injury, please contact the TUFTS HEALTH PLAN Liability and Recovery Department at 1-888-880-8699, x. 21098.

TUFTS HEALTH PLAN's right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- no-fault PIP, or MedPay under any automobile policy to the extent permissible by law;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you where a Third Party is responsible.

We have the right to be reimbursed up to the amount of any payment received by you to the extent permissible by law, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

Constructive Trust

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

MEMBER cooperation

You f urther agree:

- to notify TUFTS HEALTH PLAN promptly and in writing when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a claim to recover damages or obtain compensation;
- to cooperate with us and provide us with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this plan;
- to assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of health care services and supplies, and expenses, that we paid or will pay for your illness or injury;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any Third Party. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan;
- to serve as a constructive trustee for the benefit of this plan over any settlement or recovery funds received as a result of Third Party responsibility;
- that we may recover the full cost of all benefits provided by this plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from our recovery;
- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party; and
- that in the event you or your representative fails to cooperate with TUFTS HEALTH PLAN, you shall be responsible f o r all benefits provided by this plan in addition to costs and attorney's fees incurred by TUFTS HEALTH PLAN in obtaining repayment.

Subrogation Agent

TUFTS HEALTH PLAN may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as TUFTS HEALTH PLAN's agent.

Coordination ofBenefits

Benefits under other plans

You may have benefits under other plans for hospital, medical, dental or other health care expenses.

TUFTS HEALTH PLAN has a coordination of benefits (COB) program that prevents duplication of payment for the same health care services. We will coordinate benefits payable for COVERED SERVICES with benefits payable by other plans, consistent with Massachusetts law, 211 CMR 38.00 et seq. As permitted under this law, we will coordinate benefits for prescription drug claims pursuant to our secondary payer allowed amount in all cases.

Note: We coordinate benefits with Medicare according to federal law, rather than state law.

Primary and secondary plans

We will coordinate benefits by determining which plan has to pay first when you make a claim and which plan has to pay second. We determine the order of benefits using the first applicable rule set forth in 211 CMR 38.05 and pay or provide benef its pursuant to the rules set forth in 211 CMR 38.04 and 211 CMR 38.06. These regulations are available on the Massachusetts state website, www.mass.gov/code-of-massachusetts-regulations-cmr.

Right to receive and release necessary information

When you enroll, you must include information on your membership application about other health coverage you have. After you enroll, you must notify us of new coverage, or termination of other coverage, or if you are enrolled in any high deductible health plan with a health savings account (HSA). We may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with our COB program.

Right to recover overpayment

TUFTS HEALTH 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. TUFTS HEALTH 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 Representative and have your call transferred to the TUFTS HEALTH PLAN Liability and Recovery Department.

Medicare Eligibility

This provision does not apply to a MEMBER enrolled under an INDIVIDUAL CONTRACT.

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 is 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 is 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 is 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

TUFTS HEALTH PLAN mails a separate "NOTICE OF PRIVACY PRACTICES" to all SUBSCRIBERS to explain how TUFTS HEALTH PLAN uses and discloses your medical information. If you have questions or would like another copy of our "Notice of Privacy Practices", please call a Member Representative. Information is also available on our website.

Relationships between TUFTS HEALTH PLAN and PROVIDERS

TUFTS HEALTH PLAN and PROVIDERS

TUFTS HEALTH PLAN arranges health care services. We do not provide health care services. We have agreements with PROVIDERS practicing in their private offices throughout the NETWORK CONRACTING AREA. These PROVIDERS are independent. They are not TUFTS HEALTH PLAN employees, agents or representatives. PROVIDERS are not authorized to change this CERTIFICATE or assume or create any obligation for TUFTS HEALTH PLAN.

We are not 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

We 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, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of NETWORK PROVIDERS.

GROUP CONTRACT

Acceptance of the terms of the GROUP CONTRACT

By causing your membership application to be submitted to TUFTS HEALTH PLAN, you apply for GROUP coverage and agree, on behalf of yourself and your enrolled DEPENDENTS, to all the terms and conditions of the GROUP CONTRACT, including this CERTIFICATE.

