SAMPLE

OPEN PLAN ACCESS
CERTIFICATE OF INSURANCE
Underwritten by Tufts Insurance Company

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

© TUFTS HEALTH PLAN, Watertown, MA 02472-1508 USA. All rights reserved. The information contained in this document may not be reproduced in whole or in part without written permission by TUFTS HEALTH PLAN.

5596_1

RI-TICOPPO-002-THP

Ed. 1-2019

TUFTS HEALTH PLAN Address and Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, Massachusetts 02471-9170
Member Services Hours:
Monday through Thursday 8:00 a.m.-7:00 p.m.
Friday 10:00 a.m-5:00 p.m.

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.

You may have questions about subrogation. If so, call a Member Services Representative at 1-866-352-9114. You may not be sure about the department to call with your questions. If so, call Member Services.

Member Services Department

Call the CARELINK Member Services Department at 1-866-352-9114 for: general questions; benefit questions; and information regarding eligibility for enrollment and billing.

Behavioral Health Services

You may need information regarding mental health benefits. If so, call the Behavioral Health Department at1-800-232-1164.

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

IMPORTANT ADDRESSES:

Appeals and Grievances Department
You may need to call CARELINK about a concern or appeal. If so, call our Member Services Department at 1-866-352-9114. To submit your appeal or grievance in writing, send your letter to:

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

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

Web site
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 Web site at **www.tuftshealthplan.com**.

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
705 Mount Auburn Street
Watertown, MA 02472

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.

705 Mount Auburn St. Watertown, MA 02472

Phone: 888.880.8699 ext. 48000, [TTY number 800.439.2370 or 711]

Fax: 617.972.9048

Email: OCRCoordinator@tufts-health.com.

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C. 20201

800.368.1019, 800.537.7697 (TDD)

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

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 bą́ą́h ìlíní da Diné k'ehjí álnééhgo, hodiilnih béésh bee haní'é bee néé ho'dílzingo nantinígíí bikáá'.

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

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

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

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

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

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

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

1-800-682-8059

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

CERTIFICATE OF INSURANCE

THIS BOOKLET IS YOUR CERTIFICATE OF INSURANCE for health benefits underwritten by (“TIC”). TIC has entered into an agreement with Tufts Benefit Administrators (“TBA”) for TBA to administer health benefits. TBA also makes available a network of PROVIDERS described in this CERTIFICATE. Both TIC and Tufts Benefit Administrators (“TBA”) do business under the name of TUFTS HEALTH PLAN. TBA and TIC have entered into an agreement with Connecticut General Life Insurance Company and its affiliates, International Rehabilitation Associates, Inc. and CIGNA Behavioral Health, Inc. (These companies are collectively referenced as “CIGNA.”). Under this agreement, CIGNA, on behalf of TIC, provides certain administrative services including participating PROVIDER network contracting and maintenance outside of Massachusetts and Rhode Island, medical management, and contracting and maintenance of a behavioral health PROVIDER network. Throughout this CERTIFICATE, your health insurance coverage provided in accordance with this agreement is referred to as CARELINK.

NETWORK PROVIDERS are hospitals, community-based physicians and other community-based health care professionals. 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.

This CERTIFICATE describes the benefits, exclusions, conditions and limitations provided under the GROUP CONTRACT. It applies to persons covered under the GROUP CONTRACT. It replaces any CERTIFICATE previously issued to you. Read this CERTIFICATE 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:

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 TUFTS HEALTH PLAN Member Services.

PLEASE READ THIS CERTIFICATE OF INSURANCE CAREFULLY.

TUFTS HEALTH PLAN Address and Telephone Directory **2**
Translating services for over 200 languages **5**
5
CERTIFICATE OF INSURANCE **6**
Introduction......6
BENEFIT OVERVIEW **11**
Benefit Limits **34**
MENTAL HEALTH PARITY STATEMENT...... 35
Chapter 1--How Your Preferred PROVIDER Plan Works **36**
IN-NETWORK LEVEL OF BENEFITS......36
OUT-OF-NETWORK LEVEL OF BENEFITS...... 38
INPATIENT and Intermediate Behavioral Health and Substance Use Disorder Services......39
EMERGENCY Care...... 40
Financial Arrangements between TUFTS HEALTH PLAN and NETWORK PROVIDERS...... 40
Member Identification Card......41
Utilization Review......41
Preadmission Certification and Continued Stay Review 44
Chapter 2--Eligibility, Enrollment and Continuing Eligibility **45**
Eligibility......45
Enrollment...... 46
Adding DEPENDENTS under FAMILY COVERAGE...... 47
Newborn CHILDREN and ADOPTIVE CHILDREN......48
Continuing Eligibility for DEPENDENTS......48
Chapter 3--COVERED SERVICES **50**
COVERED SERVICES...... 52
EMERGENCY care......52
OUTPATIENT care......53
- Allergy testing, treatment, and allergy injections...... 53
- Autism spectrum disorders - diagnosis and treatment for CHILDREN under age 15 53
- Cardiac rehabilitation services...... 53
- Chemotherapy......53
- Diabetes services and supplies 55
- Diagnostic imaging (PA)......55
- Diagnostic Tests (PA)...... 55
- Early intervention services...... 55
- Family planning......56
- Hemodialysis......56
- Human leukocyte antigen testing or histocompatibility locus antigen testing......56
- Immunizations......56
- Infertility services...... 57
- Laboratory tests......58
- Lead Screenings......58
- Lyme Disease...... 58
- Nutritional counseling...... 58
- Office visits to diagnose and treat illness or injury......59
- Oral health services......60
- OUTPATIENT surgery in a PROVIDER'S office...... 60
- Preventive health care for MEMBERS through age 19......61
- Preventive health care for MEMBERS age 20 and older......61
- Preventive Screenings and Diagnostic Procedures & Exams......62
- Preventive screenings compared to diagnostic procedures & exams......62
- Radiation therapy......62
- Respiratory therapy and pulmonary rehabilitation services......62
- Speech, Physical and Occupational therapy services......63
- Smoking cessation counseling sessions......63
- Spinal manipulation...... 63
- Telemedicine services......63
- URGENT CARE in an urgent care center......64
- Vision care services...... 64

