TUFTS Health Plan

Rhode Island Large Group

Preferred PROVIDER Organization

Advantage PPO

EVIDENCE OF COVERAGE

Underwritten by Tufts Insurance Company

SAMPLE

TUFTS HEALTH PLAN
1 Wellness Way
Canton, MA 02021

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TUFTS HEALTH PLAN Address and Telephone Directory

TUFTS HEALTH PLAN

1 Wellness Way

Canton, Massachusetts 02021

Member Services Hours:

Monday through Thursday 8:00 a.m.-7:00 p.m. E.T.

Friday 8:00 a.m-5:00 p.m. E.T.

IMPORTANT PHONE NUMBERS:

EMERGENCY Care

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

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

Liability Recovery

Call the Liability and Recovery Department at 1-888-880-8699, x.1098 for questions about coordination of benefits and workers' compensation. For example, call that department with questions about how TUFTS HEALTH PLAN coordinates coverage with other health care coverage you may have. The department is available from 8:00 a.m. – 5:00 p.m. Monday through Friday.

If you have questions about subrogation, call Member Services at 1-800-682-8059.

Member Services Department

Call the TUFTS HP Member Services Department at 1-800-682-8059 for general questions; benefit questions; and information regarding eligibility for enrollment and billing. For help finding a PRIMARY CARE PROVIDER (PCP) in Our network 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 Services

Call our Behavioral Health department at 1-800-208-9565 for information about COVERED SERVICES; and/or help finding a behavioral health or substance use PROVIDER.

Services for Hearing Impaired MEMBERS

You may be hearing impaired. If so, these services are provided:

Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call 711 or 1-800-868-5850. You will reach our Member Services Department.

Massachusetts Relay (MassRelay)

711 or 1-800-720-3480

Rhode Island Relay

711 or 1-800-745-5555

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IMPORTANT ADDRESSES:

Appeals and Grievances Department

You may need to call TUFTS HEALTH PLAN about a concern or appeal. If so, call our Member Services Department at 1-800-682-8059. To submit your appeal or grievance in writing, send your letter to:

TUFTS HEALTH PLAN
Attn: Appeals and Grievances Department
P.O. Box 9193
Watertown, MA 02471-9193

Or you may submit your appeal or grievance in-person at the address above; or by fax at 617-972-9509.

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Website

You may want more information about TUFTS HEALTH PLAN or to learn about the self-service options available to you. If so, see the TUFTS HEALTH PLAN website at **www.tuftshealthplan.com**.

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.**

Fraud, Waste and Abuse

You may have concerns 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 and abuse, or if you have questions, please call us at 1-800-682-8059, or email fraudandabuse@tufts-health.com. You can also call our confidential hotline anytime at 877-824-7123 or send an anonymous letter to us at:

TUFTS HEALTH PLAN
Attn: Fraud and Abuse
1 Wellness Way
Canton, MA 02021

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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 TUFTS HEALTH PLAN at 800.462.0224.

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

TUFTS HEALTH PLAN, Attention:

Civil Rights Coordinator Legal Dept.

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.

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Translating services for over 200 languages

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 ສຳລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo bą́ąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'é bee néé ho'dílzingo nantinigií 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.

1-800-682-8059

Telecommunications Device for the Deaf (TDD) 711 or Call 1-800-868-5850.

EVIDENCE OF COVERAGE

THIS BOOKLET IS YOUR EVIDENCE OF COVERAGE for health benefits underwritten by Tufts Insurance Company ("TIC"). TIC has entered into an agreement with Tufts Benefit Administrators ("TBA") for TBA to administer the health benefits and make available a network of PROVIDERS described in this EVIDENCE OF COVERAGE. Both TIC and Tufts Benefit Administrators ("TBA") do business under the name of TUFTS HEALTH PLAN.

This EVIDENCE OF COVERAGE describes the benefits, exclusions, conditions and limitations provided under the GROUP CONTRACT. It applies to persons covered under the GROUP CONTRACT. It replaces any EVIDENCE OF COVERAGE previously issued to you. Read this EVIDENCE OF COVERAGE for a complete description of benefits and an understanding of how the preferred PROVIDER plan works.

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.

NETWORK PROVIDERS are hospitals, community-based physicians and other community-based health care professionals. They work 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. They are not the employees or agents of TUFTS HEALTH PLAN for any purposes.

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 Note: IN-NETWORK LEVEL OF BENEFITS refers to COVERED SERVICES that are provided by a NETWORK PRIMARY CARE PROVIDER or other NETWORK PROVIDER. According to Rhode Island law §27-20-65, you are required to designate a PRIMARY CARE PROVIDER as your usual source of medical care; however, failure to designate a PRIMARY CARE PROVIDER will not result in cancellation of coverage.

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 you receive outside of the 50 United States qualify as COVERED SERVICES. In addition, URGENT CARE services you receive while traveling outside of the 50 United States also qualify as COVERED SERVICES. Any other service, supply, or medication you receive outside of the 50 United States is not covered under this plan.

For more information about these benefit levels and how to receive covered health care services, see Chapter 1. If you have any questions, call our TUFTS HEALTH PLAN Member Services.

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 you have questions, please call Member Services. We will be happy to help you. We are committed to excellent service. All calls are recorded for training and quality purposes.

PLEASE READ THIS EVIDENCE OF COVERAGE CAREFULLY.

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IMPORTANT TERMS AND DEFINITIONS

All defined terms are in italics and listed in Appendix A.

Below are terms to keep in mind as you read this Benefit Overview.

COINSURANCE is the percentage of costs you pay for certain COVERED SERVICES. See definition in Appendix A for details.

CONTRACT YEAR is the 12-month period determined by the GROUP. Under this plan, benefit limits, DEDUCTIBLEs, OUT-OF-POCKET MAXIMUMs, and COINSURANCE are calculated for a CONTRACT YEAR. A CONTRACT YEAR can be either a calendar year (January 1st through December 31st) or a plan year (a 12 consecutive month period). For example, a plan year might run from July 1st in one calendar year through June 30th in the following calendar year. For the CONTRACT YEAR dates that apply to your plan, call Member Services or contact your GROUP.

COPAYMENT is the fee you pay for COVERED SERVICES. COPAYMENTs are paid to the PROVIDER when you receive care unless the PROVIDER arranges otherwise.

COST SHARING AMOUNT is the cost you pay for certain COVERED SERVICES. This amount may consist of DEDUCTIBLEs, COPAYMENTs, and/or COINSURANCE.

DEDUCTIBLE is the amount you and the enrolled MEMBERS of your family (if applicable) must pay each year for certain COVERED SERVICES before payments are made under this EVIDENCE OF COVERAGE. See definition in Appendix A for details.

OUT-OF-POCKET MAXIMUM is the maximum amount a MEMBER pays during a CONTRACT YEAR for certain COVERED SERVICES. The OUT-OF-POCKET MAXIMUM consists of COST SHARING AMOUNTS. It does not include: (1) premiums you pay for this plan; (2) costs above the Reasonable Charge; or (3) costs for services that are not COVERED SERVICES under the GROUP Contract. If you meet the OUT-OF-POCKET MAXIMUM in a CONTRACT YEAR, then you no longer pay COST SHARING AMOUNTS in that CONTRACT YEAR subject to the terms of this EVIDENCE OF COVERAGE.

IN-NETWORK LEVEL OF BENEITS is the level of benefits that a MEMBER receives when COVERED SERVICES are provided by a NETWORK PROVIDER.

NETWORK PROVIDER (or In-Network) is a PROVIDER or hospital that has an agreement with TUFTS HEALTH PLAN (either directly or with a PROVIDER network with whom we have a contract) to provide COVERED SERVICES to MEMBERS.

NON-NETWORK PROVIDER (OUT-OF-NETWORK) is a PROVIDER who does not have an agreement with TUFTS HEALTH PLAN (either directly or with a PROVIDER network with whom we have a contract) to provide COVERED SERVICES.

OUT-OF-NETWORK LEVEL OF BENEITS is the level of benefits that a MEMBER receives when COVERED SERVICES are provided by NON-NETWORK PROVIDERS.

BENEFIT OVERVIEW

This "Benefit Overview" section describes your COST SHARING AMOUNTS, DEDUCTIBLE and OUT-OF POCKET MAXIMUM under this plan. Please see Chapter 3, COVERED SERVICES for more details about your benefits:

- Important Terms and Definitions
- COST SHARING Highlights
    - Important information about your COST SHARING AMOUNTS
- Your DEDUCTIBLE
    - Important Information about Your DEDUCTIBLE
- Your OUT-OF-POCKET MAXIMUM
    - Important information about your OUT-OF-POCKET MAXIMUM
- Table of benefits, cost sharing and certain benefit limits

See Chapter 3, COVERED SERVICES, for details about benefits under this plan.

If you have questions, please visit our website at **www.tuftshealthplan.com**. Or call our Member Services department at 1-888-682-8059.

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COST SHARING HIGHLIGHTS

Not all COST SHARING AMOUNTS under this plan are listed in the table below.

See the table of benefits and cost sharing later in this "Benefit Overview"

IN-NETWORK LEVEL OF BENEFITS - COVERED SERVICES received from NETWORK PROVIDERS	
EMERGENCY room	$150.00 per visit
URGENT CARE visit	Cost sharing varies depending upon type of PROVIDER and PROVIDER location. See "Important Information About Your COST SHARING AMOUNTS" below.
Office Visit - Network PCP	$20.00 COPAYMENT per visit
Office Visit - Any other NETWORK PROVIDER (specialist)	$30.00 COPAYMENT per visit
NETWORK HOSPITAL INPATIENT admission Physician surgical and medical services	IN-NETWORK DEDUCTIBLE then Covered in full Physician fees: IN-NETWORK DEDUCTIBLE then Covered in full
DAY SURGERY admission Physician surgical and medical services	IN-NETWORK DEDUCTIBLE then Covered in full Physician fees: IN-NETWORK DEDUCTIBLE then Covered in full
OUT-OF NETWORK LEVEL OF BENEFITS – COVERED SERVICES received from NON-NETWORK PROVIDERS	
Unless otherwise stated later in this "Benefit Overview," you pay the OUT-OF-NETWORK DEDUCTIBLE and then 20% COINSURANCE for COVERED SERVICES received from NON-NETWORK PROVIDERS.	

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Important Information About Your COST SHARING AMOUNTS
In accordance with the Affordable Care Act (ACA), preventive care services covered in full. -- Services include but are not limited to: (i) women's preventive health care services, (ii) certain prescription medications, and certain over-the-counter medications when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription. 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**. Call Member Services with questions about whether specific services are considered preventive under the ACA. Diagnostic OUTPATIENT services provided 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" later in this "Benefit Overview." You may be charged an office visit COST SHARING AMOUNT for certain diagnostic OUTPATIENT services provided in conjunction with an office visit. COST SHARING AMOUNTS for URGENT CARE service vary depending on (i) type of PROVIDER (PCP vs. Specialist); where services are provided, and (ii) any additional diagnostic OUTPATIENT services provided during the visit; such services, including but not limited to laboratory tests, x-rays, or DURABLE MEDICAL EQUIPMENT, may be subject to separate COST SHARING AMOUNTS. See specific benefits later in this "Benefit Overview" for cost sharing. For more information, call Member Services. When certain OUTPATIENT services are provided in a hospital setting or a FREE-STANDING facility, you may be billed separately for facility services and physician services for a single episode of care. Any COST SHARING AMOUNT in the form of a DEDUCTIBLE or COINSURANCE will apply to both facility and physician services. When the COST SHARING AMOUNT is in the form of a COPAYMENT, a single COPAYMENT will apply unless otherwise stated in the "Benefit Overview." A telemedicine services visit with a TUFTS HEALTH PLAN PROVIDER will apply the same COST SHARING AMOUNT that applies to an in-person office visit with that TUFTS HEALTH PLAN PROVIDER.

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YOUR DEDUCTIBLE

IN-NETWORK LEVEL OF BENEFITS

Individual DEDUCTIBLE (SUBSCRIBER only covered – no DEPENDENTS)	$6,000.00 each CONTRACT YEAR
Family DEDUCTIBLE	$6,000.00 per MEMBER and $12,000.00 per family each CONTRACT YEAR

OUT-OF-NETWORK LEVEL OF BENEFITS

Individual DEDUCTIBLE (SUBSCRIBER only covered – no DEPENDENTS)	$6,000.00 each CONTRACT YEAR
Family DEDUCTIBLE	$6,000.00 per MEMBER and $12,000.00 per family each CONTRACT YEAR

IMPORTANT INFORMATION ABOUT YOUR DEDUCTIBLE

Your DEDUCTIBLE applies to all COVERED SERVICES except as listed in the cost sharing table later in this "Benefit Overview."

This plan has separate In-Network and Out-of-Network DEDUCTIBLES. You must satisfy each of these DEDUCTIBLES separately.

The Family DEDUCTIBLE is satisfied with any combination of DEDUCTIBLE payments for COVERED SERVICES for any MEMBERs in a FAMILY PLAN. If any MEMBER in a FAMILY PLAN satisfies the per MEMBER 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: No MEMBER of a FAMILY PLAN will pay more in a CONTRACT YEAR towards the Family DEDUCTIBLE than the yearly amount set by the federal government as the OUT-OF-POCKET MAXIMUM amount for one person.

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.

Note: Any DEDUCTIBLE 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.

Any DEDUCTIBLE amount carried forward will be applied to the next CALENDAR YEAR OUT-OF POCKET MAXIMUM.

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YOUR OUT-OF-POCKET MAXIMUM

IN-NETWORK LEVEL OF BENEFITS

Individual OUT-OF-POCKET MAXIMUM (SUBSCRIBER only covered – no DEPENDENTS)	$7,900.00 each CONTRACT YEAR
Family OUT-OF-POCKET MAXIMUM	$7,900.00 per MEMBER and $15,800.00 per family each CONTRACT YEAR

OUT-OF-NETWORK LEVEL OF BENEFITS

Individual OUT-OF-POCKET MAXIMUM (SUBSCRIBER only covered – no DEPENDENTS)	$7,900.00 each CONTRACT YEAR
Family OUT-OF-POCKET MAXIMUM	$7,900.00 per MEMBER and $15,800.00 per family each CONTRACT YEAR

IMPORTANT INFORMATION ABOUT YOUR OUT-OF POCKET MAXIMUM

Any DEDUCTIBLE, COPAYMENT or COINSURANCE amount you pay for COVERED SERVICES under this plan counts toward your OUT-OF POCKET MAXIMUM. Once you satisfy your OUT-OF POCKET MAXIMUM, you no longer pay DEDUCTIBLES, COPAYMENTS or COINSURANCE.

This plan has a separate Prescription Drug Benefit OUT-OF-POCKET MAXIMUM. See the Prescription Drug Benefit section for more information

In-Network and Out-of-Network Out-of-Pocket Maximums are separate under this plan. You must satisfy each of these Out-of-Pocket Maximums separately.

Any combination of MEMBERs in a FAMILY PLAN can pay towards 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 MEMBERs in a FAMILY PLAN subject to the terms of this EVIDENCE OF COVERAGE. If any MEMBER in a FAMILY PLAN meets the per MEMBER 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 EVIDENCE OF COVERAGE.

Note: OUT-OF POCKET MAXIMUMs are set every year by the federal government. This plan's OUT-OF POCKET MAXIMUM amount(s) do not exceed federal maximums.

The following amounts do not count towards your OUT-OF POCKET MAXIMUMs:

- 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.

Note: Any DEDUCTIBLE 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.

Any DEDUCTIBLE amount carried forward will be applied to the next CALENDAR YEAR OUT-OF POCKET MAXIMUM.

SAMPLE

SAMPLE

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
EMERGENCY Care		
EMERGENCY room	$150.00 COPAYMENT. (not subject to DEDUCTIBLE)	$150.00 COPAYMENT. (not subject to DEDUCTIBLE)
	Note: INPATIENT or DAY SURGERY COST SHARING AMOUNTS will apply if you are admitted as an INPATIENT or for DAY SURGERY. If you are admitted, your EMERGENCY room COPAYMENT will be waived; please call Member Services to request this COPAYMENT waiver. Observation services will take an EMERGENCY room COST SHARING AMOUNT.	
Please contact TUFTS HEALTH PLAN within 48 hours after you recieve EMERGENCY care. If you are admitted as an INPATIENT after receiving EMERGENCY care, you or someone acting for you should call us within 48 hours. A family MEMBER or the attending PROVIDER can call for you. Coverage is the same for EMERGENCY COVERED SERVICES whether provided by a NETWORK PROVIDER or a NON-NETWORK PROVIDER.		
Acupuncture services	$30.00 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Allergy Injections	IN-NETWORK DEDUCTIBLE then Covered in full per injection.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Allergy testing and treatment	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Ambulance services **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full per visit.	EMERGENCY ambulance services - Same as IN-NETWORK LEVEL OF BENEFITS. OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Ground, sea, and air ambulance transportation for EMERGENCY care are COVERED SERVICES at the IN-NETWORK LEVEL OF BENEFITS. Prior approval is not required. Non-EMERGENCY ambulance transportation is covered only when an AUTHORIZED REVIEWER determines in advance that such services are MEDICAL NECESSARY.		

(PA) - Prior approval by an AUTHORIZED REVIEWER is required for this service or certain services in this benefit category at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see Chapter 1 for Important Information about prior approval and INPATIENT Notification by an AUTHORIZED REVIEWER.

*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

SAMPLE

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	**IN-NETWORK LEVEL OF BENEFITS**	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Autism spectrum disorders - diagnosis and treatment Applied behavioral analysis (ABA) services **(AR)**		OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
When provided by a PARAPROFESSIONAL:	$20.00 COPAYMENT	
When provided by a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA)	$20.00 COPAYMENT	
Speech-language, physical and occupational therapies provided by licensed therapists **(AR)**	$30.00 COPAYMENT	

SAMPLE

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Behavioral Health and Substance Use Disorders	**To contact the TUFTS HEALTH PLAN Behavioral Health Department, call 1-800-208-9565.**	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
OUTPATIENT individual and GROUP therapy services	$20.00 COPAYMENT per visit. (not subject to DEDUCTIBLE)	
Intermediate care **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full.	
INPATIENT services	IN-NETWORK DEDUCTIBLE then Covered in full	
MEDICALLY NECESSARY services in a residential treatment facility	IN-NETWORK DEDUCTIBLE then Covered in full.	
COMMUNITY RESIDENTIAL care **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full.	
Medication assisted treatment, including methadone maintenance, when provided by a NETWORK medication assisted treatment clinic	Covered in full	
Note: Certain services in this benefit category require approval by an AUTHORIZED REVIEWER. See “Behavioral Health and Substance Use Disorders” in Chapter 1 and Chapter 3 for additional information. Psychological services and neuropsychological assessment services are covered as “Office visits to diagnose and treat illness or injury.” Prior approval is required by an AUTHORIZED REVIEWER. EMERGENCY care: We recommend that you call TUFTS HEALTH PLAN within 48 hours after you receive EMERGENCY care. If you are admitted as an INPATIENT after receiving EMERGENCY care, you or someone acting for you should call us within 48 hours. A family MEMBER or the attending PROVIDER can call for you. Coverage is the same for EMERGENCY COVERED SERVICES whether provided by a NETWORK PROVIDER or a NON-NETWORK PROVIDER.		
Cardiac rehabilitation	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Coverage is limited to 36 visits per CALENDAR YEAR. (IN-NETWORK and OUT-OF-NETWORK LEVELS of BENEFITS combined).		

Chemotherapy administration	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

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*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

SAMPLE

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
For costs of the medications used in chemotherapy see “Injectable, infused, or inhaled medications” later in this Benefit Overview.		
Diagnostic laboratory tests and x-rays provided during a chiropractic visit are covered as described under “Laboratory tests” and “Diagnostic imaging.”		
Clinical trials – Patient care services provided on an INPATIENT or OUTPATIENT basis as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions.	See applicable COVERED SERVICES	See applicable COVERED SERVICES
Colonoscopies	See Diagnostic or preventive screening procedures	See Diagnostic or preventive screening procedures
DAY SURGERY **(AR)**	DAY SURGERY admission *	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Diabetes self-management education services and supplies	See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.**	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Diabetic test strips: See the Prescription Drug Benefit. later in this Benefit Overview Diabetes supplies covered as Durable Medical Equipment (DME): See the DME benefit later in this Benefit Overview.		
Diagnostic Imaging General imaging (such as x-rays and ultrasounds)	Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
MRI/MRA, CT/CTA, PET and nuclear cardiology **(AR)***	IN-NETWORK DEDUCTIBLE then Covered in full.	