Payments for coverage

We will bill your GROUP and your GROUP will pay PREMIUMS to TUFTS HEALTH PLAN for you. We are not responsible if your GROUP fails to pay the PREMIUM. This is true even if your GROUP has charged you (for example, by payroll deduction) for all or part of the PREMIUM.

Note: If your GROUP fails to pay the PREMIUM on time, we may cancel your coverage in accordance with the GROUP CONTRACT and applicable state law. For more information on the notice to be provided, see "Termination of the GROUP CONTRACT and Notice" in Chapter 4.

We may change the PREMIUM. If the PREMIUM is changed, the change will apply to all MEMBERS in your GROUP.

Changes to this CERTIFICATE

We may change this CERTICATE. Changes do not require your consent. Notice of changes in COVERED SERVICES will be sent to your GROUP at least 60 days before the effective date of the modifications and will include information regarding any changes in clinical review criteria and detail the effect of such changes on a MEMBER's personal liability for the cost of such charges.

Changes will apply to all benefits for services received on or after the effective date with one exception.

Exception: A change will not apply to you if you are an INPATIENT on the effective date of the change until your discharge date.

Note: If changes are made, they will apply to all MEMBERS in your GROUP, not just to you.

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, P.O. Box 9173, Watertown, MA 02472-9173.

Enforcement of terms

TUFTS HEALTH PLAN may choose to waive certain terms of the GROUP CONTRACT, if applicable, including the CERTIFICATE. This does not mean that TUFTS HEALTH PLAN gives up its rights to enforce those terms in the future.

When this CERTIFICATE Is Issued and Effective

This CERTIFICATE is issued and effective on your GROUP ANNIVERSARY DATE on or after January 1, 2022 and supersedes all previous CERTIFICATES.

Appendix A - Glossary of Terms and Definitions

This section defines the terms used in this CERTIFICATE.

ADOPTIVE CHILD
A CHILD is an ADOPTIVE CHILD as of the date he or she:

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

Note: As required by state law, a foster CHILD is considered an ADOPTIVE CHILD as of the date that a petition to adopt was filed.

ALLOWED COST or ALLOWED AMOUNT

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense", "payment allowance", or "negotiated rate".

ANNIVERSARY DATE
The date upon which the GROUP CONTRACT first renews and each successive annual renewal date.

ANNUAL COVERAGE LIMITATIONS
Annual dollar or time limitations on COVERED SERVICES.

AUTHORIZED REVIEW
AUTHORIZED REVIEW refers to prospective, concurrent, and retrospective reviews of health care services for MEDICAL NECESSITY and is performed by the REVIEW ORGANIZATION.

BEHAVIORAL HEALTH DISORDERS
Psychiatric illnesses or diseases listed as mental disorders in the latest edition, at the time treatment is given, of the American Psychiatric Association's Diagnostic and Statistical Manual: Mental Disorders.

BOARD- CERTIFIED BEHAVIOR ANALYST (BCBA)
A BOARD- CERTIFIED BEHAVIOR ANALYST (BCBA) meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A BCBA professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for MEMBERS with diagnoses of autism spectrum disorders. BCBAs may supervise the work of Board-Certified Assistant Behavior Analysts and other PARAPROFESSIONALS who implement behavior analytic interventions.

CARELINK
CARELINK is an open access benefit plan insured by TUFTS HEALTH PLAN. In Massachusetts and Rhode Island, Tufts Insurance Company and its affiliate, Tufts Benefit Administrators, Inc., are responsible for participating provider network contracting and maintenance, certain credentialing, provider services and claims payment, and behavioral health and substance use disorder utilization management. Cigna provides certain administrative services including participating provider network contracting and maintenance outside of Massachusetts and Rhode Island, medical management, and behavioral health and substance use disorder utilization management outside of Massachusetts and Rhode Island.