DAY SURGERY...... 65
INPATIENT Care...... 65
- Acute Hospital services 65

Extended Care Services....65
Gender reassignment surgery and related services....65
Hematopoietic stem cell transplants, and human solid organ transplants....67
Reconstructive surgery and procedures and mastectomy surgeries, surgery to treat 68
functional deformity or impairment 68
Maternity Care.... 69
Behavioral Health Services (OUTPATIENT, INPATIENT, and Intermediate)....71
OUTPATIENT behavioral health treatment services....71
INPATIENT and intermediate behavioral health treatment services....72
Substance Use Disorder Services (OUTPATIENT , INPATIENT, and Intermediate)....73
OUTPATIENT substance use disorder services.... 73
INPATIENT and intermediate Substance Use Disorder Services 73
Other health services....74
Ambulance services....74
DURABLE MEDICAL EQUIPMENT.... 74
Hearing Aids 76
Home health care 76
Hospice care services 77
Injectable, infused, or inhaled medications....77
Medical supplies.... 78
New therapies for cancer or other life-threatening diseases or conditions....78
Orthoses and prosthetic devices....79
Scalp hair prostheses or wigs for cancer or leukemia patients....80
Special medical formulas.... 80
Prescription Drug Benefit....81
Exclusions from Benefits.... 87
Chapter 4--When Coverage Ends **91**
When a MEMBER is No Longer Eligible.... 92
Membership Termination for Acts of Physical or Verbal Abuse....93
Membership Termination or Rescission for Misrepresentation or Fraud....93
Termination of a GROUP CONTRACT.... 95
Extension of Benefits....95
Transfer to Other Employer Group Health Plans....95
Chapter 5--Continuation of GROUP CONTRACT Coverageand Conversion Privilege **96**
Federal Continuation Coverage (COBRA).... 96
Rhode Island Continuation Coverage.... 98
Coverage under an Individual Contract 98
The Uniformed Services Employment and Reemployment Rights Act (USERRA).... 98
Chapter 6--How to File a Claim and MEMBER Satisfaction **100**
How to File a Claim....100
MEMBER Satisfaction Process.... 101
Bills from PROVIDERS/Member Reimbursement Process....107
Chapter 7--Other Plan Provisions **108**
Subrogation.... 108
Coordination of This GROUP CONTRACT's Benefits with Other Benefits.... 112
Medicare Eligibility.... 116
Relationships between TUFTS HEALTH PLAN and PROVIDERS....116
Circumstances beyond TUFTS HEALTH PLAN's Reasonable Control.... 117
GROUP CONTRACT.... 117
Appendix A--Glossary of Terms and Definitions **119**
Appendix B -- ERISA Information (applies to GROUP CONTRACTS only) **131**
ERISA RIGHTS....131
STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT....134
FAMILY AND MEDICAL LEAVE ACT OF 1993.... 135
NOTICE OF PRIVACY PRACTICES....135

BENEFIT OVERVIEW

This 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 Overview
- Important information about your
  - IN-NETWORK DEDUCTIBLE
  - IN-NETWORK OUT-OF POCKET MAXIMUM
  - OUT-OF-NETWORK DEDUCTIBLE
  - OUT-OF-NETWORK OUT-OF POCKET MAXIMUM
- Preventive Care Services
- Schedule of Benefits
  - COST SHARING table
  - Benefit limits

IMPORTANT TERMS AND DEFINITIONS

As you read through this section please keep the following definitions and terms in mind:

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

DEDUCTIBLE: This 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 CERTIFICATE.