SAMPLE

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*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Diagnostic or preventive screening procedures (for example, colonoscopy, sigmoidoscopy and proctosigmoidoscopy) Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Diagnostic **procedure only** (for example colonoscopy associated with symptoms) **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Diagnostic procedures **accompanied by treatment/ surgery** (for example polyp removal **(AR)**	See DAY SURGERY admission*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
In accordance with Rhode Island law, certain procedures may be covered in full when performed by a NETWORK PROVIDER to diagnose colorectal cancer; for example, a follow-up colonoscopy if results of an initial colorectal cancer screening are abnormal. Call Member Services for details.		
Diagnostic testing **(AR)**	Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
DURABLE MEDICAL EQUIPMENT **(AR)**	MEMBER pays 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)**	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

The maximum benefit payable in each CONTRACT YEAR is 100 days. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

(PA) - Prior approval by an AUTHORIZED REVIEWER is required for this service or certain services in this benefit category at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see Chapter 1 for Important Information about prior approval and INPATIENT Notification by an AUTHORIZED REVIEWER.

*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

SAMPLE

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Family planning (procedures, services and contraceptives) Office visits DAY SURGERY	See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.** DAY SURGERY admission*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
At the In-Network Level of Benefits, women's preventive health services are covered in full in accordance with the ACA, including contraceptives and female sterilization procedures.		
Hearing Aids **(AR)**	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Coverage is limited to: ● one hearing aid per ear every three (3) years for MEMBERS up to age 19. Coverage is provided up to $1,500 for each individual hearing aid; ● one hearing aid per ear every three (3) years for MEMBERS age 19 and older. Coverage is provided up to $700 for each individual hearing aid. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined)		
Hemodialysis	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Home health care **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Hospice care **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Hospital INPATIENT services (acute care)	Hospital INPATIENT admission*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Note: Certain services in this benefit category require approval by an AUTHORIZED REVIEWER. See more information about INPATIENT hospital services in Chapter 1 and Chapter 3. Also, see "Surgery" later in this section. EMERGENCY care: We recommend that you call TUFTS HEALTH PLAN within 48 hours after you receive EMERGENCY Care. If you are admitted as an INPATIENT after receiving EMERGENCY care, you or someone acting for you should call us within 48 hours. A family MEMBER or the attending PROVIDER can call for you. Coverage is the same for EMERGENCY COVERED SERVICES whether provided by a NETWORK PROVIDER or a NON-NETWORK PROVIDER.		
House calls to diagnose and treat illness or injury	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Human leukocyte antigen testing or histocompatibility locus antigen testing **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

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*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
HLA testing is limited to one testing per lifetime. (In-Network and OUT-OF-NETWORK Levels of Benefits combined).		
Immunizations	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Preventive immunizations, including those for travel, that are recommended by the Center for Disease Control (CDC) are listed on their website at: https://www.cdc.gov/vaccines/schedules/		
Infertility services **(AR)**	20% COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then 20% COINSURANCE
Coverage is limited to $100,000 per MEMBER per lifetime. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined). Note: This limit applies to infertility services covered under the “OUTPATIENT Care” benefit oral and injectable drug therapies used in the treatment of infertility and covered under the “Prescription Drug Benefit”, if applicable.		
Injectable, infused, or inhaled medications **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Laboratory tests **(AR)**	Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
At the In-Network Level of Benefits , laboratory tests performed as part of routine preventive care are covered in full in accordance with the ACA.		
Lead screenings	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Lyme disease - MEDICALLY NECESSARY diagnosis and treatment of chronic Lyme disease	See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.**	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Mammograms Routine mammograms Diagnostic mammograms	 Covered in full Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Mastectomy care INPATIENT services OUTPATIENT services	 Covered in full. Covered in full.	OUT-OF- NETWORK DEDUCTIBLE then COINSURANCE
In accordance with Rhode Island law, Mastectomy care COVERED SERVICES are provided for mastectomy surgery (Prior approval by an AUTHORIZED REVIEWER is required); and breast reconstruction surgery, breast prostheses, and treatment of physical complications for all stages of mastectomy.		

SAMPLE

(PA) - Prior approval by an AUTHORIZED REVIEWER is required for this service or certain services in this benefit category at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see Chapter 1 for Important Information about prior approval and INPATIENT Notification by an AUTHORIZED REVIEWER.

*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Maternity care INPATIENT services OUTPATIENT services Routine maternity care, including pre-natal & post-natal visits Non-routine maternity care: PCP or Ob/GYN Any other PROVIDER All other services	Hospital INPATIENT admission* Covered in full See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.** See applicable COVERED SERVICES	OUT-OF- NETWORK DEDUCTIBLE then COINSURANCE
At the In-Network Level of Benefits, routine laboratory tests associated with maternity care are covered in full, in accordance with the ACA. Member cost sharing will apply to diagnostic tests and diagnostic laboratory tests when ordered during a routine maternity care visit.		
Medical Supplies **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Nutritional counseling Preventive services All other nutritional counseling services	Covered in full. See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.**	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
At the In-Network Level of Benefits, certain nutritional counseling services are covered in full in accordance with ACA preventive services requirements, including obesity counseling and healthy diet counseling for adults with hyperlipidemia and other risk factors for cardiovascular disease and diet-related chronic disease.		
Office visits to diagnose and treat illness and injury	See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.**	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

SAMPLE

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*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Oral health services **(AR)** EMERGENCY services:	EMERGENCY room*	Same as In-Network Level of Benefits
INPATIENT services:	Hospital INPATIENT admission*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
DAY SURGERY: Services in PROVIDER's office:	DAY SURGERY* admission See "Surgery in a PROVIDER's office" under "Surgery"	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Orthoses and prosthetic devices **(AR)** Breast prostheses following mastectomy	MEMBER pays 20% COINSURANCE Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Pap tests (cervical cancer screening) Routine screening Diagnostic cytology testing	Covered in full Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Preventive health care in accordance with the ACA and Rhode Island law (including hearing screening) for MEMBERs through age 19)	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
for MEMBERS age 20 and over	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Visit Our website at **https://tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for a list of preventive services. Also see **Important Information About Your COST SHARING AMOUNTs** at the front of this Benefit Overview and Chapter 3, COVERED SERVICES. Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam or a routine annual gynecological exam is subject to a COST SHARING AMOUNT.		

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*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	**IN-NETWORK LEVEL OF BENEFITS**	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Prostate and colorectal exam:		OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Routine screening exam	Covered in full	
Diagnostic prostate & colorectal exams	Covered in full	
Radiation therapy **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Respiratory therapy and pulmonary rehabilitation services	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Scalp hair prostheses or wigs for cancer or leukemia patients	IN-NETWORK DEDUCTIBLE then Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Covered up to a maximum benefit of $350 per CALENDAR YEAR. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).		
Smoking cessation counseling services	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Special Medical Formulas		
Low protein foods	Covered in full per 30-day supply	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE per 30-day supply
Nonprescription enteral formulas (**AR**)	Covered in full per 30-day supply	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE per 30-day supply
Speech, Physical and Occupational therapy services **(AR)** (including rehabilitation and HABILITATION Services)	$30.00 COPAYMENT per visit.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
The maximum benefit payable per CALENDAR YEAR is 30 visits for occupational rehabilitation therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined). The maximum benefit payable per CALENDAR YEAR is 30 visits for occupational habilitation therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).		

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

SAMPLE

(PA) - Prior approval by an AUTHORIZED REVIEWER is required for this service or certain services in this benefit category at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see Chapter 1 for Important Information about prior approval and INPATIENT Notification by an AUTHORIZED REVIEWER.

*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
The maximum benefit payable per CALENDAR YEAR is 30 visits for speech rehabilitation therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined). The maximum benefit payable per CALENDAR YEAR is 30 visits for speech habilitation therapy services (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).		
Spinal manipulation	$30.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Surgery - Hematopoietic stem cell transplants, and human solid organ transplants **(AR)**	Hospital INPATIENT admission*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Surgery - Reconstructive surgery and procedures,surgical treatment of functional deformity or impairment **(AR)**	Hospital INPATIENT admission*	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Surgery - Surgery in a PROVIDER's office **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Surgery - Gender reassignment surgery **(AR)**	Hospital INPATIENT admission*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
DAY SURGERY: See DAY SURGERY admission* for surgery provided on an OUTPATIENT basis. OUTPATIENT care related to gender reassignment surgery (including pre-operative and post-operative OUTPATIENT care): Covered as described under "Office visits to diagnose and treat illness or injury". Behavioral health care services related to gender reassignment surgery (pre-operative and post-operative): Covered as described under "Behavioral health care". Prescription medications: Covered as described under "Prescription Drug Benefit". **Note:** Gender reassignment surgery and related services only qualify as COVERED SERVICES when authorized in advance by an AUTHORIZED REVIEWER; and obtained within the 50 United States from: (i) a NETWORK PROVIDER; or (ii) a NON-NETWORK PROVIDER in the event services are not available in the NETWORK CONTRACTING AREA or from any NETWORK PROVIDER.		

SAMPLE

(PA) - Prior approval by an AUTHORIZED REVIEWER is required for this service or certain services in this benefit category at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see Chapter 1 for Important Information about prior approval and INPATIENT Notification by an AUTHORIZED REVIEWER.

*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	**IN-NETWORK LEVEL OF BENEFITS**	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Telemedicine services when obtained through TUFTS HEALTH PLAN's designated telemedicine vendor.(also called "telehealth")		
General Medicine Services and Behavioral Health Services	Covered in full	See note.
Dermatology services	Covered in full	
Telemedicine services when provided by a PROVIDER	Office visit - PCP* Office visit - Any other NETWORK PROVIDER*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Remote patient monitoring	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Remote medical date transfer/ evaluation	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
The same COST SHARING AMOUNT applies to a telemedicine visit with a NETWORK or NON-NETWORK PROVIDER as an in-person office visit with that PROVIDER.		

SAMPLE

(PA) - Prior approval by an AUTHORIZED REVIEWER is required for this service or certain services in this benefit category at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see Chapter 1 for Important Information about prior approval and INPATIENT Notification by an AUTHORIZED REVIEWER.
*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

Benefit Overview, continued

The following cost sharing table provides basic information about your benefits under this plan. Please see Chapter 3 for details about COVERED SERVICES.

YOUR COST

COVERED SERVICE	**IN-NETWORK LEVEL OF BENEFITS**	**OUT-OF-NETWORK LEVEL OF BENEFITS**
URGENT CARE		OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
In a PROVIDER's office	See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.**	
In a LIMITED SERVICES MEDICAL CLINIC	Office visit - PCP*	
In a hospital walk-in clinic	See Office Visit NETWORK PCP.** See Office Visit NETWORK PROVIDER.**	
In a FREE-STANDING URGENT CARE Center	$30.00 COPAYMENT	
Note: See **Follow these guidelines for receiving Urgent Care** in Chapter 1 under "Emergency and Urgent Care." Diagnostic Outpatient services provided during an Urgent Care visit may be subject to Cost Sharing Amounts. Such services may include but are not limited to laboratory tests, x-rays, or Durable Medical Equipment. See those benefits for cost sharing. For questions, call Member Services.		
Vision care services		
Routine eye examination	$20.00 COPAYMENT	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Other vision care services **(AR)** One pair of eyeglass lenses and frames following cataract surgery or other surgery to replace the natural lens of the eye when the MEMBER does not receive an intraocular implant. See Chapter 3 for more information.	Care from an optometrist $20.00 COPAYMENT	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
	Care from an ophthalmologist Office visit - Any other NETWORK PROVIDER*	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Coverage is provided for one routine eye examination for MEMBERS every 01 year (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).		

SAMPLE

(PA) - Prior approval by an AUTHORIZED REVIEWER is required for this service or certain services in this benefit category at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see Chapter 1 for Important Information about prior approval and INPATIENT Notification by an AUTHORIZED REVIEWER.

*See **COST SHARING HIGHLIGHTS** at the beginning of this "Benefit Overview."

SAMPLE

PRESCRIPTION DRUG COVERAGE TABLE

DRUGS OBTAINED AT A RETAIL PHARMACY

(See Infertility Drugs and Oral Chemotherapy Drugs below for exceptions)

Covered prescription drugs including both acute and maintenance drugs when you obtain them directly from a TUFTS HEALTH PLAN designated retail pharmacy.

TIER-1 drugs:	$20.00 COPAYMENT for up to a 30-day supply. $40.00 COPAYMENT for a 31-60-day supply. $60.00 COPAYMENT for a 61-90-day supply.
TIER-2 drugs:	$40.00 COPAYMENT for up to a 30-day supply. $80.00 COPAYMENT for a 31-60-day supply. $120.00 COPAYMENT for a 61-90-day supply.
TIER-3 drugs:	$70.00 COPAYMENT for up to a 30-day supply. $140.00 COPAYMENT for a 31-60-day supply. $210.00 COPAYMENT for a 61-90-day supply.
● Coverage When Drugs Are Not Obtained Through a TUFTS HEALTH PLAN Designated RetailPharmacy: You may choose to obtain a covered prescription drug at a retail pharmacy that is not a TUFTS HEALTH PLAN designated pharmacy. If so, you will need to pay for the prescription up front and submit a claim for reimbursement. Prescription drug claim forms can be obtained by contacting a MEMBER Specialist. You can also get one at our website at **www.tuftshealthplan.com**.	
INFERTILITY DRUGS	20% COINSURANCE* for up to a 30-day supply.
***Note:** COINSURANCE is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your GROUP's PREMIUM. Coverage for infertility is limited to $100,000 per MEMBER per lifetime. This limit applies to both: (1) infertility services covered under the "OUTPATIENT Care" benefit earlier in this chapter; and (2) oral and injectable drug therapies used to treat infertility and covered under this "Prescription Drug Benefit."	

ORAL CHEMOTHERAPY DRUGS	Covered in full for up to a 30-day supply

Notes:

You may fill your prescription in a state that allows you to request a brand drug even though your physician authorized a generic equivalent. In this case, you will also pay the applicable Tier COST SHARING AMOUNT. You will pay the difference in cost between the brand-name drug and the generic drug. If the cost of a drug is less than the minimum COST SHARING AMOUNT, you pay only for the cost of the drug.

SAMPLE

***NOTE:** Certain drugs on our formulary are designated as part of our low cost drug program. Your retail pharmacy COPAYMENT for these low cost drugs is $5 for up to a 30-day supply and $10 for a 31-90-day supply. Check the plan formulary on our website at:

http://formularysearch.caremark.com/FormularySearch/servlet/FdmsFormularyServlet?com=tufts&menu=1&formulary=6

Or you may call Member Services

DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a TUFTS HEALTH PLAN designated mail services pharmacy.	
TIER-1 drugs:	$20.00 COPAYMENT for up to a 90 day supply.
TIER-2 drugs:	$40.00 COPAYMENT for up to a 90 day supply.
TIER-3 drugs:	$70.00 COPAYMENT for up to a 90 day supply.

SAMPLE

SAMPLE

MENTAL HEALTH PARITY STATEMENT

This plan provides parity in the benefits for mental/behavioral health and substance use disorder services. This means that coverage of benefits for mental/behavioral health and substance use disorders is generally comparable to, and not more restrictive than, the benefits for coverage of physical health.

For example:

- COST SHARING AMOUNTS such as DEDUCTIBLES, COPAYMENTS, COINSURANCE, or OUT-OF-POCKET MAXIMUMS, are not more restrictive for mental/behavioral health and substance use disorder services than they are for medical/surgical services.
- Limitations on the use of services, such as limits on the number of INPATIENT days or OUTPATIENT visits that are covered, are not more restrictive for mental/behavioral health and substance use disorder services than they are for medical/surgical services.
- Other kinds of treatment limitations, such as requirements for MEDICAL NECESSITY determinations, PRIOR AUTHORIZATIONS, or INPATIENT NOTIFICATIONS are applied in comparable ways to both mental health and substance use disorder services and medical/surgical services.

SAMPLE

Chapter 1--How Your Preferred PROVIDER Plan Works

Eligibility for Benefits

You can obtain health care 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.
- You may be a MEMBER living outside of Rhode Island. If so, your coverage may also include benefits required by the laws of your state. For more information, call a MEMBER Specialist.

Changes to PROVIDER NETWORK

TUFTS HEALTH PLAN offer MEMBERS access to an extensive network of physicians, hospitals, and other PROVIDERS. They are located throughout the NETWORK CONTRACTING AREA. NETWORK PROVIDERS may change during the year. This can happen for many reasons. For example, a PROVIDER may retire; move out of the NETWORK CONTRACTING AREA; or fail to continue meeting credentialing standards. Also, PROVIDERS are independent contractors. They may leave the network if they do not reach agreement on a network contract.

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

IN-NETWORK LEVEL OF BENEFITS

You may choose to receive care from a NETWORK PROVIDER. If so, you are covered at the IN-NETWORK LEVEL OF BENEFITS for COVERED SERVICES. This includes behavioral health and substance use disorder services; and services at a participating LIMITED SERVICES MEDICAL CLINIC or FREE-STANDING URGENT CARE CENTER.

- NETWORK PROVIDERS are listed in the DIRECTORY OF HEALTH CARE PROVIDERS. Or visit our web site tuftshealthplan.com and use the **Find a Doctor, Hospital** search function. You may also call Member Services at 1-800-682-8059 or our Behavioral Health Department at 1-800-208-9565.
- When a NETWORK PROVIDER provides your care, you do not have to submit any claim forms. The NETWORK PROVIDER will submit the claim forms to us for you.

Selecting a PROVIDER

You can find NETWORK PROVIDERS through our searchable directory on our website at www.tuftshealthplan.com.

Note: Under certain circumstances required by law, if your PROVIDER is not in the TUFTS HEALTH PLAN network, you will be covered for a short period of time for services provided by your PROVIDER. See "Continuity of Care" later in this chapter.

No INPATIENT NOTIFICATION by You

When your INPATIENT hospitalization is provided by a NETWORK PROVIDER, you do not have to notify TUFTS HEALTH PLAN about the INPATIENT hospitalization or transfer. Your NETWORK PROVIDER will notify TUFTS HEALTH PLAN for you. See INPATIENT NOTIFICATION later in this chapter.

SAMPLE

Canceling Appointments

You may have to cancel an appointment with a NETWORK PROVIDER. Be sure to give at least 24 hours' notice. If you do not, and the NETWORK PROVIDERS bills you, you will have to pay the charges. We will not pay for missed appointments that you did not cancel in advance.

OUT-OF-NETWORK LEVEL OF BENEFITS

You may choose to receive COVERED SERVICES from a NON-NETWORK PROVIDER. This includes behavioral health and substance use disorder COVERED SERVICES. You will be covered at the OUT-OF-NETWORK LEVEL OF BENEFITS listed in the "Benefit Overview." TUFTS HEALTH PLAN will pay up to the REASONABLE CHARGE for COVERED SERVICES you receive from a NON-NETWORK PROVIDER.

When a NON-NETWORK PROVIDER provides your care, you must submit a claim form to TUFTS HEALTH PLAN. For more information, see Chapter 6, How to File A Claim and MEMBER Satisfaction.

If COVERED SERVICES are Not Available from a NETWORK PROVIDER

If a COVERED SERVICE is not available from a NETWORK PROVIDER you must obtain our approval to go to a NON-NETWORK PROVIDER. In this case, you will receive the COVERED SERVICE at the IN-NETWORK LEVEL OF BENEFITS up to the REASONABLE CHARGE.

If You Receive COVERED SERVICES Outside of the 50 United States

EMERGENCY CARE SERVICES you receive outside of the 50 United States are COVERED SERVICES. URGENT CARE services you receive while traveling outside of the 50 United States also qualify as COVERED SERVICES. However, any other service, supply, or medication you receive outside of the 50 United States is not covered under this plan.