CERTIFICATE
This document, and any future amendments, which describes the health benefits under the GROUP CONTRACT.

CHILD
The following individuals until the last day of the month in which their 26th birthday occurs:

- the SUBSCRIBER's or SPOUSE's natural child, stepchild, or ADOPTIVE CHILD; or
- the child of an enrolled CHILD;
- any other child for whom the SUBSCRIBER has legal guardianship; or
- any other child who meets the IRS Code definition of a DEPENDENT of the SUBSCRIBER or the SPOUSE.

COINSURANCE
The MEMBER's share of costs for COVERED SERVICES.

For services provided by a NETWORK PROVIDER, the MEMBER's share is a percentage of

- the applicable NETWORK fee schedule amount for those services; or
- the NETWORK PROVIDER's charges, whichever is less.

For services provided by a NON-NETWORK PROVIDER, the MEMBER pays a share of the REASONABLE CHARGE. Costs in excess of the REASONABLE CHARGE are not subject to COINSURANCE. The MEMBER may be responsible for paying for costs in excess of the REASONABLE CHARGE.

See "Contract and Benefit Overview" at the front of this CERTIFICATE OF INSURANCE for more information.

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

CONTRACT YEAR
The 12-month period in which benefit limits, DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, and COINSURANCE are calculated under this plan. A CONTRACT YEAR can be either a calendar year or a plan year.

- Calendar year: Coverage based on a calendar year runs from January 1st through December 31st within a year.
- Plan year: Coverage based on a plan year runs during a period of 12 consecutive months that are not a calendar year (for example, July 1st in one calendar year through June 30th in the following calendar year).

Note:

- For a GROUP CONTRACT, the CONTRACT YEAR is determined by the GROUP.

For more information about the type of CONTRACT YEAR that applies to your plan, please call Member Services. If you are enrolled in a GROUP CONTRACT, you can also contact your employer for more information about the type of CONTRACT YEAR that applies to your plan.

COPAYMENT
The MEMBER's payment for certain COVERED SERVICES provided by either a NETWORK PROVIDER or a NON-NETWORK PROVIDER. The MEMBER pays COPAYMENTS to the PROVIDER at the time services are rendered, unless the PROVIDER arranges otherwise.

COST SHARING AMOUNT
The cost you pay for certain COVERED SERVICES. This amount may consist of DEDUCTIBLES, COPAYMENTS, and/or COINSURANCE.

COVERED SERVICES
The services and supplies for which TUFTS HEALTH PLAN will pay. They must be:

- described in Chapter 3 of this CERTIFICATE (subject to the "Exclusions from Benefits" section in Chapter 3); and
- MEDICALLY NECESSARY.

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 do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any PROVIDER, MEMBER, service, supply or medication.

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; or
- routine maintenance of colostomies, ileostomies, and urinary catheters; or
- adult and pediatric day care.

Note: CUSTODIAL CARE is not covered by TUFTS HEALTH 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 24 hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care".

DEDUCTIBLE
For each CALENDAR YEAR, the amount paid by the MEMBER for certain COVERED SERVICES before any payments are made under this CERTIFICATE.
(Any amount paid by the MEMBER for a COVERED SERVICE rendered during the last 3 months of a CALENDAR YEAR shall be carried forward to the next CALENDAR YEAR's DEDUCTIBLE.). However, any DEDUCTIBLE amount carried forward will not be applied to the next CALENDAR YEAR OUT-OF-POCKET MAXIMUM.
Costs in excess of the REASONABLE CHARGE do not count towards the DEDUCTIBLE. See "Benefit Overview" at the front of this CERTIFICATE for more information.

Note: The amount credited towards the MEMBER'S DEDUCTIBLE is based on the NETWORK PROVIDER negotiated rate at the time the services are rendered and does not reflect any later adjustments, payments, or rebates that are calculated on an individual claim basis.

DEPENDENT
The SUBSCRIBER's SPOUSE, CHILD, or DISABLED DEPENDENT.

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 list of NETWORK PROVIDER with whom we contract. It also lists, their affiliated NETWORK HOSPITAL(s).

Note: This list updated from time to time to reflect changes in those NETWORK PROVIDERS. For information about the PROVIDERS listed in the DIRECTORY OF HEALTH CARE PROVIDERS, you can call CARELINK Member Services or check the website at http:cignathp.benefitnation.net/cignathp/.

DISABLED DEPENDENT
The SUBSCRIBER's CHILD who:

- became permanently physically or mentally disabled before the last day of the month in which their 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 the last day of the month in which their 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 TUFTS HEALTH PLAN's records, when you become a MEMBER and are first eligible for COVERED SERVICES.

EMERGENCY
An illness or medical condition, whether physical, behavioral, related to substance use disorder, or mental, 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 or her unborn CHILD's physical and/or mental 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 Cigna's corresponding MEDICAL NECESSITY Guidelines.

FAMILY COVERAGE
Coverage for a SUBSCRIBER and his or her DEPENDENTS.

FREE-STANDING URGENT CARE CENTER
A medical facility that provides treatment for URGENT CARE services (see definition of URGENT CARE). A FREE-STANDING 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. A FREE-STANDING 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. A FREE-STANDING 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. FREE-STANDING URGENT CARE CENTERs are not part of a hospital or hospital system and are not LIMITED SERVICE MEDICAL CLINICS. To find a FREE-STANDING URGENT CARE CENTER in our network, please our website and click on "Find a Doctor", or call Member Services.

GROUP
An employer or other legal entity with which TUFTS HEALTH PLAN has an agreement to provide GROUP coverage. An employer GROUP subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. If you are covered under a GROUP CONTRACT, 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 GROUP coverage; and
- the GROUP agrees to pay a PREMIUM to TUFTS HEALTH PLAN on your behalf.

The GROUP CONTRACT includes this CERTIFICATE and any amendments.

HABILITATIVE
Health care services provided in accordance with the federal Affordable Care Act (ACA) in order for a person to attain, maintain or prevent deteriorate of a life skill or function never learned or acquired due to a disabling condition. These services may include physical and occupational therapy, and speech-language pathology services in various INPATIENT and OUTPATIENT settings.

INDIVIDUAL COVERAGE
Coverage for a SUBSCRIBER only (no DEPENDENTS).

IN-NETWORK LEVEL OF BENEFITS
The level of benefits that a MEMBER receives when COVERED SERVICES are provided by a NETWORK PROVIDER. (or, with respect to INPATIENT behavioral health or INPATIENT substance use disorder care, when care is provided or authorized by a NETWORK HOSPITAL). See Chapter 1 for more information.

INPATIENT
A patient who is admitted to a hospital or other facility licensed to provide continuous care and is 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, as based on scientific evidence.

MEDICAL NECESSITY Guidelines are used to determine coverage for MEDICALLY NECESSARY Services. These Guidelines are:

- based on current literature review;
- developed with input from practicing PROVIDERS in the NETWORK CONTRACTING AREA;
- developed in accordance with the standards adopted by government agencies and national accreditation organizations;
- updated annually or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- scientific evidence-based, if practicable.

Cigna's MEDICAL NECESSITY Guidelines are available on the website at:
https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview.
If you prefer, call Member Services. Or call the CARELINK Behavioral Health Department at 1-800-232-1164.

MEMBER
A person enrolled in TUFTS HEALTH PLAN under the GROUP CONTRACT. Also referred to as "you."

NETWORK CONTRACTING AREA
The geographic area within which TUFTS HEALTH PLAN has developed or arranged for a network of PROVIDERS to afford MEMBERS with adequate access to COVERED SERVICES.

Note: For information about PROVIDERS in the NETWORK CONTRACTING AREA, you can call Member Services or check our website at www.tuftshealthplan.com/carelink.

Certain services may be available outside of the NETWORK CONTRACTING AREA through the TUFTS HEALTH PLAN telemedicine vendor. For more information, please visit https://tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth.