Continuity of Care

If your PROVIDER'S contract with CARELINK terminates for reasons other than quality or fraud, you may continue to receive care from that PROVIDER for the following continuing care conditions for up to 90 days from the date we notify you of your PROVIDER'S termination:

- You are in treatment for a Serious or Complex Condition.
- You are pregnant.
- You are undergoing a course of institutional or INPATIENT care.
- You are scheduled to undergo nonelective surgery; this includes postoperative care.
- You are terminally ill (having a life expectancy of 6 months or less).

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.

Prior Approval by AUTHORIZED REVIEWER and INPATIENT NOTIFICATION

Prior approval by an AUTHORIZED REVIEWER is required for certain COVERED SERVICES. This is an approval request usually sent to us by a NETWORK PROVIDER. It asks us to determine in advance if certain services are COVERED SERVICES under your benefit plan. We require prior approval by an AUTHORIZED REVIEWER for services identified by **(AR)** in the "Benefit Overview." **Note**: EMERGENCY CARE does not require prior approval by an AUTHORIZED REVIEWER.

When you receive services from NETWORK PROVIDER:

They are responsible for obtaining prior approval on your behalf.

When you receive services from NON-NETWORK PROVIDER:

SAMPLE

You are responsible for making sure prior approval is obtained by your PROVIDER when **AR** is required. If you receive services that we (or our or delegate) determine are not COVERED SERVICES, you will be responsible for the full cost of these services.

SAMPLE

INPATIENT NOTIFICATION

INPATIENT Notification is a process that informs TUFTS HEALTH PLAN or its delegate of an INPATIENT admission or transfer to another hospital. TUFTS HEALTH PLAN or its delegate (1) will evaluate the anticipated hospital stay; (2) may review your proposed medical care and/or verify MEDICAL NECESSITY; and (3) may assess the need for a care management program after discharge or recommend an alternative treatment setting.

When you receive services from a NETWORK HOSPITAL:

Your NETWORK PROVIDER is responsible for notifying TUFTS HEALTH PLAN or its delegate on your behalf.

When you receive services from a NON-NETWORK HOSPITAL:

You are responsible for making sure that TUFTS HEALTH PLAN or its delegate is notified by your PROVIDER when you have an INPATIENT admission or transfer. If you receive services that we (or our delegate) determine are not COVERED SERVICES, you will be responsible for the full cost of these services.

INPATIENT NOTIFICATION to TUFTS HEALTH PLAN does not guarantee payment to the PROVIDER. We are not obligated to pay claims: (1) for persons who are not eligible for coverage; (2) for persons who receive care that is determined not to be MEDICALLY NECESSARY; or (3) if the claim is not for a COVERED SERVICE.

More Information

If a request for coverage is denied, you have a right to appeal. Please see Chapter 6, MEMBER Satisfaction, for information about how to file an appeal.

For questions, contact Member Services at 1-800-682-8059. Or for behavioral health and substance use disorder services, call the TUFTS HEALTH PLAN Behavioral Health Department at 1-800-208-9565.

EMERGENCY and URGENT CARE

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

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

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

SAMPLE

EMERGENCY and URGENT CARE, continued

Follow these guidelines for receiving EMERENCY care

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

Go to the nearest emergency medical facility.

If you receive EMERGENCY care as an OUTPATIENT:

- At a NETWORK HOSPITAL, you will be covered at the IN-NETWORK LEVEL OF BENEFITS. You will pay a COST SHARING AMOUNT for each EMERGENCY room visit.
- At a NON-NETWORK HOSPITAL, We will pay up to the REASONABLE CHARGE for COVERED SSERVICES you receive. You only pay the applicable COST SHARING AMOUNT. You also pay any amount in excess of the REASONABLE CHARGE.

If you are admitted as an INPATIENT after receiving EMERGENCY care:

- A NETWORK HOSPITAL will notify Us of your admission. You will be covered at the IN-NETWORK LEVEL OF BENEFITS. You will pay the applicable COST SHARING AMOUNTS for the INPATIENT stay.
- If you are admitted to a NON-NETWORK HOSPITAL:
  - notify Us within 48 hours. The attending PROVIDER or a family member can do this for you.
  - you will be covered at the IN-NETWORK LEVEL OF BENEFITS.
  - We will pay up to the REASONABLE CHARGE.
  - you will pay the HOSPITAL INPATIENT COST SHARING AMOUNTS.
  - you will be covered at the OUT-OF-NETWORK LEVEL OF BENEFITS: **IF:**
    - We (or Our delegate) determine that transfer to a TUFTS HEALTH PLAN HOSPITAL is medically appropriate; and
    - you refuse the transfer and decide to remain at the NON-NETWORK HOSPITAL.

<u>Note</u>: If you receive a bill, call Member Services; or see “Bills from Providers” in Chapter 6.

SAMPLE

EMERGENCY and URGENT CARE, continued

URGENT CARE is defined as follows**:** 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.

Note: Care may be provided after the urgent condition is treated and stabilized and the MEMBER is safe for transport. This care is not considered URGENT CARE.

Follow these guidelines for receiving URGENT CARE

Place of Service	NETWORK PROVIDER	NON-NETWORK PROVIDER inside the NETWORK CONTRACTING AREA	NON-NETWORK PROVIDER outside the NETWORK CONTRACTING AREA
LIMITED SERVICE MEDICAL CLINIC, 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.
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 IN-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.
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.

SAMPLE

INPATIENT and Intermediate Behavioral Health and Substance Use Disorder Services

IN-NETWORK LEVEL OF BENEFITS: You may need INPATIENT or intermediate behavioral health or substance use disorder services. To be covered for these services at the IN-NETWORK LEVEL OF BENEFITS these services must be provided by a NETWORK PROVIDER. There is no need to contact TUFTS HEALTH PLAN first. Simply call or go directly to any NETWORK PROVIDER. Identify yourself as a TUFTS HEALTH PLAN MEMBER. The NETWORK PROVIDER is responsible for providing (1) notifying TUFTS HEALTH PLAN of your admission; and (2) all INPATIENT and/or intermediate behavioral health and substance use disorder services.

OUT-OF-NETWORK LEVEL OF BENEFITS: You may want to receive INPATIENT or intermediate behavioral health or substance use disorder services from a NON-NETWORK PROVIDER; your coverage will be at the OUT-OF-NETWORK LEVEL OF BENEFITS.

- You are responsible for making sure your NON-NETWORK PROVIDER: (1) provides notificationto us, and (2) obtains any required approval by an AUTHORIZED REVIEWER.
- We can let you know in advance whether the services you want to receive are COVERED SERVICES. Contact the TUFTS HEALTH PLAN Behavioral Health Department at 1-800-208-9565.

If you receive services that TUFTS HEALTH PLAN (or our delegate) determine are not COVERED SERVICES, you will be responsible for the full cost of these services.

SAMPLE

Utilization Management

TUFTS HEALTH PLAN or its delegate has a utilization management program. This program evaluates whether health care services provided to MEMBERs are: (1) MEDICALLY NECESSARY; and (2) provided in the most appropriate and efficient manner.

MEDICAL NECESSITY Guidelines are used to determine MEDICAL NECESSITY for services or items which are covered when found to be MEDICALLY NECESSARY. These Guidelines are developed for specific services or items found to be safe and proven effective in a limited, defined population of patients or clinical circumstances.

MEDICAL NECESSITY Guidelines are:

- based on current literature review;
- developed with input from practicing PROVIDERS in SERVICE 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.

TUFTS HEALTH PLAN considers these guidelines and the MEMBER'S individual health care needs to evaluate if a service or supply is MEDICALLY NECESSARY.

This program sometimes includes prospective, concurrent, and retrospective review of health care services for MEDICAL NECESSITY (Authorized Review). Such review is performed by an AUTHORIZED REVIEWER.

Prospective review is used to determine if proposed treatment is MEDICALLY NECESSARY. This review happens before that treatment begins. It is also called “Pre-Service Review”.

Concurrent review is used to (1) monitor the course of treatment as it occurs; and (2) to determine when that treatment is no longer MEDICALLY NECESSARY.

Retrospective review is used to evaluate care after it is provided. Sometimes, we use retrospective review to more accurately decide if a MEMBER’s health care services are appropriate. It is also called “Post-Service Review”.

TIME FRAMES TO REVIEW YOUR REQUEST FOR COVERAGE

Type of Review	Timeframe for Determinations*
Prospective (Pre-service) review	● Urgent: Within 72 hours of receiving all necessary information. ● Non-urgent: Within 15 calendar days of receiving all necessary information.
Concurrent review	● Within 24 hours of receipt of the request and at least prior to the end of the current certified period.
Retrospective (Post-service) review	● Within 30 calendar days of receipt of a request for payment with all supporting information.

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

Note: 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.

If your request for coverage is denied, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal. TUFTS HEALTH PLAN or its delegate makes coverage determinations. You and your PROVIDER make all treatment decisions.

IMPORTANT NOTE:

MEMBERs can call TUFTS HEALTH PLAN at these numbers to determine the status or outcome of utilization review decisions:

- Behavioral health or substance use disorder utilization review decisions - 1-800-208-9565;
- All other utilization review decisions - 1-800-682-8059.

SAMPLE

Extension of Hospitalization

All INPATIENT hospitalizations are monitored. It may be MEDICALLY NECESSARY for you to stay in the hospital longer than the originally approved stay. If this happens, TUFTS HEALTH PLAN or its delegate will request additional clinical information from your attending PROVIDER or hospital for additional MEDICALLY NECESSARY hospital days. Or, after consulting with your PROVIDER, TUFTS HEALTH PLAN or its delegate may determine that INPATIENT hospitalization is no longer MEDICALLY NECESSARY. If this happens, you will be notified that any additional hospital days will not be covered. You will be responsible for paying for all hospital and PROVIDER charges if you choose to stay in the hospital beyond the discharge date.

Care Management

Some MEMBERS with Severe Illnesses or Injuries may need care management. The specialty care management program: (1) encourages the use of the most appropriate and cost-effective treatment; and (2) supports the MEMBER'S treatment and progress.

If a MEMBER is identified or referred as an appropriate candidate for care management, the MEMBER and his or her NETWORK PROVIDER will be contacted to discuss a treatment plan and establish prioritized goals. Alternative services or supplies available to the MEMBER may also be suggested.

The MEMBER'S treatment plan may be reviewed periodically. If alternatives to the current treatment plan are identified that (1) qualify as COVERED SERVICES; (2) are cost effective; and (3) are appropriate for the MEMBER; then the MEMBER and his or her NETWORK PROVIDER will be contacted to discuss these alternatives

In this case, we will contact the MEMBER and his or her NETWORK PROVIDER to discuss these alternatives.

A Severe Illness or Injury may be medical or behavioral health related and may include, but not limited to, the following:

- AIDS or other immune system diseases;
- Certain neurological disease;
- High-risk pregnancy and newborn CHILDREN;
- Severe traumatic injury;
- Serious heart or lung disease;
- Cancer;
- Major depressive disorders;
- Bipolar disorder;
- Schizophrenia; or
- Substance use disorders.

SAMPLE

Individual care management

In certain circumstances, TUFTS HEALTH PLAN or its delegate may approve an individual care management ("ICM") plan for a MEMBER with a Severe Illness or Injury. These MEMBERS must already be participating in the care management program. The ICM plan is designed to arrange for the most appropriate type, level, and setting of health care services and supplies for the MEMBER.

As a part of the ICM plan, a MEMBER may be approved for coverage of certain alternative services and supplies that do not otherwise qualify as COVERED SERVICES for that MEMBER. This will occur only if TUFTS HEALTH PLAN or its delegate determines that all of the following conditions are satisfied:

- The MEMBERS condition is expected to require medical treatment for an extended duration;
- The alternative services and supplies are MEDICALLY NECESSARY to treat the MEMBERS condition;
- The alternative services and supplies are provided directly to the MEMBER with the condition;
- The alternative services and supplies are provided in place of or to prevent more expensive treatment that qualifies as COVERED SERVICES or supplies. These are services and supplies that the MEMBER otherwise might have incurred during the current episode of illness;
- The MEMBER and TUFTS HEALTH PLAN or its designee agrees to the alternative treatment program; and
- The MEMBER continues to show improvement in his or her condition. TUFTS HEALTH PLAN or its designee will determine this periodically.

These alternative services and supplies will be monitored over time TUFTS HEALTH PLAN or its delegate may decide at any time that these services and supplies no longer satisfy any of the conditions described above. At that time, coverage of services or supplies provided to the MEMBER under the ICM plan may be modified or terminated.

Please note that ICM plans are not used to:

- authorize services or supplies that are specifically excluded under the MEMBER'S plan;
- authorize services or supplies that fall within the limits of the Utilization Review program described above; or
- authorize services that do not meet the relevant MEDICAL NECESSITY criteria for authorization.

SAMPLE

Financial Arrangements between TUFTS HEALTH PLAN and NETWORK PROVIDERS

Methods of payment to NETWORK PROVIDERS

Our goal in paying PROVIDERS is to encourage preventive care and active illness management. We strive to be sure that our financial reimbursement system: (1) encourages appropriate access to care; and (2) rewards PROVIDERS for providing high quality care to our MEMBERS. We use a variety of mutually agreed upon methods to compensate NETWORK PROVIDERS.

The DIRECTORY OF HEALTH CARE PROVIDERS indicates the method of payment for each PROVIDER 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 that can be both harmful and costly to MEMBERS.

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

Member IDentification Card

Introduction

TUFTS HEALTH PLAN gives each MEMBER a Member Identification card (Member ID card).

Reporting errors

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

Identifying yourself as a TUFTS HEALTH PLAN MEMBER

Your Member ID card is important; it identifies you as a TUFTS HEALTH PLAN MEMBER. Please:

1) Carry your Member ID card at all times;

(2) Have your Member ID card with you for medical, hospital and other appointments;

(3) Show your Member ID card to any PROVIDER before you receive health care services. When you receive services, tell the office staff that you are a TUFTS HEALTH PLAN MEMBER.

Membership requirement

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

Membership identification number

If you have any questions about your Member Identification number, call a TUFTS HEALTH PLAN MEMBER Specialist.

SAMPLE

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 SUBSCRIBER and that SPOUSE or CHILD:

- Qualifies as a DEPENDENT, as defined in this EVIDENCE OF COVERAGE; and
- Meets your GROUP's and TUFTS HEALTH PLAN's eligibility rules; and
- Lives, works or resides in the NETWORK CONTRACTING AREA.

***Note:** In some cases, DEPENDENTS who live, work or reside outside of the NETWORK CONTRACTING AREA can be eligible for coverage under this plan. See "If you do not live, work or reside in the NETWORK CONTRACTING AREA" below for more information.

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

You can be covered ONLY if:

- You are a CHILD; or
- You are a DEPENDENT subject to a Qualified Medical Child Support Order (QMCSO); or
- You are a divorced SPOUSE that TUFTS HEALTH PLAN must cover.

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.

SAMPLE

Enrollment

When to enroll

You may enroll yourself and your eligible DEPENDENTS, if any, for this coverage only:

(1) During the annual OPEN ENROLLMENT PERIOD; or

(2) Within 30 days of the date you or your DEPENDENT is first eligible for this coverage.

<u>Note</u>: You may fail to enroll for this coverage when first eligible. You may be eligible to enroll yourself and your eligible DEPENDENTS at a later date **IF**:

- You failed to enroll because you or your eligible DEPENDENT were covered under another GROUP health plan or other health care coverage at that time; or
- You acquired a DEPENDENT through marriage, birth, adoption, or placement for adoption.

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

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

In addition, you or your eligible DEPENDENT may enroll 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

Once we accept your application and receive the needed PREMIUM, <u>your coverage starts on the date your GROUP chooses</u>. Coverage for enrolled DEPENDENTS coverage starts when the SUBSCRIBER'S coverage starts. Coverage may start at a later date if the DEPENDENT becomes eligible after the SUBSCRIBER. DEPENDENT coverage cannot start before the SUBSCRIBER'S coverage starts.

You or your enrolled DEPENDENT may be an INPATIENT on your EFFECTIVE DATE. If so, your coverage starts on the later of:

- The EFFECTIVE DATE; or
- The date TUFTS HEALTH PLAN is notified and given the chance to manage your care.

SAMPLE

Adding DEPENDENTS under FAMILY COVERAGE

When DEPENDENTS may be added

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

- During your OPEN ENROLLMENT PERIOD; or
- Within 30 days after any of the following events:
  - A change in your marital status;
  - The birth of a CHILD;
  - The adoption of a CHILD as of the earlier of the date the CHILD is placed with you for the purpose of adoption or the date you file a petition to adopt the CHILD;
  - A court orders you to cover a CHILD through a qualified medical CHILD support order;
  - A DEPENDENT loses other health care coverage involuntarily;
  - If your GROUP has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add DEPENDENTS

You may have a FAMILY PLAN. If so, fill out a Membership application form listing the DEPENDENTS. Give this form to your GROUP during the OPEN ENROLLMENT PERIOD. Or, give your GROUP the form within 30 days after the date of an event listed above (under "When DEPENDENTS may be added").

If you do not have a FAMILY PLAN, you must ask your GROUP or TUFTS HEALTH PLAN to change your coverage to a FAMILY PLAN. If you do not, your DEPENDENTS will not be covered.

EFFECTIVE DATE of DEPENDENTS' coverage

We may accept your application to add DEPENDENTS. If so, TUFTS HEALTH PLAN 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 on 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 provided on or after your EFFECTIVE DATE.

SAMPLE

Newborn CHILDREN and ADOPTIVE CHILDREN

Importance of enrolling newborn CHILDREN and ADOPTIVE CHILDREN.

- **Newborn CHILD:** You must notify TUFTS HEALTH PLAN of the birth of a newborn CHILD and pay the required PREMIUM within 31 days after the date of birth. Otherwise, that CHILD will not be covered beyond the 31-day period. No coverage is provided for a newborn CHILD who remains hospitalized beyond the 31-day period and has not been enrolled in this plan.
- **ADOPTIVE CHILD:** You must enroll your ADOPTIVE CHILD within 31 days after the CHILD has been adopted or placed for adoption with you. This is required so the CHILD is covered from the date of his or her adoption. Otherwise, you must wait until the next OPEN ENROLLMENT PERIOD to enroll the ADOPTIVE 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.

Note: This age limit does not apply to a CHILD who qualifies as a DISABLED DEPENDENT at any age.

Coverage after termination

A CHILD may lose coverage under this EVIDENCE OF COVERAGE. If this happens, he or she may be eligible for federal or state continuation. The CHILD may also be eligible to enroll in INDIVIDUAL COVERAGE. See Chapter 5 for more information.

DISABLED DEPENDENTS

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 disability.

Coverage after termination

The former DISABLED DEPENDENT may be eligible to enroll in INDIVIDUAL COVERAGE. See Chapter 5 for more information.

SAMPLE

Continuing Eligibility for DEPENDENTS, continued

Rule for former SPOUSES under a GROUP Contract (Also see Chapter 5)

If you and your SPOUSE divorce, your former SPOUSE may continue coverage as a DEPENDENT under your FAMILY COVERAGE in accordance with Rhode Island law if the order for continued coverage is included in the judgment when entered.

Coverage for your divorced SPOUSE continues until:

- Either you or your divorced SPOUSE remarry;
- The time provided by the judgment for divorce; or
- Your divorced SPOUSE becomes eligible for coverage in a comparable plan through his or her own employment.

Follow these steps to continue coverage for a former SPOUSES

Call a MEMBER Specialist within 30 days after the divorce decree is issued. Do this to tell us about your divorce. Send us proof of your divorce when asked.

Keeping TUFTS HEALTH PLAN'S records current

You must notify us of any changes that affect your eligibility and/or the eligibility of your DEPENDENTS. 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 DEPENDENTS.

We have forms to report these changes. The forms are available from your GROUP or Member Services.