NETWORK HOSPITALS
A hospital which has an agreement either with TUFTS HEALTH PLAN directly or with a PROVIDER network with whom TUFTS HEALTH PLAN has a contract to provide certain COVERED SERVICES to MEMBERS. NETWORK HOSPITALS are independent. They are not owned by TUFTS HEALTH PLAN. NETWORK HOSPITALS are not TUFTS HEALTH PLAN's agents or representatives, and their staff are not TUFTS HEALTH PLAN's employees. NETWORK HOSPITALS are subject to change.

NETWORK PROVIDERS
A PROVIDER who has an agreement either with TUFTS HEALTH PLAN directly or with a provider network with whom TUFTS HEALTH PLAN has a contract to provide COVERED SERVICES to MEMBERS. NETWORK PROVIDERS are located throughout the NETWORK CONTRACTING AREA.

NON-CONVENTIONAL MEDICINCE

A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the 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 MEDICINCE 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 MEDICINCE 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, medication, 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 MEDICINCE services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).

NON-NETWORK PROVIDER
A PROVIDER who does not have an agreement with TUFTS HEALTH PLAN directly or with a PROVIDER network with whom TUFTS HEALTH PLAN has a contract to participate as a NETWORK PROVIDER.

OBSERVATION
The use of hospital service 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
For a GROUP CONTRACT, the period each year when TUFTS HEALTH PLAN and the GROUP allow eligible persons to apply for GROUP coverage in accordance with the GROUP CONTRACT.

OUT-OF-NETWORK LEVEL OF BENEFITS
The level of benefits that a MEMBER receives when COVERED SERVICES are not provided by a NETWORK PROVIDER. See Chapter 1 for more information.

OUTPATIENT
A patient who receives care other than on an INPATIENT basis. This includes services provided in:

- a PROVIDER's office;
- a DAY SURGERY or ambulatory care unit; and
- an EMERGENCY room or OUTPATIENT clinic.

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

OUT-OF-POCKET MAXIMUM
The maximum amount of money paid by a MEMBER during a CALENDAR YEAR for COVERED SERVICES.

See "Benefit Overview" at the front of this CERTIFICATE for detailed information about your OUT-OF-POCKET MAXIMUM.

PARAPROFESSIONAL

As it pertains to the treatment of autism and autism spectrum disorders, a PARAPROFESSIONAL is an individual who performs applied behavior analysis (ABA) services under the supervision of a Board-Certified Behavior Analyst (BCBA).

PRECERTIFICATION
CARELINK's process of verifying authorization required for all INPATIENT admissions and transfers. PRECERTIFICATION is not a guarantee of payment. See Chapter 1 for further information.

PRE-EXISTING CONDITION

A condition which had during the six months immediately preceding your EFFECTIVE DATE manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received. Pregnancy and infertility are not considered pre-existing conditions.

PREMIUM
The total monthly cost of INDIVIDUAL or FAMILY COVERAGE which the GROUP pays to TUFTS HEALTH PLAN.

PRIMARY CARE PROVIDER
A NETWORK PROVIDER who is a general practitioner, family practitioner, internist, pediatrician, physician assistant, nurse practitioner or obstetrician/gynecologist who provides primary care 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), FREE-STANDING URGENT CARE CENTERs, physicians, doctors of osteopathy, certified nurse midwives, certified registered nurse anesthetists, physician assistants, nurse practitioners, optometrists, podiatrists, 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, Licensed Alcohol and Drug Counselor I; licensed marriage and family therapists, licensed speech-language pathologists, and licensed audiologists.

TUFTS HEALTH 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.

Notes:

- With respect to OUTPATIENT services for the treatment of alcoholism, PROVIDER means an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health or other applicable state law.
- With respect to INPATIENT services for the treatment of alcoholism, PROVIDER an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health; or a residential alcohol treatment program, as defined under Massachusetts law.