SAMPLE

Chapter 3--COVERED SERVICES

- **Chapter 3** describes plan benefits and services. See the "Preventive health care" section for information about coverage provided in accordance with the Affordable Care Act and state law.
- See the **Benefit Overview** at the beginning of this document for COST SHARING AMOUNTS and any benefit limits that apply under this plan.
- Certain COVERED SERVICES described in this chapter require **prior approval by an AUTHORIZED REVIEWER**. This prior approval is required whether services are received from a NETWORK PROVIDER or a NON-NETWORK PROVIDER. If prior approval is not obtained, you may have to pay the full cost of those services and supplies.

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;
- Determined to be MEDICALLY NECESSARY by us or our designee;
- Consistent with applicable state or federal law;
- Consistent with the Necessity Guidelines in effect at the time the services or supplies are provided. MEDICAL NECESSITY Guidelines are available on our website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview**. Or, you may call Member Services or our Behavioral Health department and speak with a representative.
- Provided to treat an injury, illness or pregnancy, except for preventive care.
- Obtained within the 50 United States. The only exception to this rule are EMERGENCY care services and URGENT CARE services while traveling, which are COVERED SERVICES when provided outside of the 50 United States;

Important Note:

Please see the following sections in **Chapter 1** for important information:

- **PRIOR APPROVAL by an AUTHORIZED REVIEWER and INPATIENT Notification**
- **EMERGENCY and URGENT CARE**
- **INPATIENT and Intermediate Behavioral Health and Substance Use Disorder Services**

SAMPLE

EMERGENCY care

Notes:
- The EMERGENCY room COST SHARING AMOUNT is waived if the EMERGENCY room visit results in immediate hospitalization or DAY SURGERY.
- You may receive EMERGENCY COVERED SERVICES from a NON-NETWORK PROVIDER. In this case, we will pay up to the REASONABLE CHARGE. You pay the applicable COST SHARING AMOUNT.
- You may receive a bill from the NON-NETWORK PROVIDER. If you receive a bill, please call Member Services or see “Bills from PROVIDERS” later in this EVIDENCE OF COVERAGE for more information on what to do if you receive a bill.

Acupuncture services

Acupuncture is covered when rendered by a licensed doctor of acupuncture (D. Ac.) or physician (State of Rhode Island licensed MD or DO)* only. An initial evaluation is allowed for new patients. A new patient is one who has not received any professional services from the physician within the past three years.

* Acupuncture services may be rendered by a physician (MD or DO) when the following Rhode Island Department of Health criteria have been met:

2.2 Any physician licensed in Rhode Island under the provisions of Chapter 5-37 who seeks to practice medical acupuncture as a therapy shall comply with the following:

- 2.2.1 Meet the requirements for licensure as a doctor of acupuncture set forth in the Rules and Regulations for Licensing Doctors of Acupuncture and Acupuncture Assistants promulgated by the Department of Health; or
- 2.2.2 Successfully complete a course offered to physicians that meets the requirements set forth in these regulations and includes no less than the following:
  - a) a minimum of three hundred (300) hours of formal instruction;
  - b) a supervised clinical practicum incorporated into the formal instruction required in subsection 2.2.2(a) (above).

When 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;
- any other service not specifically listed as a covered service.

See the "Benefit Overview" at the beginning of this document for visit limits that may apply.

Allergy testing, treatment, and allergy injections

Coverage is provided for MEDICALLY NECESSARY allergy services, including antigens

Ambulance services
(AR)

- Ground, sea, and air ambulance transportation for EMERGENCY care are COVERED SERVICES.
- Air ambulance services means transportation by helicopter or fixed-wing plane (for example, Medflight). Emergency ambulance transportation does not require prior approval by an AUTHORIZED REVIEWER.
- Non-EMERGENCY ambulance transportation is covered only when an AUTHORIZED REVIEWER determines in advance that such services are MEDICALLY NECESSARY.

Important Note: You may be treated by EMERGENCY Medical Technicians (EMTs) or other ambulance staff. At that time, you may refuse to be transported to the hospital or other medical facility. In that case, you will be responsible for the costs of this treatment.

SAMPLE

Autism spectrum disorders - diagnosis and treatment (AR)

Coverage is provided, in accordance with Rhode Island law, for the diagnosis and treatment of autism spectrum disorders for CHILDREN under age 15. 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. Services with an asterisk (*) require prior approval by an AUTHORIZED REVIEWER.

- HABILITATIVE or rehabilitative services: professional, counseling, and guidance services; and treatment programs necessary to develop, maintain, and restore an individual. These programs may include, but are not limited to: Applied behavioral analysis services (ABA)*, supervised by a Board-Certified Behavior Analyst (BCBA) who is a licensed health care clinician. For the purposes of this benefit, ABA includes:
    - the design, implementation, and evaluation of environmental modification;
    - using behavioral stimuli and consequences;
    - to product socially significant improvement in human behavior;
    - including the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.

For more information about these services, call the TUFTS HEALTH PLAN Behavioral Health Department at 1-800-208-9565.

- Services provided by licensed or certified speech therapists, physical therapists, occupational therapists or social workers*. There are no visit limits when services are provided under this autism spectrum disorders benefit..*
- Prescription drugs covered under your Prescription Drug Benefit.
- Psychiatric and psychological care covered under the Behavioral Health and Substance Use Disorder benefit.

Behavioral health and substance use disorder services

* Certain services in this category may require approval by an AUTHORIZED REVIEWER. See Chapter 1, “INPATIENT and Intermediate Behavioral Health and Substance Use Disorder Services” for additional information.

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 treatment services

OUTPATIENT services: for diagnose and treat MENTAL DISORDERS. This includes individual, GROUP, and family therapies.

Prior approval by an AUTHORIZED REVIEWER is required for the following services.

- Psychological and neuropsychological testing services (covered as “Office visits to diagnose and treat illness or injury”);
- Repetitive transcranial magnetic stimulation (rTMS); and
- Applied behavioral analysis (ABA).

SAMPLE

INPATIENT and intermediate behavioral health treatment services

INPATIENT services: MEDICALLY NECESSARY behavioral health services for Mental Disorders in a facility licensed as a general hospital, mental health hospital, substance use disorder facility or mental health residential treatment facility.

Intermediate services. MEDICALLY NECESSARY behavioral health services that are more intensive than traditional OUTPATIENT behavioral health services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate mental health care services are

- level III community-based detoxification;
- crisis stabilization;
- intensive OUTPATIENT programs;
- partial hospital programs;
- Home and community Based Adult intensive services (AIS) and Child and Family Intensive Treatment (CFIT). AIS/CFIT programs offer services primarily based in the home and community for qualifying adults and children with moderate-to-severe mental health conditions. These programs consist at a minimum of ongoing emergency/ crisis evaluations, psychiatric assessment, medication evaluation and management, case management, psychiatric nursing services, and individual, group, and family therapy.

OUTPATIENT substance use disorder services

OUTPATIENT services for the treatment of substance abuse, including methadone maintenance or methadone treatment related to chemical dependency disorders.

INPATIENT and intermediate Substance Use Disorder Services

INPATIENT services for substance use disorder detoxification and treatment services in a general hospital, substance use disorder facility, or COMMUNITY RESIDENCE.

Intermediate services These services are more intensive than traditional OUTPATIENT substance use disorder services. They are less intensive than 24-hour hospitalization. Some examples of Covered intermediate substance use disorder services are day treatment and partial hospital programs, and intensive OUTPATIENT programs. Also see AIS/CFIT above.

Substance use disorder treatment in a Community Residential care setting*.

Note: Treatment for the use of tobacco or caffeine is not covered under this substance use disorder services benefit.

Cardiac rehabilitation services

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.

Chemotherapy administration

Administration of chemotherapy is covered. For more information about coverage of medications used in chemotherapy, see “Injectable, infused or inhaled medications” listed later in this chapter.

SAMPLE

Clinical trials - Patient care services provided on an INPATIENT or OUTPATIENT basis as part of a qualified clinical trialfor the treatment of cancer or other life-threatening diseases or conditions

Provides coverage for certain experimental/investigational services as required by:

- Rhode Island General Laws Sections § 27-20-60 entitled "Coverage for individuals participating in approved clinical trials", and
- Rhode Island General Laws Title 27, Chapter 55, entitled "Off Label Use of Prescription Drugs". (See also "Prescription Drug Benefit - What is covered" later in Chapter 3.)

In accordance with Rhode Island General Law §27-20-60, this provides coverage for MEMBERS participating in approved clinical trials.

You are qualified to participate in a clinical trial if:

- You are eligible according to the trial protocol, and
- A NETWORK PROVIDER has concluded that your participation would be appropriate; or
- You provide medical and scientific information establishing that your participation in such trial would be appropriate.

RIGL § 27-20-60 describes what an approved clinical trial is. In summary, it means a phase I, phase II, phase III, or phase IV clinical trial that is being done to prevent, detect or treat cancer or a life-threatening disease or condition (a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted).

To qualify to be a clinical trial it must:

- be federally funded, or
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration, or
- be a drug trial that is exempt from having such an investigational new drug application.

If a NETWORK PROVIDER is participating in a clinical trial, and the trial is being conducted in the State in which you reside, then you may be required to participate in the trial through the NETWORK PROVIDER.

Coverage under this includes routine patient costs for COVERED SERVICES furnished in connection with participation in the trial. These include COVERED SERVICES that are typically covered for a patient who is not enrolled in a clinical trial.

The amount you pay is based on the type of service you receive. Please see the "Benefit Overview," particularly the following sections:

- For information about office visits, see "Office visits to diagnose and treat illness or injury"
- For surgical procedures see “Hospital INPATIENT services (acute care)”
- For lab, radiology, and machine tests see "Laboratory Tests" and "Diagnostic Imaging".
- For prescription drugs, see "Prescription Drug Benefit"

In a clinical trial, this EVIDENCE OF COVERAGE does not cover:

- The investigational item, device, or service itself; or
- Items or services provided solely to satisfy data collection and that are not used in the direct clinical management; or
- A service that is clearly inconsistent with widely accepted standards of care.

DAY SURGERY

(AR)

OUTPATIENT surgery done under anesthesia in an operating room of a facility licensed to perform surgery.

- OUTPATIENT surgery performed under anesthesia in an operating room of a facility licensed to perform surgery.
- You must be expected to be discharged the same day.
- You must be shown on the facility's census as an OUTPATIENT.
- Prior approval by an AUTHORIZED REVIEWER is required.

SAMPLE

Diabetes self-management education, services and supplies

COVERED SERVICES are provided for the following services and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, or gestational diabetes. The following coverage is provided in accordance with Rhode Island General Law § 27-18-38 when MEDICALLY NECESSARY and prescribed by a PROVIDER:

- Blood glucose monitors and blood glucose monitors for the legally blind (are covered as "DURABLE MEDICAL EQUIPMENT" later in this chapter);
- Test strips for glucose monitors and/or visual reading (covered under "Prescription Drug Benefit");
- Insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar (covered under "Prescription Drug Benefit");
- insulin pumps (are covered as "Medical Supplies" later in this chapter);
- Therapeutic/molded shoes for the prevention of amputation are covered as "DURABLE MEDICAL EQUIPMENT"; and
- Diabetes self-management education, including medical nutrition therapy are covered.

Upon the approval of the United States Food and Drug Administration, new or improved diabetes equipment and supplies will be covered when MEDICALLY NECESSARY and prescribed by a PROVIDER.

Diagnostic imaging

(AR)

Coverage includes (1) general imaging (such as x-rays and ultrasounds); and (2) MRI/MRA, CT/CTA, and PET tests and nuclear cardiology. **Note:** Diagnostic MRI/MRA, CT/CTA, and PET tests and nuclear cardiology imaging services require approval of an AUTHORIZED REVIEWER.

Diagnostic or preventive screening procedures

Coverage for preventive screenings.:

Routine screenings and exams are covered in full when provided by a Network Provider. Examples included but are not limited to the following services. Also see "Preventive health care" later in this chapter.

- Preventive screenings for colon or colorectal cancer. Examples include colonoscopy and sigmoidoscopy screenings.
- Routine Pap test (cervical cancer screening)
- Routine mammograms
- Routine prostate and colorectal exams and laboratory tests

Coverage for diagnostic procedures & exams **(AR)**:

Diagnostic procedures and exams are subject to MEMBER COST SHARING AMOUNT. See "Diagnostic procedures & exams" in the "Benefit Overview" at the beginning of this document.

In accordance with guidelines established by the American Cancer Society and the Affordable Care Act, examples include but are not limited to the following:

- Diagnostic procedures, such as diagnostic endoscopy, colonoscopy, and proctosigmoidoscopy procedures.
- Diagnostic cytology, such as diagnostic Pap smear.
- Diagnostic mammograms.
- Diagnostic prostate and colorectal examinations and laboratory tests.

Diagnostic Tests

(AR)

Diagnostic tests including but are not limited to, ambulatory EKG testing, sleep studies (performed in the home or in a sleep study facility), and diagnostic audiological testing, are covered. Call Member Services with questions about specific tests.

SAMPLE

DURABLE MEDICAL EQUIPMENT

(AR)

Equipment must meet the following definition:

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.

To be eligible for coverage, the equipment must also be the most appropriate amount, supply or level of service available for the MEMBER in question considering potential benefits and harms to that individual. TUFTS HEALTH PLAN determines this.

Equipment that We determine 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.

Important Notes:

Certain DURABLE MEDICAL EQUIPMENT may require AUTHORIZED REVIEWER approval.

You may be responsible for paying towards the cost of DURABLE MEDICAL EQUIPMENT covered under this plan. See the "Benefit Overview" section at the front of this EVIDENCE OF COVERAGE.

These are examples of covered and non-covered items. They are for illustration only. Call a Member Specialist to see if we cover a certain piece of equipment.

Examples of covered items. (This list is not all-inclusive):

- 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;
- Gradient stockings (Up to three pairs are covered per CALENDAR YEAR);
- Oral appliances for the treatment of sleep apnea;
- Oxygen concentrators (stationary and portable);
- scalp hair prostheses made specifically for an individual or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury.
- Prosthetic devices, except for arms, legs or breasts*;

* **Note:** Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Orthoses and prosthetic devices" benefit.

- Power/motorized wheelchairs;
- Therapeutic/molded shoes and shoe inserts for a MEMBER with severe diabetic foot disease.

We 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 TUFTS HEALTH PLAN to provide such equipment.

SAMPLE

DURABLE MEDICAL EQUIPMENT, continued

Examples of non-covered items (This list is not all-inclusive.):

- 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, 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;
- fixtures to real property. Examples are ceiling lifts, elevators, ramps, stair lifts or stair climbers;
- EMERGENCY response systems (e.g., LifeAlert);
- exercise equipment and saunas;
- 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, and paraffin bath units;
- cooling devices;
- home blood pressure monitors and cuffs;
- hot tubs, jacuzzis, swimming pools, or whirlpools;
- mattresses except for mattresses used in conjunction with a hospital bed and ordered by a PROVIDER. Commercially available standard mattresses (Examples are Tempur-Pedic® or Posturepedic® mattresses.) are not covered. This is the case even if used in conjunction with a hospital bed;
- scooters;
- wheelchair trays;
- orthoses and prosthetic devices; see “Orthoses and prosthetic devices” later in this chapter;
- prosthetic arms and legs (in whole or in part), and breast prostheses; see “Orthotics and prosthetic devices” later in this chapter.

Early intervention services

Services provided by early intervention programs that meet standards established by the Rhode Island Department of Human Services. MEDICALLY NECESSARY early intervention services include, but are not limited to the following:

- Evaluation and case management;
- Nursing care;
- Occupational therapy;
- Physical therapy;
- Speech and language therapy;
- Nutrition;
- Service plan development and review;
- Assistive technology services and devices.

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

Extended Care Services

(AR)

Services provided in a Medicare-certified Skilled nursing facility, rehabilitation hospital or chronic disease hospital, including Skilled nursing, rehabilitation or chronic care services. Prior approval by an AUTHORIZED REVIEWER is required.

Note: CUSTODIAL CARE is not covered.

SAMPLE

SAMPLE

Family planning

Coverage includes the following: Coverage is provided for OUTPATIENT contraceptive services. This includes consultations, procedures and medical services. These services must be related to the use of all contraceptive methods approved by the United State 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 approved by the United States Food and Drug Administration*.

***Note:** We cover certain contraceptives under a Prescription Drug Benefit. Those contraceptives include oral contraceptives, over-the counter female contraceptives and diaphragms. If those contraceptives are covered under that benefit, they are not covered here.

Hearing Aids

(AR)

Coverage is provided for:

- one hearing aid per ear every three (3) years for MEMBERS up to age 19.
- one hearing aid per ear every three (3) years for MEMBERS age 19 and older.

Hemodialysis

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

SAMPLE

Home health care

(AR)

This is a MEDICALLY NECESSARY program to: (1) reduce the length of a hospital stay or; (2) delay or eliminate an otherwise MEDICALLY NECESSARY hospital admission. Prior approval by an AUTHORIZED REVIEWER is required.

Coverage includes:

- home visits by a PROVIDER;
- speech therapy;
- SKILLED nursing care and physical therapy;
- the following services, if determined to be a MEDICALLY NECESSARY component of SKILLED intermittent nursing or physical therapy:
  - speech therapy;
  - occupational therapy;
  - medical/psychiatric social work;
  - nutritional consultation;
  - prescription drugs and medication;
  - medical and surgical supplies (Examples include dressings, bandages and casts.);
  - laboratory tests, x-rays, and E.K.G. and E.E.G. evaluations;
  - the use of DURABLE MEDICAL EQUIPMENT (Coverage is not subject to limits described in the "DURABLE MEDICAL EQUIPMENT" benefit.); and
  - the services of a part-time home health aide.

Notes:

- Speech, physical and occupational therapy services covered under this home health care benefit are provided as described under the speech, physical and occupational therapy benefit later in this chapter; visit limits do not apply when these services are provided under this home health care benefit.
- Sleep studies performed in the home are not covered under this home health care benefit; these sleep studies are covered as described under Diagnostic testing earlier in this chapter.

Hospice care services

(AR)

We will cover the following services for MEMBERS who are terminally ill (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 (This includes bereavement counseling services for the MEMBER's family. This applies for up to one year after the MEMBER'S death.)

Prior approval by an AUTHORIZED REVIEWER is required.

"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.

SAMPLE

Hospital INPATIENT services (acute care) *

*Certain services in this benefit category require approval by an AUTHORIZED REVIEWER. See Chapter 1, "INPATIENT Hospital Services" for additional information. Also see "Surgery" later in this chapter.

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

House calls to diagnose and treat illness or injury

COVERED SERVICES include follow up care as appropriate and in accordance with state and federal la. A licensed physician or licensed behavioral health PROVIDER must provide this care.

Human leukocyte antigen testing or histocompatibility locus antigen testing (AR)

Coverage is provided for 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. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. Coverage includes costs of testing for A, B or DR antigens.

Immunizations

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

SAMPLE

COVERED SERVICES, continued

Infertility services

(AR)

In accordance with Rhode Island General Law §27-18-30 this plan covers

- Diagnosis and treatment of Infertility,
- Standard fertility-preservation services for MEMBERS not in active infertility treatment when a MEDICALLY NECESSARY medical treatment may directly or indirectly cause iatrogenic infertility. Standard fertility-preservation services" means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional medical organizations. "Iatrogenic infertility means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

(I.) Diagnosis of Infertility: Diagnostic procedures and tests are provided in connection with an infertility evaluation when approved in advance by an AUTHORIZED REVIEWER.

(II.) Treatment of Infertility: Infertility is defined as the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year. Attempts at conception to satisfy the diagnosis of infertility may be done naturally or through artificial insemination. **Note:** Infertility includes iatrogenic infertility, meaning an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

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.

The following procedures are COVERED SERVICES when approved in advance by an AUTHORIZED REVIEWER for MEMBERS with a diagnosis of infertility who also:

- 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. Assisted Reproductive Technology (ART) procedures include, but are not limited to:

- In-vitro fertilization (IVF) and/or embryo transfer (ET)
- 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/blasts
- Cryopreservation of sperm
- Cryopreservation of oocytes (eggs)

MEMBERS who meet the criteria for infertility services and who also (1) have a documented contraindication to pregnancy; (2) are using their own eggs; and, (3) are self-paying for a gestational carrier or surrogate; may be authorized for ovarian stimulation, egg retrieval, and fertilization. Prior approval by an AUTHORIZED REVIEWER is required. For more details on services that are available to a MEMBER who meets the definition of infertility, please call Member Services. MEDICAL NECESSITY Guidelines for infertility services are also available on our website at www.tuftshealthplan.com.

SAMPLE

B. Other related ART treatments, including:

- artificial insemination (intrauterine or intracervical);
- gonadotropin medication (FSH)
- artificial insemination (intrauterine or intracervical) used in conjunction with Gonadotropin medication
- cryopreservation of eggs (less than 90 days); andprocurement 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.

MEDICAL NECESSITY guidelines are available on our website at www.tufshealthplan.com. Or, you may call Member Services for more information.

(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 Infertility Services provided in connection with Rhode Island 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 for an inherited genetic disorder associated with severe disability and/or premature death. Prior approval by an AUTHORIZED REVIEWER is required. For more information, please call Member Services.

Oral and injectable drug therapies may be used to treat infertility. These therapies are considered COVERED SERVICES for MEMBERS covered by a "Prescription Drug Benefit." If applicable, see the “Prescription Drug Benefit” in later this chapter for information about drug therapy benefit levels.

Injectable, infused, or inhaled medications

(AR)

Coverage is provided for injectable, infused, or inhaled medications that are: (1) required for and 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. MEDICALLY NECESSARY hypodermic needles and syringes required to inject these medications are also covered. Medications may include, but are not limited to, total parenteral nutritional therapy, chemotherapy, and antibiotics.

Notes:

- Prior approval and quantity limits may apply for certain medications.
- 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. Call Member Services or see our website for more information on these medications and PROVIDERS.
- Coverage includes the components required to administer these medications. This includes, but is not limited to, DURABLE MEDICAL EQUIPMENT, supplies, pharmacy compounding, delivery of drugs, and supplies.
- Medications 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 **www.tuftshealthplan.com**.

SAMPLE

Laboratory tests

(AR)

These include, but are not limited to: blood tests; urinalysis; throat cultures; glycosylated hemoglobin (HbA1c) tests; genetic testing; urinary protein/microalbumin; and lipid profiles.

Notes:

- PRIOR approval by an AUTHORIZED REVIEWER is required for certain laboratory tests (e.g., genetic testing).
- For a complete list of laboratory tests subject to prior approval see the MEDICAL NECESSITY Guidelines on our website.
- Lab tests must be (1) ordered by licensed physician, physician assistant, or nurse practitioner; and (2) performed at a licensed laboratory.
- Lab tests considered to be preventive are covered in full at the IN-NETWORK LEVEL OF BENEFITS. COST SHARING AMOUNTS will apply at the OUT-OF-NETWORK LEVEL OF BENEFITS.
- Certain laboratory tests associated with routine preventive care are covered in full 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

Coverage includes lead screening related services, and diagnostic evaluations for lead poisoning in accordance with Rhode Island law.

Lyme disease

Coverage is provided for (1) MEDICALLY NECESSARY diagnostic testing; and (2), long-term antibiotic treatment of chronic Lyme disease, to the extent not covered under a prescription drug benefit. Treatment for Lyme disease that is otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, Experimental or Investigative.

Mammograms

(see "Diagnostic or preventive screening services" and "Preventive health care")

SAMPLE

MASTECTOMY CARE

- The following services are covered in connection with mastectomy in accordance with Rhode Island law:
  - Surgical procedures known as a mastectomy; prior approval by an AUTHORIZED REVIEWER **(AR)** is required for mastectomy surgery, except for surgery due to a cancer diagnosis;
  - Axillary node dissection;
  - Reconstruction of the breast affected by the mastectomy;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema). *Breast prostheses are covered as described under "Orthoses and prosthetic devices" later in this chapter.

INPATIENT care in hospital for mastectomies is covered for:

- a minimum of 48 hours following a surgical procedure known as a mastectomy; and
- a minimum of 24 hours following an axillary node dissection.

Any decision to shorten this minimum coverage shall be made by the attending physician in consultation with and upon agreement by the MEMBER. If the MEMBER agrees to an early discharge, coverage shall also include a minimum of one (1) home visit conducted by a physician or registered nurse.

Removal of a breast implant. This is covered when:

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

Note: Coverage is not provided for the removal of ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Note: Cosmetic surgery is not covered.

SAMPLE

Maternity Care

- OUTPATIENT coverage for routine and non-routine care, including:
  - Prenatal care, exams and tests;
  - Postpartum care provided in a PROVIDER'S office.

  Note: MEMBER cost-sharing will apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of routine maternity care. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services.

- INPATIENT coverage includes:
  - Hospital and delivery services; and
  - Well newborn CHILD care in the hospital.*

- INPATIENT care in the hospital is covered for mother and newborn CHILD for at least:
  - 48 hours following a vaginal delivery; or
  - 96 hours following a caesarean delivery.

No prior approval by an AUTHORIZED REVIEWER is required for the minimum hospital stay. And there is no requirement that the mother give birth in a hospital to qualify for this minimum stay. Hospital length of stay begins (1) at the time of delivery when delivery occurs in the hospital; or (2) at the time of admission when delivery occurs outside the hospital. Any decision to shorten these minimum coverages will be made by the attending health care PROVIDER in consultation with the mother. The attending PROVIDER may be an obstetrician, pediatrician, family practitioner, general practitioner, or certified nurse midwife.

Coverage for the newborn Child consists of coverage for injury or sickness. This includes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, as well as routine well-baby care services. Coverage of the newly-born Child will continue only for 31 days after birth. You must enroll the Child as described under “Newborn Children and Adoptive Children”, if you want coverage to continue beyond this 31-day period.

Upon discharge, COVERED SERVICES include one home visit by a registered nurse, physician, or certified nurse midwife. Additional home visits are covered when MEDICALLY NECESSARY and provided by a licensed health care PROVIDER. Such services will be available to a mother and her newborn CHILD whether or not there is an early discharge. COVERED SERVICES include, but are not limited to: parent education, assistance, and training in breast or bottle feeding; and the performance of any necessary and appropriate clinical tests.

In accordance with federal law (42 U.S.C. § 300gg-25), TUFTS HEALTH PLAN shall not:

- Deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, solely for the purpose of avoiding the requirements of this section;
- Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;
- Penalize or otherwise reduce or limit the reimbursement of an attending PROVIDER because such PROVIDER provided care to an individual participant or beneficiary in accordance with this section;
- Provide incentives (monetary or otherwise) to an attending PROVIDER to induce such PROVIDER to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or
- Restrict benefits for any portion of a period within a hospital length of stay required in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

SAMPLE

Medical supplies

(AR)

We cover the cost of certain types of medical supplies, including, but not limited to ostomy, tracheostomy, catheter supplies and insulin pumps. Contact a Member Specialist with coverage questions.

Nutritional counseling

Coverage is provided for nutritional counseling when prescribed by a physician and performed by a registered dietitian/ nutritionist. Nutritional counseling visits are covered as follows:

- When MEDICALLY NECESSARY for the purpose of treating an illness. Please see the "Benefit Overview" for applicable COST SHARING AMOUNT;
- As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, behavior change and counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full.

Note: Weight loss programs and clinics are not covered.

Office visits to diagnose and treat illness or injury

Coverage includes, but is not limited to, office visits for evaluations and consultations; MEDICALLY NECESSARY evaluations and related health care services for acute or EMERGENCY gynecological conditions; and visits to a LIMITED SERVICE MEDICAL CLINIC.

Note: Coverage for diagnostic laboratory tests and x-rays associated with these office visits is described under “Laboratory tests”, “Diagnostic imaging”, “Diagnostic tests” and earlier in this chapter.

SAMPLE

Oral health services

(AR)

If you want to make sure that a planned service is a COVERED SERVICE, call Member Services.

- EMERGENCY care
  X-rays and EMERGENCY oral surgery in a PROVIDER'S office or EMERGENCY room. This care must be done 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 in an INPATIENT or DAY SURGERY setting. Prior approval by and AUTHORIZED REVIEWER is required. Hospital/facility, PROVIDER, and surgical charges are included.
  - Extraction of seven or more permanent teeth during one visit.
  - Surgical treatment of skeletal jaw deformities.
  - Surgical repair related to Temporomandibular Joint Disorder (TMJ).
  - Surgical removal of impacted or un-erupted teeth when embedded in bone

In addition, surgical removal of impacted or un-erupted teeth when embedded in bone is covered in an office setting without prior approval by and AUTHORIZED REVIEWER.

Notes:

- See our website for guidelines used to determine MEDICAL NECESSITY for these services. https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview Or call Member Services.
- Coverage does not apply to Non-EMERGENCY oral health services provided by a dentist. MEMBER must receive these services from an oral surgeon.
- X-rays taken in association with oral health services are covered under “Diagnostic imaging”.

Orthoses and prosthetic devices

(AR)

We cover the cost of orthoses and prosthetic devices (including repairs.), as required by Rhode Island law. This includes coverage of breast prostheses as required by federal law. Coverage is provided for the most appropriate model that adequately meets the MEMBER'S needs. His or her treating PROVIDER determines this.* Prior approval by an AUTHORIZED REVIEWER is required for these services.

- Orthoses means a custom fabricated brace or support that is designed based on MEDICAL NECESSITY.
  Note: See “Durable Medical Equipment” for information about prefabricated orthoses that may be covered.
- Prosthesis means an artificial medical device that is not surgically implanted; and, that is used to replace a missing limb, appendage, or other external human body part including an artificial limb, hand, or foot.

Breast prostheses are covered as required by federal law. Breast prostheses require prior approval by an AUTHORIZED REVIEWER except when provided in connection with a mastectomy, as required by Rhode Island law.

Pap tests

(cervical cancer screening)

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

SAMPLE

Preventive health care

Important Information about Preventive Services:

Your coverage level under this plan will be different for **preventive services** compared to **diagnostic services.**

- Preventive screenings are covered in full (1) in accordance with the Affordable Care Act and current recommendations of the U.S. Preventive Services Task Force (USPSTF) and (2) when received from a NETWORK PROVIDER.
  For a current list of preventive services, please see our website at:

  https://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 services are subject to MEMBER COST SHARING AMOUNTS.
  For COST SHARING AMOUNTS, see the "Benefit Overview" at the beginning of this document.

Preventive health care for MEMBERS through age 19

Coverage is provided for pediatric preventive care for a CHILD from birth to age 19:

- in accordance with the guidelines established by the American Academy of Pediatrics;
- as required by Rhode Island General Laws Section § 27-38.1; and
- includes coverage for hearing screenings in accordance with state and federal law; and

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS.

Preventive health care for MEMBERS age 20 and older

- Routine physical examinations. These include appropriate immunizations and lab tests as recommended by a PROVIDER;
- Routine annual gynecological exam. This includes any follow-up obstetric or gynecological care we decide is MEDICALLY NECESSARY based on that exam;
- Hearing screening and exams.

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam or a routine annual gynecological exam is subject to COST SHARING AMOUNTS.

SAMPLE

Prostate and colorectal exams

(see Diagnostic and preventive screening procedures" and "Preventive health care")

Radiation therapy

(AR) Prior approval by an AUTHORIZED REVIEWER is required

Respiratory therapy and pulmonary rehabilitation services

Scalp hair prostheses or wigs for cancer or leukemia patients

Coverage is provided for scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. This benefit is limited. See this benefit in the Benefit Overview at the beginning of this document

Smoking cessation counseling sessions

Coverage is provided for 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 Rhode Island Office of the Health Insurance Commissioner Regulation 14.

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

Special medical formulas

(AR)

Includes nonprescription enteral formulas and low protein foods. A PROVIDER must prescribe the formula or food for these treatments:

Low protein foods

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

Nonprescription enteral formulas

For home use for treatment of malabsorption caused by: Crohn's disease; ulcerative colitis; gastroesophageal reflux; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids.

SAMPLE

Speech, Physical and Occupational therapy services (AR) (including rehabilitative services and HABILITATIVE services)

Prior approval by an AUTHORIZED REVIEWER is required for these services.

Rehabilitative speech, physical and occupational therapy services are covered when provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition. This includes cognitive rehabilitation and retraining. **Please note:** For these services to be covered, TUFTS HEALTH PLAN must decide that the MEMBER'S condition is subject to significant improvement within a period of 60 days from the initial treatment. That improvement must be a direct result of these therapies.

HABILITATIVE speech, physical and occupational therapy services are covered when provided to a person to attain, maintain or prevent deterioration of a life skill or function never learned or acquired due to a disabling condition.

Massage therapy may be covered as a treatment modality. This is the case when provided as part of a physical therapy visit that is:

- provided by a licensed physical therapist; and
- in compliance with MEDICAL NECESSITY guidelines.

Note: See the "Benefit Overview" earlier in this document for visit limits.

Spinal manipulation

Manual manipulation of the spine.

Surgery

(AR) Prior approval by an AUTHORIZED REVIEWER is required for these services. (Also see “Hospital INPATIENT services (acute care)” and “DAY SURGERY”)

Hematopoietic stem cell transplants, and human solid organ transplants

(AR)

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 related 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.
- We cover a MEMBER'S human leukocyte antigen (HLA) testing. See “OUTPATIENT medical care” for more information.

Reconstructive surgery and procedures and surgery to treat functional deformity or impairment

(AR)

Coverage is provided for services required to relieve pain or to restore a bodily function impaired as a result of: a congenital defect; birth abnormality; traumatic injury; or covered surgical procedure.

SAMPLE

Surgery (AR), continued

Surgery in a PROVIDER'S office

(AR)

Gender reassignment surgery and related services

(AR)

Coverage is provided for gender reassignment surgery, pre-operative and post-operative services related to the surgery, and prescription drugs and behavioral health care services for MEMBERS undergoing the gender reassignment process. COVERED SERVICES include:

- INPATIENT services, including female to male or male to female gender reassignment surgery and related surgical procedures.
- DAY SURGERY for surgical procedures related to the female to male or male to female gender reassignment surgery. These services are covered as described under "DAY SURGERY" earlier in this chapter.
- OUTPATIENT medical care (pre-operative or post-operative) related to gender reassignment surgery. These services are covered as described under "Office visits to diagnose and treat illness or injury", earlier in this chapter.
- Behavioral health care services (pre-operative or post-operative) related to gender reassignment surgery or the gender reassignment process. These services are covered as described under Behavioral Health Services, later in this chapter.
- Prescription medications required as part of the gender reassignment process. These medications are covered as described under the "Prescription Drug Benefit", later in this chapter.

Services must be authorized in advance by an AUTHORIZED REVIEWER. MEMBERS must meet specific MEDICAL NECESSITY Guidelines in order for these services to be covered.

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. Telemedicine services substitute for in-person consultation with PROVIDERS when determined to be MEDICALLY NECESSARY and clinically appropriate. Telemedicine services are available for both medical services and behavioral health services, including substance use disorders.

Telemedicine includes the delivery of clinical healthcare services by use of real time, two-way synchronous audio, video, telephone-audio-only communications or electronic media or other telecommunications technology including, but not limited to: online adaptive interviews, remote patient monitoring devices, audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery. "Telemedicine" does not include email message, or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

You may receive telemedicine services from:

- a NETWORK or NON-NETWORK PROVIDER. You will pay the same COST SHARING AMOUNT for a telemedicine visit as an in-person office visit with that PROVIDER; or
- our designated telemedicine vendor (services are referred to as “telehealth services”.) The COST SHARING AMOUNT for these services is listed in the Benefit Overview.

Important Note: Certain telemedicine services, for example, remote patient monitoring, are only available through a TUFTS HEALTH PLAN PROVIDER, not through our designated telemedicine vendor.

For additional information; including when certain URGENT CARE services may be available while you are traveling outside the 50 Unites States, please visit our website atwww.tuftshealthplan.com/telemedicine or contact Member Services.

SAMPLE

URGENT CARE services
(includes services in a FREE-STANDING URGENT CARE Center)

This plan covers URGENT CARE services. These are services provided to you 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 include:

- a broken or dislocated toe
- a cut that needs stitches but is not actively bleeding
- sudden extreme anxiety;
- symptoms of a urinary tract infection

URGENT CARE services are primarily for patients who have an injury or illness that requires immediate care but is not serious enough for a visit to an EMERGENCY room.

See "Follow these guidelines for receiving Urgent Care" under "Emergency Care and Urgent Care" in Chapter 1 for more information about referrals for these services.

Vision care services

Routine eye examination for MEMBERS : See the "Benefit Overview" at the beginning of this document for visit limits.

Note: You must receive routine eye examinations from a PROVIDER in the EyeMed Vision Care network in order to be covered at the IN-NETWORK LEVEL OF BENEFITS. Go to **www.tuftshealthplan.com** or contact Member Services for more information.

Other vision care services **(AR)**: Coverage is provided for eye examinations and necessary treatment of a medical condition. Prior approval by an AUTHORIZED REVIEWER may be required for certain services.

Note: One pair of eyeglass lenses and standard frames will be covered in each CONTRACT YEAR 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.

SAMPLE

Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. These topics are included here. They explain your prescription drug coverage:

- How Prescription Drugs Are Covered;
- What is Covered;
- What is Not Covered;
- "TUFTS HEALTH PLAN Pharmacy Management Programs;
- Filling Your Prescription for maintenance medications

How Prescription Drugs Are Covered

Prescription drugs may be considered COVERED SERVICES. This occurs only if they comply with the "TUFTS HEALTH PLAN Pharmacy Management Programs" section below and are:

- listed below under "What is Covered";
- provided to treat an injury, illness, or pregnancy;
- MEDICALLY NECESSARY; and
  written by a TUFTS HEALTH PLAN participating PROVIDER, except in cases of authorized referral or in Emergencies.

We have a current list of covered drugs. See our website at **www.tuftshealthplan.com.** You can also call a MEMBER Specialist.

For COST SHARING AMOUNT and dispensing limits under this plan see the Prescription Drug Coverage Table in the Benefit Overview section earlier in this document.

Notes:

- Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered in full .
- 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. Please see the website at www.tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy or call Member Services for more information.

SAMPLE

Prescription Drug Benefit, continued

What is Covered

We cover the following under this Prescription Drug Benefit:

- Prescribed drugs that by law require a prescription and are not listed under WHAT IS NOT COVERED (See "Important Notes" below.).
- Test strips for glucose monitors and/or visual aid reading, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar levels.
- 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.
  *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 when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription. See "Family planning" above for information about other covered contraceptive drugs and devices.
- Fluoride for CHILDREN.
- Injectables and biological serum included on the list of covered drugs on our website. Also, see our website at **www.tuftshealthplan.com.**
- Prefilled sodium chloride for inhalation (This is covered both by prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or disabling or life-threatening chronic diseases 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
  - by the commissioner of insurance.
- Compounded medications. These are only covered 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 our website. Also, see our website at **www.tuftshealthplan.com**.
- Prescription and over-the-counter smoking cessation agents. These must be recommended and prescribed by a PROVIDER.

Note: Certain prescription drug products may be subject to one of the "TUFTS HEALTH PLAN PHARMACY MANAGEMENT PROGRAMS" described below.

SAMPLE

Prescription Drug Benefit, continued

What is Not Covered

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

- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Drugs not listed on the "TUFTS HEALTH PLAN Prescription Drug List". See the list at **www.tuftshealthplan.com** . Also, you can call Member Services for more information.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act. and fluoride for CHILDREN).
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
- Topical and oral fluorides for adults.
- Medications for the treatment of idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants, Depo-Provera or its generic equivalent and FDA-approved over-the-counter female contraceptives when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription.
- 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.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under "Preventive health care" above.
- Prescriptions written by PROVIDERS who do not participate in TUFTS HEALTH PLAN. These drugs are excluded except in cases of authorized referral or EMERGENCY care.
- Prescriptions filled at pharmacies other than TUFTS HEALTH PLAN designated pharmacies, except for EMERGENCY care.
- Drugs for asymptomatic onychomycosis, except for MEMBERS with diabetes, vascular compromise, or immune deficiency status.
- Acne medications, unless MEDICALLY NECESSARY.
- 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. You can also check our website at www.tuftshealthplan.com.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once the same 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. Also, the entire class of prescription medications may not be covered. For more information, call Member Services. You can also check our website at **www.tuftshealthplan.com**.
- Prescription medications when packaged with non-prescription products.
- Drugs for the treatment of erectile dysfunction.
- Medications packaged for institutional use may be excluded from the pharmacy benefit coverage.
- Oral non-sedating antihistamines.