REASONABLE CHARGE
The lesser of:

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

Note: The amount the MEMBER pays in excess of the REASONABLE CHARGE is not included in the DEDUCTIBLE, COINSURANCE or OUT-OF-POCKET MAXIMUM.

REVIEW ORGANIZATION
The term "REVIEW ORGANIZATION" refers to TUFTS HEALTH PLAN, Cigna, or an entity to which Cigna, has delegated responsibility for performing utilization review services. The REVIEW ORGANIZATION is an organization with a staff of clinicians which may include physicians, registered graduate nurses, licensed behavioral health and substance abuse professionals, and other trained staff members who perform utilization review services.

ROUTINE NURSERY CARE
Routine hospital care provided to a well newborn child immediately following birth until discharge from the hospital.

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

SPOUSE
The SUBSCRIBER's legal SPOUSE, according to the law of the state in which you reside, or divorced SPOUSE as required by Massachusetts law.

SUBSCRIBER
The person:

- who is employed by the GROUP; and
- in whose name the PREMIUM is paid in accordance with the GROUP.

TUFTS HEALTH PLAN or TUFTS HP
Tufts Insurance Company (TIC) which is authorized to offer POS and PPO products. TIC has entered into an agreement with Tufts Benefit Administrators, Inc. (TBA) for TBA to administer the health benefits and make available a network of PROVIDERS described in this CERTIFICATE.

Both TIC and TBA do business under the name TUFTS HEALTH PLAN. TUFTS HEALTH PLAN is also referred to as "we", "us", and "our".

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

Note: Care that is rendered after the URGENT condition has been treated and stabilized and the MEMBER is safe for transport is not considered URGENT CARE.

Appendix B - ERISA Information and other State and Federal Notices

ERISA Rights

Note: Applies to Group Contracts only.

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, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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).

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 a daily penalty 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 Employee Benefits Security Administration.

PROCESSING OF CLAIMS FOR PLAN BENEFITS

Note: Applies to Group Contracts only.

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 Representative the number on your ID card 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.

Concurrent care decisions: A "concurrent care decision" is a determination relating to the continuation/reduction of an ongoing course of treatment to be provided over a period of time or number of treatments. 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.

* In accordance with Massachusetts law, Tufts Health Plan will make an initial determination regarding a proposed admission, procedure, or service that requires such a determination within two working days of obtaining all necessary information.

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

Note: Applies to Group Contracts only.

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 provider or other health care provider obtain authorization for prescribing a length of stay or up to 48 hours (or 96 hours). However, to use certain providers or facilities, you may be required to provide notification to Tufts Health Plan. For information on notification requirements, 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 servicemember 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 servicemember. The employee is entitled to a combined total of 26 weeks for 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 Premiums while on leave. In some instances, the employer may recover Premiums 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 website 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 website at **www.tuftshealthplan.com**.

NOTICE OF PRIVACY PRACTICES

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 health or condition, the provision of health care to you or the payment for that care.

You are receiving this Notice as a member of CARELINK. TUFTS HEALTH PLAN and Cigna have joined together to offer CARELINK.

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 commercial insured health benefit plans (including HMO, POS and PPO and Medicare Complement plans), and employees covered under the Tufts Associated Health Plans, Inc. group health plans. 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.

How We Use and Disclose Your PHI – continued

- **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 may 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. The following corporate affiliates of Tufts Health Plan designate themselves as a single affiliated covered entity and may share your information among them: Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., Tufts Associated Health Plans, Inc. group health plans, Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., and Harvard Pilgrim Group Health Plan.

- **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 plan 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 Govemment 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 or 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.

How We Use and Disclose Your PHI – continued

- **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 inf ormation 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

Tuf ts 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.

Your Individual Rights – continued

- **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 Tuf ts 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 upon request.