SAMPLE

TUFTS HEALTH PLAN Pharmacy Management Programs

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

Quantity Limitations Program:

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

Medication Synchronization (Med sync)

In accordance with Rhode Island state law, this program permits and applies a prorated daily cost sharing rate to covered maintenance prescription drugs that are:

- dispensed by a TUFTS HEALTH PLAN Network pharmacy;
- in a quantity less than a thirty (30) days' supply;
- used for the management or treatment of a chronic, long-term condition.

Limitation: Medication synchronization is limited to one per CONTRACT YEAR per maintenance prescription drug.

Excluded prescription drugs: Prescription drugs excluded from this program include, but are not limited to, controlled substances, pain medications and antibiotics.

Prior Approval Program:

TUFTS HEALTH PLAN restrict the coverage of certain drug products. These are drugs with a narrow indication for usage, may have safety concerns and/or are extremely expensive. We require the prescribing PROVIDER to obtain prior approval from us for such drugs.

Step Therapy PA Program:

Step therapy is a type of prior approval program (this is usually automated.) This program uses a step-wise approach. It requires the use of the most therapeutically appropriate and cost-effective agents first. After that, other medications may be covered. MEMBERS must try one or more medications on a lower step to treat a certain medical condition first. After that, a medication on a higher step may be covered for that condition.

Non-Covered Drugs:

TUFTS HEALTH PLAN's covers over 4,500 drugs. However, a small number of drugs (less than 1%) are not covered. This is because there are safe, effective and more affordable alternatives available. Drugs may not be covered for safety reasons, if they are new on the market, if they become available over-the-counter, or if a generic version of a drug becomes available. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA). They are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. For up-to-date information on these non-covered drugs and their suggested alternatives, please call Member Services, or see the website at www.tuftshealthplan.com.

New-To-Market Drug Evaluation Process:

TUFTS HEALTH PLAN's 's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. We then make a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.

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

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IMPORTANT NOTES

Formulary Exceptions

Your PROVIDER may feel it is MEDICALLY NECESSARY for you to take medications that: (1) are not on the formulary; or (2) are restricted under any of the "TUFTS HEALTH PLAN's Pharmacy Management Programs" above.

Prescribers may submit a formulary exception request to TUFTS HEALTH PLAN's using our Universal Pharmacy Medical Review Request form. This form may be submitted to us in one of the following ways:

By fax, submit the form to 617-673-0988

By phone, contact us at 617-972-1071

By mail, submit the form to:

TUFTS HEALTH PLAN

Pharmacy Utilization Management Department

1 Wellness Way

Canton, MA 02021

- We will review your request; then provide you with notification of our coverage determination **within 72 hours after receiving the request**. Exception requests are reviewed on a case by case basis. Your PROVIDER will be asked to provide medical reasons and any other important information about why you need an exception. We will determine if a request is consistent with our MEDICALLY NECESSITY Guidelines. Please see the definition of MEDICALLY NECESSITY in Appendix A: Glossary and Terms and Definitions for an explanation of how we develop our Guidelines.
- You or your prescribing Physician may request an **expedited exception process based on exigent circumstances**.
  - We will notify you and your prescribing PROVIDER of our determination **no later than 24 hours after receiving such a request**.
  - Exigent circumstances exist when a MEMBER
    - is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function; or
    - is undergoing a current course of treatment using a non-formulary drug
- We will notify you and your PROVIDER about our decision.
  - If the request for a non-covered or new to market drug is approved: then the medication will be covered on the highest tier (e.g., Tier 3 on a 3-tier formulary; Tier 4 on a 4-tier formulary)
  - If the request for coverage of a drug under another program is approved: a tier copayment will be assigned as appropriate.
- If a request is denied, you and your PROVIDER have the right to appeal.
  Your appeal can be submitted in one of the following ways:

  By phone, call a Member Specialist at 1-800-682-8059

  By mail, submit your appeal in writing to:

  TUFTS HEALTH PLAN

  Attn: Appeals and Grievances Department

  P.O. Box 9193

  Watertown, MA 02471-9193

Please see Chapter 6, "Member Satisfaction," for information regarding member appeals, including expedited appeals.

Our formulary is effective January 1st of each year. The drugs on our formulary may change periodically as needed, for example:

- due to safety reasons,
- if a prescription drug becomes available over-the-counter,
- when a new drug comes to market, or
- if a generic version of a drug becomes available.

When a generic version of a drug becomes available and it is added to the covered drug list, the associated brand drug will be removed from the list.

The TUFTS HEALTH PLAN website has a list of covered drugs with their tiers. We may change a drugs tier during the year. For example, a brand drugs patent may expire. In this case, we may change the drugs status by either (a) moving the brand drug from Tier - 2 to Tier 3 or (b) no longer covering the brand drug when a generic alternative becomes available. Many generic drugs are available on Tier-1.

You may have questions about your prescription drug benefit. You may want to know the tier of a particular drug. You might like to know if your medication is part of a Pharmacy Management Program. For these questions, please check our website at www.tuftshealthplan.com. You can also call Member Services at 1-800-682-8059.

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Prescription Drug Benefit, continued

Filling Your Prescription

Where to fill prescriptions:

You can fill your prescriptions at any pharmacy. You must fill your prescriptions at a TUFTS HEALTH PLAN designated pharmacy in order to receive coverage at the IN-NETWORK LEVEL OF BENEFITS. TUFTS HEALTH PLAN designated pharmacies include:

- many of the pharmacies in Massachusetts and Rhode Island. They also include additional pharmacies nationwide.
- You may have questions about where to fill your prescription. If so, call Member Services.

How to fill prescriptions:

- Make sure the prescription is written by a TUFTS HEALTH PLAN participating PROVIDER, except. This is not required, though, in cases of authorized referral or in EMERGENCIES.
- When you fill a prescription, provide your Member ID to any TUFTS HEALTH PLAN designated pharmacy and pay your COST SHARING AMOUNT.
- The cost of your prescription may be less than your COPAYMENT. In this case, you only need to pay 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 fill a prescription at a non-TUFTS HEALTH PLAN designated pharmacy, call TUFTS HEALTH PLAN. They will explain how to submit your prescription drug claims for reimbursement.

Filling prescriptions for maintenance medications:

You may need to take a maintenance medication. If so, TUFTS HEALTH PLAN 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. This is done through a TUFTS HEALTH PLAN designated mail services pharmacy.

*These drugs 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; or
- medications that are part of our Quantity Limitations program.

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

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Exclusions from Benefits

This chapter lists services (and categories of services), supplies, and medications that are excluded (not covered) under this EVIDENCE OF COVERAGE. **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 EVIDENCE OF COVERAGE:

1.

- A service, supply or medication which is not MEDICALLY NECESSARY.
- A service, supply or medication which is not a COVERED SERVICE.
- A service, supply or medication received outside the Service Area, except as described under "How the Plan Works" in Chapter 1.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or;
- A service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- Services related to non-COVERED SERVICES. This does not apply to complications of pregnancy terminations.
- Any services, supplies or medications required by a third party that which are not otherwise MEDICALLY NECESSARY (examples of a third party are an employer, an insurance company, a school, or court).
- Any services for which you are not legally required to pay. Services for which you would not be charged if you had no health plan.

2. Any services that is provided to a non-MEMBER, except as described in Chapter 3 for the following:

- Bereavement counseling services under **Hospice care services;**
- Costs of procurement and processing of donor sperm, egg, or embryos, under **Infertility services** (coverage is only to the extent such costs are not covered by the donors health coverage, if any); and
- Organ donor charges under **Transplants (human solid organ and hematopoietic stem cells)** in Chapter 3.

3. Any services provided to you by your relative (by blood or marriage) unless the relative is a TUFTS HEALTH PLAN PROVIDER and the service is authorized by your PCP. Please note: if you are a TUFTS HEALTH PLAN PROVIDER, you cannot provide or authorize services for yourself or be your own PCP for yourself or a MEMBER of your immediate family (by blood or marriage).

4. 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 COST SHARING.

5. Any additional fee a PROVIDER may charge as a condition of access, or any amenities that access fee is represented to cover is excluded (refer to the Directory of Health Care PROVIDERS to see if your PROVIDER charges such a fee.)

6. 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, are excluded.

7. Any drug, medicines, materials, or supplies for use outside of the hospital or any other facility, except as described in this chapter. Medications and other products that can be purchased over-the-counter except as described earlier in this chapter

8. Any examinations, evaluations or services for educational purposes. This includes physical therapy, speech therapy, and occupational therapy, except as provided earlier in this chapter. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities and behavioral problems in a school-based setting

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.

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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.

Dental care

The following dental care services, treatments, and supplies*:

- 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.
- 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), including those for TMJ disorders.
- 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.

EXPERIMENTAL or INVESTIGATIVE

A drug, device, 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 Rhode Island and federal law, this exclusion does not apply to the following.

- Approved clinical trials; i.e., new therapies conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions.
- Long-term antibiotic treatment of chronic Lyme disease.
- Off-label uses of prescription drugs for the treatment of cancer or disabling or life-threatening chronic diseases.

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.
- Reversal of voluntary sterilization.

Infertility services

- Infertility services for
    - infertility services for MEMBERs who do not meet the definition of Infertility as described in the "OUTPATIENT Care" section earlier in this chapter;
    - experimental infertility procedures;
    - reversal of voluntary sterilization; long-term;
    - costs associated with donor recruitment and compensation;
    - infertility services which are necessary for conception as a result of voluntary sterilization, or following an unsuccessful reversal of a voluntary sterilization; and
    - donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
- 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 gestational carrier; (2) costs for drugs necessary to achieve implantation in a surrogate, embryo transfer, and cryopreservation of 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. Note: We may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may

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impact a MEMBER'S future fertility. Prior approval by an AUTHORIZED REVIEWER is required for these services.

- Long-term (longer than 90 days) cryopreservation (freezing, storage and thawing) sperm or embryo unless:
  - a MEMBER is in active infertility treatment; or
  - a MEMBER is not in active infertility treatment and a MEDICALLY NECESSARY medical treatment may directly or indirectly cause iatrogenic infertility (impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

Note: Prior approval by an AUTHORIZED REVIEWER is required for these cryopreservation services.

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 PROVIDER'S office.
- Cosmetic (to change or improve appearance) surgery.
- 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 genital surgery that has been approved by an AUTHORIZED REVIEWER under **Gender reassignment surgery and procedures.**
- Liposuction or brachioplasty.
- Removal of tattoos.
- Reversal of gender reassignment surgery.
- Rhinoplasty, except as provided under **Reconstructive surgery and procedures** in Chapter 3.
- Treatment of spider veins; removal or destruction of skin tags.

Therapies (including related services, procedures, appliances, medications or supplies)

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 **Physical, occupational and speech therapy services** in Chapter 3.
- Neuromuscular stimulation; neuromuscular stimulators and supplies.
- Psychoanalysis.

Transplants

Transplants are not covered except as described in Chapter 3.

Transportation

Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" in this chapter.

Vision care

- Eyeglasses, lenses or frames, except as described earlier in this chapter; refractive eye surgery (This includes radial keratotomy.) for conditions which can be corrected by means other than surgery. Except as described earlier in this chapter, Tufts HP will not pay for contact lenses or contact lens fittings.
  - The following pediatric vision care services, treatments, and supplies:
    - Services and materials not meeting accepted standards of optometric practice.
    - Special lens designs or coatings other than those described as COVERED SERVICES.
    - Replacement of lost or stolen eyewear.
    - Plano (non-prescription) lenses and/or contact lenses.
    - Two pairs of eyeglasses in lieu of bifocals.
    - Insurance of contact lenses.
    - Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
    - Aniseikonic lenses;
    - Any eye or vision examination or corrective eyewear required by a MEMBER as a condition of employment.
    - Contact lenses insurance.

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- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when covered vision materials would next become available.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- Plano (non-prescription) lenses and/or contact lenses.
- Replacement of lost or stolen eyewear.
- Safety eyewear.
- Services and materials not meeting accepted standards of optometric practice.
- Services rendered after the date a MEMBER ceases to be covered under the plan, except when covered vision materials ordered before coverage ended are delivered; and the services rendered to the MEMBER are within 31 days from the date of such order.
- Special lens, designs, or coatings other than those described as COVERED SERVICES.
- Two pairs of eyeglasses in lieu of bifocals.

Other Exclusions under this plan

- Blood, blood donor fees, blood storage fees, or blood substitutes, blood banking, cord blood banking, and blood products are not covered. The following are exceptions:
  - Blood processing;
  - Blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (Prior approval by an AUTHORIZED REVIEWER is required for these services.);
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (Prior approval by an AUTHORIZED REVIEWER is required for these services.).
- CUSTODIAL CARE.
- Devices and procedures intended to reduce snoring. These include but are not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- 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.
- Laboratory tests ordered by a MEMBER (online or through the mail), even if they are performed at a licensed laboratory.
- 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).
- Lodging related to receiving any medical service.
- Multi-purpose general electric devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electric devices including USB devices and direct connect devices (for example, speakers, microphones, cables, cameras, batteries, etc.) Internet and modern connection or 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
- Routine foot care. Examples includes: 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 or other non-orthotic support devices for the feet. **Note:** This exclusion 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.

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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 Service Area, or cessation of bona-fide association Membership. Specifically, your coverage (including federal COBRA coverage and Rhode Island continuation coverage) ends when any of the following occurs:

- you lose eligibility because you no longer meet your GROUP'S or TUFTS HEALTH PLAN'S eligibility rules; or you lose eligibility because you no longer meet your GROUP'S or TUFTS HEALTH PLAN'S eligibility rules;
- 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 mental/behavioral condition which poses a threat to any PROVIDER, any TUFTS HEALTH PLAN MEMBER, TUFTS HEALTH or any TUFTS HEALTH PLAN employee;
- you commit an act of misrepresentation or fraud; or
- your GROUP CONTRACT with TUFTS HEALTH PLAN ends. (For more information, see "Termination of a GROUP CONTRACT" later in this chapter.)

<u>*Note:</u> Please see "If you live, work or reside outside of the NETWORK CONTRACTING AREA" in Chapter 2 for more information.

Benefits after termination

If you are totally disabled when your coverage ends, you may be able to continue your coverage as described in "Extension of Benefits" later in this chapter. Otherwise, we 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. See Chapter 5 for more information.

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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. This is done back 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 SUBSCRIBER or 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 is only covered at the OUT-OF-NETWORK LEVEL OF BENEFITS.

Before you move, tell your GROUP or call a Member Specialist before you no longer live, work, or reside there. You may have kept a residence in the NETWORK CONTRACTING AREA but been out of the NETWORK CONTRACTING AREA for more than 90 days. If this happens, coverage ends 90 days after the date you left the NETWORK CONTRACTING AREA.

For more information about coverage available to you when you no longer live, work or reside in the NETWORK CONTRACTING AREA, contact a MEMBER Specialist.

***Note:** There are a few exceptions in which DEPENDENTS are still eligible for coverage even if they live, work or reside outside of the NETWORK CONTRACTING AREA. Please see "If you live, work or reside outside of the NETWORK CONTRACTING AREA" in Chapter 2 for more information.

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DEPENDENT Coverage

An enrolled DEPENDENT'S coverage ends either:

- when the SUBSCRIBER'S coverage ends or
- when the DEPENDENT no longer meets the definition of DEPENDENT, whichever occurs first.

See Chapter 2, "Continuing Eligibility for DEPENDENTS", for more information.

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. You must do this 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

We may terminate your coverage if you commit acts of physical or verbal abuse which:

- are unrelated to your physical or mental/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 or Rescission for Misrepresentation or Fraud

Policy

We may terminate your coverage for misrepresentation or fraud under this plan. If your coverage is terminated for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an individual plan 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;
- abuse of the benefits under this plan, including the resale or transfer of supplies, medication, or equipment provided to you as COVERED SERVICES;
- keeping for yourself payments made by TUFTS HEALTH PLAN that were intended to be used to pay a PROVIDER;
- submission of any false paperwork, forms, or claims information; or
- allowing someone else to use your Member ID.

Date of termination

If we terminate your coverage for misrepresentation or fraud, your coverage will end as of a later date chosen by us. Rescission is a cancellation or discontinuance of coverage that has retroactive effect. It includes a cancellation or discontinuance that voids benefits paid. During the first two years of coverage, we reserve the right to rescind your coverage and deny payment of claims retroactive to your EFFECTIVE DATE for any false or misleading information on your application. In accordance with federal law, we shall not rescind coverage except with 30 days prior notice to each enrolled participant who would be affected and may not rescind your coverage except in cases of fraud or intentional misrepresentation of material fact.

Membership Termination or Rescission for Misrepresentation or Fraud, continued

Payment of claims after termination for acts of misrepresentation or fraud

We will pay for all COVERED SERVICES you received between:

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- your EFFECTIVE DATE; and
- your termination date, as chosen by us. In cases of rescission, we may retroactively terminate your coverage back to a date no earlier than your EFFECTIVE DATE.

We may use any PREMIUM you paid for a period after your termination date to pay for any COVERED SERVICES you received after your termination date.

The PREMIUM may not be enough to pay for that care. In this case, TUFTS HEALTH PLAN, at its option, may:

- pay the PROVIDER for those services and ask you to pay us 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, we will refund the excess to your GROUP.

Despite the above provisions related to MEMBER termination for misrepresentation or fraud:

- the validity of the GROUP CONTRACT will not be contested, except for non-payment of PREMIUMS, after the GROUP CONTRACT has been in force for two years from its date of issue; or
- no statement made for the purpose of effecting insurance coverage with respect to a MEMBER under this GROUP CONTRACT shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits thereunder after that MEMBER'S insurance under this GROUP CONTRACT has been in force for a period of two years during his or her lifetime, nor unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to him or her.

Termination of a GROUP CONTRACT

End of TUFTS HEALTH PLAN's and GROUP's relationship

Coverage will terminate if the relationship between your GROUP and TUFTS HEALTH PLAN ends for any reason, including:

- your GROUP'S contract with TUFTS HEALTH PLAN terminates;
- your GROUP fails to pay PREMIUMS on time*;
- TUFTS HEALTH PLAN stops operating; or
- your GROUP stops operating.

  ***Note:** In accordance with the provisions of the GROUP CONTRACT, the GROUP is entitled to a one-month grace period for the payment of any PREMIUM due, except for the first month's PREMIUM. During that one-month grace period, the GROUP CONTRACT will continue to stay in force. However, upon termination of the GROUP CONTRACT, the GROUP will be responsible for the payment of PREMIUM, prorated based on the actual date of the termination. That termination date will be at the end of the grace period, unless the GROUP notifies us of an earlier termination date.

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Extension of Benefits

If you are totally disabled on the date the GROUP CONTRACT ends, you will continue to receive COVERED SERVICES for 12 months.

The following conditions apply:

- the COVERED SERVICES must be:
  - MEDICALLY NECESSARY,
  - provided while the total disability lasts, and
  - directly related to the condition that caused the MEMBER to be totally disabled on that date; and
  - all of the terms, conditions, and limitations of coverage under the GROUP'S contract with TUFTS HEALTH PLAN will apply during the extension of benefits.

The extension of benefits will end on the earliest of:

- the date the total disability ends;
- the date you become eligible for coverage under another plan; or
- 12 months after your extended benefits began.

Transfer to Other Employer GROUP Health Plans

Conditions for transfer

If both your GROUP and the other plan agree, you may transfer from TUFTS HEALTH PLAN to any other health plan offered by your GROUP as follows:

- during your GROUP'S OPEN ENROLLMENT PERIOD; or
- as of the date your GROUP no longer offers TUFTS HEALTH PLAN.