- **How to Exercise Your Rights:** To exercise any of the individual rights described above or for more information, please call a Member Services Representative at 1-866-352-91144 (TDD: 711) or write to:

Privacy Officer
Tuf ts Health Plan
1 Wellness Way
Canton, MA 02021

Effective Date of Notice

This Notice takes effect February 1, 2021. We must follow the privacy practices described in this Notice while it is in ef f ect. This Notice will remain in ef f ect 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 of the new Notice. Whenever we make an important change, we will publish the updated Notice on our website 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 Representative at the number listed above. You can also download a copy from our website 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
Tufts Health Plan
1 Wellness Way
Canton, MA 02021

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.

1 Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., Tufts Insurance Company, TAHP Brokerage Corporation, and Tufts Associated Health Plans, Inc. group health plans do business as TUFTS HEALTH PLAN. TUFTS HEALTH PLAN is a registered trademark of Tufts Associated Health Maintenance Organization, Inc.

2 "Cigna" refers to various subsidiaries of Cigna. Products and services are provided by these subsidiaries, not by Cigna. "Cigna" is a registered service mark, and "CARELINK" is a service mark, licensed for use by Cigna and its subsidiaries. ©2007 Cigna. All rights reserved

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
  - Information written in other languages

If you need these services, contact Member Services.

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

Tufts Health Plan

Attention: Civil Rights Coordinator Legal Dept.

1 Wellness Way Canton, MA 02021

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

Appendix C – Schedule II and III Opioid Medications

Schedule II drugs are defined under Massachusetts law as drugs: (1) with a high potential for abuse; (2) with a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; and (3) whose abuse may lead to severe psychological or physical dependence.

Schedule III drugs are defined under Massachusetts law as drugs: (1) with a potential for abuse is less than the drugs in Schedules I and II; (2) that have a currently accepted medical use in treatment in the United States; and (3) whose abuse may lead to moderate or low physical dependence or high psychological dependence.

Appendix C – Schedule II and III Opioid Medications

Effective January 1, 2022, the following opioid medications have been classified as Schedule II or Schedule III controlled substances by the state of Massachusetts. In accordance with Massachusetts law, if you are prescribed any of these medications and wish to have a quantity less than what was prescribed, no additional cost or penalty will be imposed on you. If the MEMBER fills a lesser quantity than is prescribed of a Schedule II opioid controlled substance, and then decides to fill the remainder of the original prescription at the same pharmacy within 30 days of the original prescription date, no additional COPAYMENT or other cost sharing will be applied. This list is subject to change throughout the year. Please call a Member Representative for the most current information about Schedule II and III medications covered by Tufts Health Plan.

Schedule II medications

- acetaminophen/hydrocodone
- acetaminophen/oxycodone
- aspirin/oxycodone
- belladonna/opium suppositories
- brompheniramine/hydrocodone/phenylephrine
- brompheniramine/hydrocodone/pseudoephedrine
- chlorpheniramine polistirex/hydrocodone polistirex
- chlorpheniramine/hydrocodone
- chlorpheniramine/hydrocodone/phenylephrine
- chlorpheniramine/hydrocodone/pseudoephedrine
- codeine sulfate
- dexbrompheniramine/hydrocodone/phenylephrine
- dexchlorpheniramine/hydrocodone/phenylephrine
- diphenhydramine/hydrocodone/phenylephrine
- fentanyl
- guaifenesin/hydrocodone/phenylephrine
- guaifenesin/hydrocodone/pseudoephedrine
- hydrocodone
- hydrocodone ER
- hydrocodone/homatropine
- hydrocodone/ibuprofen
- hydrocodone/phenylephrine/pyrilamine
- hydrocodone/potassium guaiacolsulfonate
- hydrocodone/pseudoephedrine
- hydromorphone
- hydromorphone ER
- ibuprofen/oxycodone
- levorphanol tartrate
- meperidine
- meperidine/promethazine
- methadone
- morphine
- morphine ER
- morphine sulfate ER
- morphine/naltrexone
- naltrexone/oxycodone
- opium tincture
- oxycodone
- oxycodone ER
- oxymorphone
- oxymorphone ER
- tapentadol