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Chapter 5--Continuation of GROUP CONTRACT Coverage and Conversion Privilege

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 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 (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.

SAMPLE

Federal Continuation Coverage (COBRA), continued

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.

SAMPLE

Rhode Island Continuation Coverage

If your employment is terminated because of involuntary layoff or death, or as a result of the workplace ceasing to exist, or the permanent reduction in size of the workforce, the benefits under this GROUP CONTRACT may be continued as provided under Rhode Island General Laws, Chapter 27-19.1. The period of this continuation will be for up to eighteen (18) months from your termination date. The continuation period cannot exceed the shorter of:

- the period that represents the period of your continuous employment preceding termination with your GROUP; or
- the time from your termination date until the date that you or any other covered MEMBER under your plan becomes employed by another employer and eligible for benefits under another GROUP plan.

Note: We must receive the applicable PREMIUM in order to continue coverage under this provision.

Coverage under an Individual Contract

If GROUP coverage ends, the MEMBER may be eligible to enroll in coverage under an Individual Contract offered through the Rhode Island Health Benefits Exchange called Health Source R.I. For more information, contact Health Source R.I. either by phone (1-855-840-HSRI) or on its website (www.healthsourceri.com).

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Under USERRA:

- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed services, and (1) you ensure that your employer receives advance written or verbal notice of your service; (2) you have five years or less of cumulative service in the uniformed services while with that particular employer; (3) you return to work or apply for reemployment in a timely manner after conclusion of service; and (4) you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.
- If you are a past or present MEMBER of the uniformed services, have applied for Membership in the uniformed services, or are obligated to serve in the uniformed services, then an employer may not deny you initial employment, reemployment, retention in employment, promotion, or any benefit of employment because of this status. In addition, an employer may not retaliate against any assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for your 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 1-866-4USA-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.

SAMPLE

Chapter 6--How to File a Claim and MEMBER Satisfaction

How to File a Claim

NETWORK PROVIDERS

You may get care from a NETWORK PROVIDER. If so, you do not have to submit claim forms. The NETWORK PROVIDER will submit claim forms to TUFTS HP for you. TUFTS HP will make payment directly to the NETWORK PROVIDER.

NON-NETWORK PROVIDERS

You may get care from a NON-NETWORK PROVIDER. If so, it may be necessary to file a claim form. Claim forms are available from the GROUP or TUFTS HP (see "To Obtain Claim Forms" below).

Hospital Admission or DAY SURGERY

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

OUTPATIENT Medical Expenses

When you receive 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 TUFTS HP. If not, you must submit the claim form directly to TUFTS HP yourself.)

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

If you do not sign the appropriate section on the claim form, TUFTS HP will make the appropriate payment directly to you. If you have not already paid, you will be responsible for paying the NON-NETWORK PROVIDER for the services you received. If you are responsible for any portion of the bill, TUFTS HP 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 Get Claim Forms

You can get claim forms from the GROUP. Or, you can call TUFTS HP Member Services.

Where to Forward Medical Claim Forms

Send completed claim forms to:

TUFTS HEALTH PLAN
Claims Department
P.O. Box 9185
Watertown, MA 02471-9185

You should submit separate claim forms 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 TUFTS HP MEMBER Specialist or through our website at www.tuftshealthplan.com.

Time Limit for Providing Claim Forms

We will provide the MEMBER making a claim, or to the GROUP for delivery to such person, the claim forms we furnish for filing proof of loss for COVERED SERVICES obtained at the OUT-OF-NETWORK Level of Benefits. If we do not provide such forms within 15 days after we received notice of any claim under the GROUP Contract, the MEMBER making that claim will be deemed to have met the requirements under that GROUP Contract for proof of loss, upon submitting to us within the time fixed in the GROUP Contract for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

SAMPLE

MEMBER Satisfaction Process

TUFTS HEALTH PLAN has a multi-level MEMBER Satisfaction Process including:

- Internal Inquiry;
- MEMBER Grievance Process;
- Internal MEMBER Appeals; and
- External Review by an independent review organization (IRO) designated by the Rhode Island Office of the Health Insurance Commissioner.

Mail all grievances and appeals to us at:

TUFTS HEALTH PLAN

Attn: Appeals and Grievances Department

P.O. Box 9193

Watertown, MA 02471-9193

You can also call TUFTS HEALTH PLAN Member Services at 1-800-682-8059 or submit your grievance or appeal in person at the address listed above.

Internal Inquiry:

Call a TUFTS HEALTH PLAN MEMBER Specialist to discuss concerns you have about your health care coverage. We will make every effort to resolve your concerns. You may choose to file a grievance or appeal. If you do this, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

MEMBER Grievance Process

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

It is important that you contact us as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. You may choose to file a grievance verbally. If you do this, please call a TUFTS HEALTH PLAN MEMBER Specialist. That person 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. Then, send it to the address at the beginning of this section. Your explanation should include:

- your name and address;
- your TUFTS HEALTH PLAN Member ID number;
- a detailed description of your concern. This includes 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.

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Administrative Grievances

An administrative grievance is a complaint about a TUFTS HEALTH PLAN employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline

- You may file your grievance verbally or in writing. If you do this, we will notify you by mail. We will do this within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That notification will provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your grievance.
- We will review your grievance and will send you a letter regarding the outcome. As allowed by law, we will send that 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. This would be done by mutual written agreement between you or your authorized representative and TUFTS HEALTH PLAN.

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. You may have concerns about your medical care. If so, you should discuss them directly with your PROVIDER. You may not be satisfied with your PROVIDER'S response. If so, you may contact TUFTS HEALTH PLAN Member Services to file a clinical grievance.

- You may file your grievance verbally or in writing. We will notify you, within five (5) business days after receiving your grievance, that your verbal grievance or grievance letter has been received. That notification will provide you with the name, address, and telephone number of the Quality Management Intake Coordinator who is coordinating the review of your grievance.
- We will review your grievance and will send you a letter regarding the outcome. As allowed by law, we will send that 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. This would be done by mutual written agreement between you or your authorized representative and TUFTS HEALTH PLAN.

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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 TUFTS HEALTH PLAN based on: MEDICAL NECESSITY ; or a denial of coverage for a specifically excluded service or supply or a failure to make payment in whole or part for a service or supply.

The TUFTS HEALTH PLAN Appeals and Grievances Department will review all of the information submitted upon appeal. That review will consider your benefits as detailed in this EVIDENCE OF COVERAGE.

It is important that you contact TUFTS HEALTH PLAN as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage, claim payment. Appeals may be filed either verbally or in writing. You may file a verbal appeal. To do this, call a TUFTS HEALTH PLAN MEMBER Specialist. That person will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing. Then, send it to the address listed earlier in this section. Or you may submit your appeal or grievance in-person at the address at the beginning of this chapter.

Your explanation should include:

- your name and address;
- your TUFTS HEALTH PLAN Member ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and PROVIDER names; and
- any supporting documentation.

Appeals Timeline

- Within 48 hours of receiving your appeal we will notify you in writing. Our letter will include the: (1) name, address, and number of the Appeals and Grievances Specialist coordinating the review of your appeal; and (2) a summary of our understanding of your concerns.
- TUFTS HEALTH PLAN or its delegate ill review your appeal, and make a decision. TUFTS HEALTH PLAN will send you a decision letter within thirty (30) calendar days of receipt.

Note: If you need help, Rhode Island's health insurance consumer assistance program, RIREACH, can help you. Contact RIREACH at 1-855-747-3224.

When Medical Records are Necessary

Your appeal may require the review of medical records. In this event, we will send you a form. You must sign that form to authorize your PROVIDERS to release to TUFTS HEALTH PLAN medical information relevant to your appeal. You must sign and return the form to us before TUFTS HEALTH PLAN can begin the review process. If you do not sign and return the form to us within thirty (30AS) calendar days of the date you filed your appeal, TUFTS HEALTH PLAN may issue a response to your request without reviewing the medical records. You will have access to any medical information and records relevant to your appeal in our possession and control of TUFTS HEALTH PLAN.

Please note: prior to issuing any adverse benefit determination, our review process will comply with Rhode Island law 27-18.9-7 (b)(3).

SAMPLE

Who Reviews Appeals?

Appeals of a MEDICAL NECESSITY determination will be reviewed by a licensed practitioner:

- In the same or similar specialty as typically treats the medical condition, procedure or treatment under review.
- who did not participate in any of the prior decisions on the case.
- Who has not participated in your direct care.

A committee within the Appeals and Grievances Department designated reviewer will review appeals involving non-COVERED SERVICES.

Appeal Response Letters

The letter you receive from TUFTS HEALTH PLAN will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding an adverse MEDICAL NECESSITY determination will include: the specific information upon which the adverse MEDICAL NECESSITY determination was based; the 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; the title and credentials of the individual who reviewed the case; notification of the steps by an External Appeals Agency, designated by the Rhode Island Office of the Health Insurance Commissioner, as appropriate and the availability of translation services and consumer assistance programs.

Expedited Appeals

TUFTS HEALTH PLAN recognize that there are circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. TUFTS HEALTH PLAN will expedite an appeal when 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. We may also process an appeal for a non-covered drug with a quicker turnaround.

Additionally, TUFTS HEALTH PLAN will expedite your appeal if a medical professional determines it involves emergent health care services (defined as services provided in the event of the sudden onset of a medical, mental/behavioral health, or substance use disorder or other health care condition manifesting itself by acute symptoms of a severity (e.g., severe pain) where the absence of immediate medical attention could be reasonably expected to result in placing your health in serious jeopardy, serious impairment to bodily or mental//behavioral functions, or serious dysfunction of any body organ or part). If your request meets the criteria for an expedited review, you may also file a request for a simultaneous external appeal.

If you feel your request meets the criteria cited above, you or your attending PROVIDER should contact TUFTS HEALTH PLAN Member Services. Under these circumstances, you will be notified of the decision as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after the review is initiated.

If your request meets the criteria for an expedited review, you may also file a request for a simultaneous external appeal. See the following section, External Review.

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External Review

TUFTS HEALTH PLAN provides for independent external review of final adverse determinations (decisions based on MEDICAL NECESSITY). The Rhode Island Office of the Health Insurance Commissioner (OHIC) has designated independent review organizations (IROs) to who perform independent external reviews. Assignment of IROs to perform these reviews is on a rotational basis as directed by OHIC.

Please note that the IROs are not connected in any way with TUFTS HEALTH PLAN. Also, appeals for coverage of services excluded from coverage under your plan are not eligible for review.

To initiate an external appeal, you must send a letter to us within four (4) months of the receipt of your internal appeal adverse determination letter. In your letter requesting an external appeal, you must include any additional information that you would like the IRO to consider.

There is no filing fee and no minimum dollar claim amount required to request an external appeal.

You will have at least five (5) business days for standard appeals or twenty-four (24) hours for expedited appeals to submit additional information for your external review to TUFTS HEALTH PLAN.

All medical exigencies are considered when handling an external review, and the request will be processed as expeditiously as possible. No later than five (5) business days for standard appeals and two (2) business days for expedited appeals of receipt of your written request, TUFTS HEALTH PLAN will forward the complete review file, including the criteria utilized in rendering its decision, to the IRO.

The IRO shall notify you and your PROVIDER of record of its decision to uphold or overturn appeal:

- no more than 10 calendar days from receipt of all the information necessary to complete the review for standard appeals and within 72 hours from receipt of the request for expedited appeals; and
- no greater than forty-five (45) calendar days after receipt of the request for external review.

The decision of the IRO is binding. However, any person who is not satisfied with the IRO's final decision is entitled to judicial review in a court of competent jurisdiction.

The IRO external review shall be based on the following:

- the review criteria used by TUFTS HEALTH PLAN to make the internal appeal determination;
- the MEDICAL NECESSITY for the care, treatment or service for which coverage was denied; and
- the appropriateness of the service delivery for which coverage was denied.

If the IRO overturns the appeal decision, we will send you a written notice within five (5) business days of receipt of the written decision from IRO. This notice will:

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

SAMPLE

Bills from PROVIDERS/MEMBER Reimbursement Process

Occasionally, you may receive a bill from a NON-NETWORK PROVIDER for COVERED SERVICES. Before paying the bill, contact the TUFTS HEALTH PLAN Member Services Department.

If you do pay the bill, you must send the Reimbursement Medical Claims Department:

- A completed, signed MEMBER Reimbursement Medical Claim Form. You can obtain this from our website. You can also get one by contacting the TUFTS HEALTH PLAN Member Services Department.
- The documents required for proof of service and payment. Those documents are listed on the Reimbursement Medical Claim Form.

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

Note: You must contact TUFTS HEALTH PLAN regarding your bill(s) or send your bill(s) to TUFTS HEALTH PLAN within 90 days from the date of service, or as soon as reasonably possible. If you do not, the bill cannot be considered for payment, unless you are legally incapacitated. In no event, except in cases of legal incapacitation, can bills be considered for payment after a period of 1 year.

If you receive COVERED SERVICES from a NON-NETWORK PROVIDER, we will pay up to the REASONABLE CHARGE for the services within 30 days of receiving a completed MEMBER Reimbursement Medical Claim Form and all required supporting documents. 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.

TUFTS HEALTH PLAN reserve the right to be reimbursed by the MEMBER for payments made due to our error.

IMPORTANT NOTE: Certain services you receive from NON-NETWORK PROVIDERs at an in-network setting within our NETWORK CONTRACTING AREA are reimbursable. Some examples of these types of NON-NETWORK PROVIDERs include:

- radiologists, pathologists, and anesthesiologists who work at NETWORK HOSPITALS; and
- EMERGENCY room specialists.

You may receive a bill from a NON-NETWORK PROVIDER. If this happens, please follow the MEMBER reimbursement process described above.

Pharmacy Expenses

If you obtain a prescription at a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a Member Specialist. You can also get one at our website at www.tuftshealthplan.com.

Limitation on Actions

You cannot bring an action at law or in equity to recover on this GROUP CONTRACT prior to the expiration of sixty (60) days after a claim has been filed in accordance with the requirements stated under “How to File a Claim” earlier in this chapter. You cannot bring such action at all unless you bring it within three (3) years from the expiration of the time within which a claim must be filed as listed under “Bills from PROVIDERS” earlier in this chapter.

SAMPLE

Chapter 7--Other Plan Provisions

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, or 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;
- medical payments coverage under any automobile policy;
- 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.

Personal Injury Protection/MedPay Benefits

You may be entitled to benefits under your own or another individual's automobile coverage, regardless of fault. These benefits are commonly referred to as Personal Injury Protection (PIP) and Medical Payments (MedPay) benefits. Our coverage is secondary to both PIP and MedPay benefits. If we pay benefits before PIP or MedPay benefits have been exhausted, we may recover the cost of those benefits as described above.

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;
- medical payments coverage under any automobile policy,
- 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. This is 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

SAMPLE

Subrogation, continued

MEMBER cooperation

You further agree:

- to notify us 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 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 for all benefits provided by this PLAN in addition to costs and attorney's fees incurred by TUFTS HEALTH PLAN in obtaining repayment.

Workers' compensation

Employers provide workers' compensation insurance for their employees. Employers do this 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. We will not provide coverage for any injury or illness for which it determines that the MEMBER is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability (2) or indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay the costs of health care services or medications for any work-related illness or injury. If we do this, we have 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 us for any work-related illness or injury, contact the Liability and Recovery Department at 1-888-880-8699, x. 1098.

Subrogation Agent

We may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as our agent.

Constructive Trust

By accepting benefits from TUFTS HEALTH PLAN, 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. This is the case whether the payment of such benefits is made to you directly or made on your behalf, for example to a PROVIDER. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to TUFTS HEALTH PLAN.

SAMPLE

Coordination of This GROUP CONTRACT'S Benefits with Other Benefits

Applicability

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered DEPENDENT has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of “This Plan” are determined before or after those of another plan. The benefits of “This Plan”:

(1) shall not be reduced when, under the order of benefit determination rules, “This Plan” determines its benefits before another plan; but

(2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the "Effect on the Benefits of “This Plan” section below.

(3) medical benefits coverage under group or individual automobile contracts.

Definitions

A. "Plan" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

(1) GROUP insurance or GROUP-type coverage whether insured or uninsured. This includes prepayment, GROUP practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the GROUP CONTRACT that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether “This Plan” is a Primary Plan or Secondary Plan as to another plan covering the person. When “This Plan” is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When “This Plan” is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, “This Plan” may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is MEDICALLY NECESSARY either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. As permitted under Rhode Island law, we will coordinate benefits for prescription drug claims pursuant to secondary payer allowed amount (our contracted rate) in all cases.

E. "Claim Determination Period" means a CALENDAR YEAR. However, it does not include any part of a year during which a person has no coverage under “This Plan”, or any part of a year before the date this COB provision or a similar provision takes effect.

SAMPLE

Order of Benefit Determination Rules

A. General. When there is a basis for a claim under “This Plan” and another plan, “This Plan” is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of “This Plan”; and

(2) Both those rules and “This Plan”'s rules, in Subsection B below, require that “This Plan”'s benefits be determined before those of the other plan.

B. Rules. “This Plan” determines its order of benefits using the first of the following rules which applies:

(1) Non-DEPENDENT/DEPENDENT.

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, MEMBER, SUBSCRIBER, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(b)

(i) If the person is a Medicare beneficiary, and, as a result of the provisions on Title XV111 of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Then the order of benefits is reversed so that the plan covering the person as an employee, MEMBER, SUBSCRIBER, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan

(2) DEPENDENT CHILD/Parents Not Separated or Divorced. Except as stated in Paragraph B(3) below, when “This Plan” and another plan cover the same CHILD as a DEPENDENT of different person, called "parents:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of the plan which covered the other parent for a shorter period of time.

SAMPLE

(3) DEPENDENT CHILD/Separated or Divorced. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(a) If a court decree states that one of the parents is responsible for the health care expenses or health care coverage of the dependent child, and the plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree;

(b) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Paragraph B(2) above shall determine the order of benefits;

(c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Paragraph B(2) above shall determine the order of benefits; or

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) The plan covering the Custodial Parent;

(ii) The plan covering the spouse of the Custodial Parent;

(iii) The plan covering the non-custodial parent; and then

(iv) The plan covering the spouse of the non-custodial parent.

(4) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Paragraph B(2) or B(3) above shall determine the order of benefits as if those individuals were the parents of the child.

(5) Parental and Spousal Coverage.

(a) For a dependent child who has coverage under either or both parents' plans, and also has his or her own coverage as a dependent under a spouse's plan the rule in Paragraph B(9) applies.

(b) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Paragraph B(2) to the dependent child's parent(s) and the dependent's spouse.

(6) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(7) COBRA or State Continuation.

(a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, MEMBER, SUBSCRIBER or retiree or covering the person as a dependent of an employee, MEMBER, SUBSCRIBER or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (8) is ignored.

(c) This rule does not apply if the rule in Paragraph B(1) can determine the order of benefits.

SAMPLE

(8) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, MEMBER or SUBSCRIBER longer are determined before those of the Plan which covered that person for the shorter term.

(a) If the preceding rules do not determine the order of benefits, the plan that covered the person longer is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage from the first ended.

(c) The start of a new plan does not include:

(i) A change in the amount or scope of the plan's benefits;

(ii) A change in the entity which pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer to that of a multiple employer plan.

(d) The person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If the date is not readily available, the date the person first became a MEMBER of the GROUP shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(9) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

SAMPLE

Effect on the Benefits of "This Plan"

A. When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules" section above, "This Plan" is a Secondary Plan as to one or more other plans. In that event the benefits of "This Plan" may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in "This Plan"'s Benefits. The benefits of "This Plan" will be reduced when the sum of:

> (1) The benefits that would be payable for the Allowable Expenses under "This Plan" in the absence of this COB provision; and
>
> (2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of "This Plan" will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. As permitted under Rhode Island law, for prescription drug claims the benefits of "This Plan" will be reduced so that they and the benefits payable under the other plans do not total more than the Allowable Expenses of "This Plan". When the benefits of "This Plan" are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of "This Plan". As permitted under Rhode Island law for prescription drug claims, the benefits of "This Plan" will be reduced so that they and the benefits payable under the other plans do not total more that the Allowable Expenses of "This Plan".

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. TUFTS HEALTH PLAN has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. TUFTS HEALTH PLAN need not tell, or get the consent of, any person to do this. Each person claiming benefits under "This Plan" must give TUFTS HEALTH PLAN any facts it needs to pay the claim. After you enroll, you must notify us of new coverage, termination of other coverage, or if you are enrolled in any high DEDUCTIBLE health plan with a health savings account (HSA).

Facility of Payment

A payment made under another plan may include an amount which should have been paid under "This Plan". If it does, TUFTS HEALTH PLAN may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under "This Plan". TUFTS HEALTH PLAN will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by TUFTS HEALTH PLAN is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

For more information

Contact the Liability and Recovery Department at 1-888-880-8699, x.1098. You can also call a MEMBER Specialist. That person can transfer your call to the Liability and Recovery Department.

SAMPLE

Medicare Eligibility

Medicare eligibility

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

TUFTS HEALTH PLAN will pay benefits **before** Medicare:

- for you or your enrolled SPOUSE, if you or your SPOUSE 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. This notice explains how we use and disclose your medical information. If you have questions or would like another copy of our NOTICE OF PRIVACY PRACTICES, please call a MEMBER Specialist. Information is also available on our website at **www.tuftshealthplan.com**.

Relationships between TUFTS HEALTH PLAN and PROVIDERS

TUFTS HEALTH PLAN and PROVIDERS

We arrange health care services. We do not provide health care services. We have agreements with PROVIDERS practicing in their private offices throughout the NETWORK CONTRACTING AREA. These PROVIDERS are independent. They are not TUFTS HEALTH PLAN employees, agents or representatives. PROVIDERS are not authorized to:

- change this EVIDENCE OF COVERAGE; or
- assume or create any obligation for TUFTS HEALTH PLAN.

We are not liable for acts, omissions, representations or other conduct of any PROVIDERS.

SAMPLE

SAMPLE

Circumstances beyond TUFTS HEALTH PLAN' Reasonable Control

TUFTS HEALTH PLAN shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond our reasonable control. 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 signing and returning the Membership application form, you: (1) apply for GROUP coverage; and (2) agree, on behalf of yourself and your enrolled DEPENDENTS, to all the terms and conditions of the GROUP CONTRACT, including this EVIDENCE OF COVERAGE.

Notes:

- The validity of the GROUP CONTRACT cannot be contested, except for non-payment of PREMIUM, after it has been in force for two years from its date of issue.
- A copy of the GROUP's application will be attached to the GROUP CONTRACT when issued. All statements made by the GROUP or by MEMBERS in that application shall be deemed representations and not warranties.
- No agent has authority to change the GROUP CONTRACT or waive any of its provisions. In addition, no change in the GROUP CONTRACT shall be valid unless approved by an officer of TUFTS HEALTH PLAN and evidenced by an amendment to the GROUP CONTRACT signed by us. Please note, though, that any such amendment that reduces or eliminates coverage must be requested in writing by the GROUP or signed by the GROUP.

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: Your GROUP may fail to pay the PREMIUM on time. If this happens, 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" in Chapter 4.

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

SAMPLE

Changes to this EVIDENCE OF COVERAGE

We may change this EVIDENCE OF COVERAGE. Changes do not require your consent.

An amendment to this EVIDENCE OF COVERAGE describing the changes will be sent to you. It will include the EFFECTIVE DATE of the change. 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 the earlier of:

- your discharge date; or
- the date ANNUAL COVERAGE LIMITATIONS are used up.

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

Notice

Notice to MEMBERS: When we send a notice to you, it will be sent to your last address on file with us.

Notice to TUFTS HEALTH PLAN: MEMBERS should address all correspondence to:

TUFTS HEALTH PLAN

P.O. Box 9173

Watertown, MA 02471-9173

Enforcement of terms

We may choose to waive certain terms of the GROUP CONTRACT, if applicable. This includes the EVIDENCE OF COVERAGE. This does not mean that we give up our rights to enforce those terms in the future.

When this EVIDENCE OF COVERAGE Is Issued and Effective

This EVIDENCE OF COVERAGE is issued and effective on your GROUP ANNIVERSARY DATE on or after January 1, 2022. It supersedes all previous EVIDENCE OF COVERAGES. We will issue a copy of the EVIDENCE OF COVERAGE to the GROUP and to all SUBSCRIBERS enrolled under this plan.

SAMPLE

SAMPLE

Appendix A--Glossary of Terms and Definitions

This section defines the terms used in this EVIDENCE OF COVERAGE.

Terms and Definitions

ADOPTIVE CHILD

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

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

Note: A foster CHILD is considered an ADOPTIVE CHILD as of the date of placement for adoption.

ADVERSE BENEFIT DETERMINATION

This means any of the following, in accordance with federal law (29 C.F.R. 2560.503-1): a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to GROUP health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not MEDICALLY NECESSARY or appropriate. Adverse Benefit Determination also includes a Rescission, as this term is defined in Chapter 4, "When Coverage Ends."

ANNIVERSARY DATE

The date when the GROUP CONTRACT first renews. Then, each successive annual renewal date.

ANNUAL COVERAGE LIMITATIONS

Annual dollar or time limitations on COVERED SERVICES.

AUTHORIZED REVIEWER

An AUTHORIZED REVIEWER reviews and approves certain services and supplies for MEMBERS. He or she is TUFTS HEALTH PLAN'S Chief Medical Officer (or equivalent) or someone that person names (which may include a delegate.).

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. BCBAs must also be individually licensed by the Rhode Island Department of Health as a healthcare PROVIDER/clinician, and credentialed by TUFTS HEALTH PLAN. 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.

CHILD

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

- The SUBSCRIBER'S or SPOUSE'S natural unmarried child, stepchild, or ADOPTIVE CHILD who qualifies as a DEPENDENT for federal tax purposes; or
- any other CHILD for whom the SUBSCRIBER has legal guardianship.

SAMPLE

COINSURANCE

This is the MEMBER's share of costs for COVERED SERVICES when COVERED SERVICES are not provided by NETWORK PROVIDERS.

- For services provided by a NON-NETWORK PROVIDER, your share is a percentage of the REASONABLE CHARGE for those services.
- For services provided by a NETWORK PROVIDER, your share is a percentage of:
  - the applicable TUFTS HEALTH PLAN fee schedule amount for those services; or
  - the NETWORK PROVIDER's actual charges for those services, whichever is less.

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

CONTRACT YEAR

This is the 12-month period determined by the GROUP 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. As an example, a plan year can run from July 1st in one calendar year through June 30th in the following calendar year.

For more information about the type of CONTRACT YEAR that applies to your plan, please call Member Services. You can also contact your employer.

COMMUNITY RESIDENCE

Any home or other living arrangement which is established, offered, maintained, conducted, managed, or operated by any person for a period of at least 24 hours, where, on a 24-hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, habilitation, psychological support, and/or social guidance for three or more persons with substance use disorders or MENTAL DISORDERS, or persons with DEVELOPMENTAL disabilities or cognitive disabilities such as brain injury. Examples include, but are not limited to, GROUP homes, halfway homes, and fully-supervised apartment programs. Semi-independent living programs, foster care, and parent deinstitutionalization subsidy aid programs are not considered COMMUNITY RESIDENCES under this EVIDENCE OF COVERAGE.

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. COPAYMENTS are not included in DEDUCTIBLE or COINSURANCE

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 we will pay. They must be:

- described in Chapter 3 of this EVIDENCE OF COVERAGE (They are subject to the "Exclusions from Benefits" section in Chapter 3.); and
- MEDICALLY NECESSARY.

These services include MEDICALLY NECESSARY coverage of pediatric specialty care (This includes mental health care.) by PROVIDERS with recognized expertise in specialty pediatrics, including mental health care.

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.

SAMPLE

CUSTODIAL CARE

- Care provided primarily to assist in the activities of daily living. Examples include bathing, dressing, eating, and maintaining personal hygiene and safety;
- care, other than behavioral health 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. The MEMBER must be expected to depart the same day or in some instances within twenty-four hours. Also called "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 EVIDENCE OF COVERAGE.

(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.). See "Benefit Overview" at the front of this EVIDENCE OF COVERAGE for more information.

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

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 searchable list of Network physicians with whom we contract. It also includes their affiliated NETWORK HOSPITAL(s), and certain other NETWORK PROVIDERS. **Note:** This list is 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 Member Services.

DISABLED DEPENDENT

The SUBSCRIBER'S or SPOUSE'S natural CHILD, stepchild, or ADOPTIVE CHILD of any age who:

- is medically determined to have a physical or mental/behavioral impairment or has a disability which can be expected to result in death, or can be expected to last for a period of not less than 12 months; and
- who is financially DEPENDENT on the SUBSCRIBER.

SAMPLE

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 our 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 health, that manifests itself by symptoms of sufficient severity (This includes severe pain.) that the absence of prompt medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

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

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

EVIDENCE OF COVERAGE

This document and any future amendments that describe the health benefits under the GROUP CONTRACT.

SAMPLE

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; or
- 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; or
- evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe safe; or
- 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.

Note: We do not consider treatment for a Phase IV clinical trial to be EXPERIMENTAL OR INVESTIGATIVE, if that treatment is required by state or federal law.

FAMILY PLAN

Coverage for a SUBSCRIBER and his or her DEPENDENTS.

FREE-STANDING ambulatory surgery center or imaging center

A FREE-STANDING ambulatory surgery center or imaging center is a facility not affiliated with a hospital or a hospital system.

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 they are not LIMITED SERVICE MEDICAL CLINICs. To find an IIN-NETWORK FREE-STANDING URGENT CARE CENTER in our network, please visit our website at www.tuftshealthplan.com, and click on "Find a Doctor".

GROUP

An employer or other legal entity with which we have 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. The GROUP is your agent. It is not TUFTS HEALTH PLAN's agent.

GROUP CONTRACT

The agreement between TUFTS HEALTH PLAN and the GROUP under which:

- we agree to provide GROUP coverage; and
- the GROUP agrees to pay a PREMIUM to us on your behalf.

The GROUP CONTRACT includes this EVIDENCE OF COVERAGE and any amendments.

SAMPLE

HABILITATION, HABILITATIVE

Health care services provided in accordance with the federal Affordable Care Act (ACA) in order for a person to attain, maintain or prevent deterioration 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 PLAN

Coverage for a SUBSCRIBER only (no DEPENDENTS).

IN-NETWORK LEVEL OF BENEFITS

The level of benefits that a MEMBER receives when COVERED SERVICES are provided by a NETWORK PROVIDER. See Chapter 1 for more information.

INPATIENT

A patient who is:

- admitted to a hospital or other facility licensed to provide continuous care; and
- classified as an INPATIENT for all or a part of the day on the facility's INPATIENT census.

INPATIENT NOTIFICATION (formerly known as "Preregistration")

TUFTS HEALTH PLAN process of validating all information required for all INPATIENT admissions and transfers. INPATIENT NOTIFICATION is not a guarantee of payment. See Chapter 1 for more information.

LIMITED SERVICE MEDICAL CLINIC

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

SAMPLE

MEDICALLY NECESSARY (also referred to as MEDICAL NECESSITY)

A service or supply that is:

- required for the prevention, diagnosis, cure, or treatment of a health related condition, including such services necessary to prevent a decremental change in either medical or mental health status;
- appropriate, in terms of type, amount, frequency, level, setting and duration to the MEMBER'S diagnosis or condition; or
- informed by generally accepted medical or scientific evidence and consistent with general accepted practice parameters.

In determining coverage for MEDICALLY NECESSARY services, we use MEDICALLY NECESSARY Guidelines. These Guidelines are:

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

MEDICAL NECESSITY Guidelines are available on our website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview**.

Or, call Member Services at 1-800-682-8059 or our Behavioral Health department at 1-800-208-9565.

MEMBER

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

MENTAL DISORDERS

Any mental/behavioral disorder and substance use disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization.Mental Disorders do not include tobacco and caffeine in the definition of substance.

NETWORK CONTRACTING AREA

The geographic area within which we have developed or arranged for a network of PROVIDERS to provide MEMBERS adequate access to COVERED SERVICES.

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

NETWORK HOSPITAL (In-Network)

A hospital that 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.

SAMPLE

NETWORK PROVIDER (In-Network)

A PROVIDER that 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-NETWORK HOSPITAL (OUT-OF-NETWORK)

A hospital that does not have an agreement either with TUFTS HEALTH PLAN directly or with a PROVIDER network with whom we have a contract to participate as a NETWORK HOSPITAL.

NON-NETWORK PROVIDER (OUT-OF-NETWORK)

A PROVIDER who does not have 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.

NON-CONVENTIONAL MEDICINE

A GROUP of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the TUFTS HEALTH PLAN definition of MEDICAL NECESSITY and are not covered. PROVIDERS of these non-COVERED SERVICES may be contracting or non-contracting traditional medical PROVIDERs. These services may be offered in connection with a traditional office visit. PROVIDERS of NON-CONVENTIONAL MEDICINE services often request payment up front because health insurance typically does not cover these services.

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

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

OBSERVATION

The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within fourty-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

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. This is also the period each year when TUFTS HEALTH PLAN allows eligible individuals to apply for coverage in accordance with an Individual Contract

OUT-OF-NETWORK LEVEL OF BENEFITS

The level of benefits that a MEMBER receives when COVERED SERVICES are provided by a NON-NETWORK PROVIDER. See Chapter 1 for more information.

OUT-OF-POCKET MAXIMUM

The maximum amount of money paid by a MEMBER during a CALENDAR YEAR for certain COVERED SERVICES. See "Benefit Overview" at the front of this EVIDENCE OF COVERAGE for detailed information about your OUT-OF-POCKET MAXIMUM.

SAMPLE

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.

PARAPROFESSIONAL

As it pertains to the treatment of autism and autism spectrum disorders, a PARAPROFESSIONAL is an individual who performs applied behavioral analysis (ABA) services under the supervision of a Board-Certified Behavioral Analyst (BCBA) who is a licensed health care clinician. As required by Rhode Island law, Board-Certified Assistant Behavioral Analysts (BCaBAs) are considered PARAPROFESSIONALS.

PREMIUM

The total monthly cost of INDIVIDUAL or FAMILY COVERAGE which the GROUP pays to us.

PRIMARY CARE PROVIDER

A NETWORK PROVIDER who is a general practitioner, or nurse practitioner family practitioner, internist, pediatrician, 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), URGENT CARE CENTERS (if available), physicians, doctors of osteopathy, licensed nurse midwives, certified registered nurse anesthetists, certified registered nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, tobacco treatment specialists, licensed speech-language pathologists, licensed marriage and family therapists, and licensed audiologists.

We will only cover services of a PROVIDER, if those services are:

- listed as COVERED SERVICES; and
- within the scope of the PROVIDER'S license.

REASONABLE CHARGE

The lesser of the:

- the amount charged by a NETWORK PROVIDER; or
- the amount that we determine. We decide this amount based upon nationally accepted means and amounts of claims payment. These means and amounts 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 MAXIMUMS.

SKILLED

A type of care that is MEDICALLY NECESSARY. This care 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.

SAMPLE

SPOUSE

The SUBSCRIBER'S legal SPOUSE, according to the law of the state in which you reside.

SPOUSE also includes the spousal equivalent of the SUBSCRIBER who is the registered domestic partner, civil union partner, or other similar legally recognized partner of the SUBSCRIBER who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

SUBSCRIBER

The person who:

- is an employee of the GROUP;
- enrolls in TUFTS HEALTH PLAN and signs the Membership application form on behalf of himself or herself and any DEPENDENTS; and
- in whose name the PREMIUM is paid in accordance with a GROUP CONTRACT.

TUFTS HEALTH PLAN

Tufts Associated Health Maintenance Organization, Inc., a Massachusetts corporation d/b/a TUFTS HEALTH PLAN. TUFTS HEALTH PLAN is licensed by Rhode Island as a health maintenance organization (HMO). Also called "we", "us", and "our".

URGENT CARE

Care provided when your health is not in serious danger, but you need immediate attention for a condition or an unforeseen illness or injury, whether medical, physical, behavioral, related to a substance use disorder, or mental/ behavioral health. 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 may be provided after the Urgent condition is treated and stabilized and the MEMBER is safe for transport. This care is not considered URGENT CARE.

SAMPLE

Appendix B -- ERISA Information (applies to GROUP CONTRACTS only)

ERISA RIGHTS

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

ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue GROUP health plan coverage, and prudent actions by plan fiduciaries.

Receiving Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

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

Continuing GROUP health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

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

Prudent Actions by Plan Fiduciaries

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

SAMPLE

ERISA RIGHTS, continued

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you 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 Pension and Welfare Benefits 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.

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 Represenative at the number on your ID card for the specifics on how to appoint an authorized claimant.

SAMPLE

PROCESSING OF CLAIMS FOR PLAN BENEFITS

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, we will respond to you within 72 hours after receipt of the claim. If we determine 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. We 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 decision: 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 we have already approved an ongoing course of treatment for you and consider reducing or terminating the treatment, we 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, we 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, we will respond to you within 15 days after receipt of the claim. If we determine 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 us to make a determination, we will notify you within 15 days and describe the information that you need to provide to us. 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, we will respond to you within 30 days after receipt of the claim. If we determine 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 us to make a determination, we will notify you within 30 days and describe the information that you need to provide to us. 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.

SAMPLE

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

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care PROVIDER obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain PROVIDERS or facilities, you may be required to obtain PRECERTIFICATION. For more information, please see Maternity Care in Chapter 3 or call Member Services.

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/esa/whd/fmla/finalrule/FMLAPoster.pdf.

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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 approval 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 approval 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.

SAMPLE

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.

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, PPO plans and Medicare Complement plans) and to 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 manged care plan. The following describes the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

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

SAMPLE

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

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

How We Protect PHI Within Our Organization

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

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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 inpsect or copy. If you PHI is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable cost-based fee for paper or electronic copies as established by state or federal law. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice of denial describing the basis of our denial. You may request that we send a copy of your PHI directly to another person that you designate. Your request must be in writing, signed by you, and clearly identify the person and the address where the PHI should be sent.
- **Right to Request Restrictions:** You have the right to ask that we restrict uses or disclosures of your PHI to carry out treatment, payment and health care operations, and disclosures to family MEMBERs or friends. We will consider the request. However, we are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made verbally or in writing to TUFTS HEALTH PLAN.
- **Right to Receive Confidental Communications:** You have the right to ask us to send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the SUBSCRIBER's address. We will accommodate your request if: you state that disclosure of your PHI through our usual means could endanger you; your request is reasonable; it specifies the alternative means or location; and it contains information as to how payment, if any, will be handled. Requests may be made verbally or in writing to TUFTS HEALTH PLAN.
- **Right to Amend PHI:** You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to TUFTS HEALTH PLAN and must include a reason to support the requested amendment.
- **Right to Receive an Accounting of Disclosures:** You have the right to a written accounting of the disclosures of your PHI that we made in the last six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to: (i) disclosures we made for treatment, payment or health care operations; (ii) disclosures made to you or people you have designated; (iii) disclosures you or your personal representative have authorized; (iv) disclosures made before April 14, 2003; and (v) certain other disclosures, such as disclosures for national security purposes. IF you request an accounting more than once in a 12-month period, we may charge you a reasonable fee. All requests for an accounting of disclosures must be made in writing to TUFTS HEALTH PLAN.
- **Right to authorized 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 Coordinator at 1-800-462-0224 (TDD: 1-800-815-8580) or write to:

Compliance Department

TUFTS 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 effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to privacy of your medical information.

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Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the futureand make the new Notice effective for all PHI that we maintain - whether created or received before or after the effective date for the new Notice. Whenever we make an important change, we will publish the updated Notice on our 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 Coordinator at the number listed above. You can also download a copy form our Web site at www.tuftshealthplan.com. If you believe your privacy rights may have been violated, you have a right to complain to TUFTS HEALTH PLAN by calling the Privacy Officer at 1-800-208-9549 or writing to:

Privacy Officer

Compliance Department

TUFTS HEALTH PLAN

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.

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