Schedule III medications

- acetaminophen/butalbital/caffeine/codeine
- acetaminophen/caffeine/dihydrocodeine
- acetaminophen/chlorpheniramine/codeine
- acetaminophen/codeine
- aspirin/butalbital/caffeine/codeine
- aspirin/caffeine/dihydrocodeine
- aspirin/carisoprodol/codeine
- aspirin/codeine
- brompheniramine/dihydrocodeine/pseudo-ephedrine
- chlorpheniramine/codeine
- codeine/guaifenesin
- codeine/guaifenesin/pseudoephedrine
- dihydrocodeine/guaifenesin
- dihydrocodeine/guaifenesin/phenylephrine
- dihydrocodeine/phenylephrine/pyrilamine

Appendix D -- COVID-19 Testing and Treatment

Your TUFTS HEALTH PLAN CERTIFICATE OF INSURANCE (COC) has been amended as described below with respect to coverage for Coronavirus (COVID-19) testing, treatment, and vaccinations. The following COVERED SERVICES are provided in accordance with federal and Massachusetts law.

COVID-19 Testing

MEDICALLY NECESSARY COVID-19 polymerase chain reaction (PCR) and antigen testing is covered for symptomatic individuals, individuals identified as close contacts by state or local health officials, and asymptomatic individuals under circumstances in accordance with federal and Massachusetts law. COVID-19 testing solely intended for return to work, school, or other locations is not MEDICALLY NECESSARY and accordingly not covered.

Antibody tests will be covered when MEDICALLY NECESSARY to support COVID-19 treatments, or for a MEMBER whose immune system is compromised and/or knowledge of COVID-19 antibodies may impact the future outcome of treatment. Antibody tests will not be covered when part of a "return to work" program or when not associated with treatment for COVID-19.

MEDICALLY NECESSARY COVID-19 testing will be covered with no out-of-pocket costs. This means that no COPAYMENT, COINSURANCE or DEDUCTIBLE will apply. COVID-19 testing does not require prior approval by an AUTHORIZED REVIEWER. Please contact Member Services for more information.

COVID-19 Treatment

MEDICALLY NECESSARY COVID-19-related treatment for all EMERGENCY INPATIENT, OUTPATIENT and cognitive rehabilitation services—including all professional, diagnostic, and laboratory services—will be covered with no out-of-pocket costs. This means that no COPAYMENT, COINSURANCE or DEDUCTIBLE will apply. Please note that MEMBER COST SHARING AMOUNTS may apply to COVERED SERVICES related to the treatment of reactions to COVID-19 vaccinations. MEMBERS are encouraged to see TUFTS HEALTH PLAN PROVIDER whenever possible. However, this policy is also applicable to treatment provided by NON-TUFTS HEALTH PLAN PROVIDERS. COVID-19-related treatment does not require prior approval by an AUTHORIZED REVIEWER. Please contact Member Services for more information.

COVID-19 Vaccinations

MEDICALLY NECESSARY COVID-19-vaccinations are covered with no out-of-pocket costs. This means that no COPAYMENT, COINSURANCE or DEDUCTIBLE will apply. COVID-19 vaccinations do not require prior approval by an AUTHORIZED REVIEWER. Please contact Member Services for more information.

For the most up-to-date information on policy changes, please visit the "COVID-19 Resource Center" on our website at **https://tuftshealthplan.com/covid-19/member/home**.

1. If you are covered under a Saver plan, your health insurance is designed to comply with the Internal Revenue Service requirements for a "High Deductible Health Plan." This means the DEDUCTIBLE may apply to certain services.

2. MEMBERS on an HMO plan (or Tufts Medicare Complement plan) must receive all other non-emergency services from a TUFTS HEALTH PLAN PROVIDER. MEMBERS on a POS or PPO plan are covered to receive services from both TUFTS HEALTH PLAN and NON-TUFTS HEALTH PLAN PROVIDERS. To find a PROVIDER, please visit our website at **www.tuftshealthplan.com**. Click on "Find a Doctor or Hospital" to start your search.