OUT-OF-POCKET MAXIMUM : This is the maximum amount a MEMBER pays during a CALENDAR YEAR for certain COVERED SERVICES. The OUT-OF-POCKET MAXIMUM consists of COST SHARING AMOUNTS.

It does not include: (1) costs above the REASONABLE CHARGE; or (2) costs for services that are not COVERED SERVICES under the Group Contract. If you meet the OUT-OF-POCKET MAXIMUM in a CALENDAR YEAR then you no longer pay COST SHARING AMOUNTS in that CALENDAR YEAR.

IN-NETWORK Level of Benefits: This is the level of benefits that a MEMBER receives when COVERED SERVICES are provided by a NETWORK PROVIDER.

OUT-OF-NETWORK Level of Benefits: This is the level of benefits that a MEMBER receives when COVERED SERVICES are provided by Non-NETWORK PROVIDERS.

PRIMARY CARE PROVIDER (PCP)

A NETWORK PROVIDER who is a general practitioner, family practitioner, physician assistant, nurse practitioner, internist, pediatrician, or obstetrician/gynecologist who provides primary care services.

NETWORK Provider: A PROVIDER who 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: 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.

Please see Appendix A for these and other terms used throughout this CERTIFICATE.

COST SHARING OVERVIEW
Please note: This chart does not include all COST SHARING AMOUNTS.
See the Schedule of Benefits.

IN-NETWORK LEVEL OF BENEFITS	
PRIMARY CARE PROVIDER (PCP)	$35.00 COPAYMENT per visit
NETWORK HOSPITAL	DEDUCTIBLE then COINSURANCE per admission.
COINSURANCE	20% (unless otherwise noted)

IN-NETWORK LEVEL OF BENEFITS	
DEDUCTIBLE (per CALENDAR YEAR)	
Individual MEMBER	$3,000.00
Family of two or more MEMBERS	$6,000.00 per family
OUT-OF-POCKET MAXIMUM (per CALENDAR YEAR)	
Individual MEMBER	$6,000.00
FAMILY of two or more MEMBERS	$12,000.00

OUT-OF-NETWORK LEVEL OF BENEFITS	
DEDUCTIBLE (per CALENDAR YEAR)	
Individual MEMBER	$3,000.00
Family of two or more MEMBERS	$6,000.00 per family
OUT-OF-POCKET MAXIMUM (per CALENDAR YEAR)	
Individual MEMBER	$6,000.00
FAMILY of two or more MEMBERS	$12,000.00
OUT-OF NETWORK LEVEL OF BENEFITS	
COINSURANCE	40% (unless otherwise noted)

EMERGENCY ROOM	$200.00 per visit	**Call 911 for emergency medical assistance or go to the nearest emergency medical facility.**

Important information about your IN-NETWORK DEDUCTIBLE

The Schedule of Benefits later in this Benefit Overview states which COVERED SERVICES are subject to the DEDUCTIBLE.
 	
• The Family DEDUCTIBLE applies to all enrolled MEMBERS of a family for COVERED SERVICES.
<u>Important Note:</u>
  • All amounts any enrolled MEMBERS in a family pay toward their Individual DEDUCTIBLES are applied toward their Family DEDUCTIBLE.
  • Once this Family DEDUCTIBLE has been met during a CALENDAR YEAR, all enrolled MEMBERS in a family have thereafter satisfied their Individual DEDUCTIBLES for the remainder of that CALENDAR YEAR.
• These amounts cannot count towards your **IN-**NETWORK DEDUCTIBLE:
  • Any amount you pay for COVERED SERVICES received at the OUT-OF-NETWORK Level of Benefits.
  • Any amount paid for services, supplies or medications that are not COVERED SERVICES.
  • Costs in excess of the REASONABLE CHARGE.
• Once you meet your **IN-**NETWORK DEDUCTIBLE in a CALENDAR YEAR, you still pay the following for COVERED SERVICES:
  • COPAYMENTS
  • COINSURANCE
  • Any amounts you pay for prescription drugs. For more information, see Prescription Drug Benefit in the Benefit Overview and Chapter 3, COVERED SERVICES.
• See the following OUT-OF-POCKET MAXIMUM for COVERED SERVICES chart for the most you pay for COVERED SERVICES.

- 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 YEARs DEDUCTIBLE. Any amount carried forward will not apply towards the next CALENDAR YEAR’s IN-NETWORK OUT-OF POCKET MAXIMUM.

Important information about your
IN-NETWORK OUT-OF POCKET MAXIMUM

- This Individual OUT-OF POCKET MAXIMUM applies to each MEMBER per CALENDAR YEAR for COVERED SERVICES.
- This Family OUT-OF-POCKET MAXIMUM applies per CALENDAR YEAR for all enrolled MEMBERS of a family for COVERED SERVICES.
- All amounts any enrolled MEMBERS in a family pay toward their Individual OUT-OF-POCKET MAXIMUMs are applied toward the Family OUT-OF-POCKET MAXIMUM.
- Once the Family OUT-OF-POCKET MAXIMUM has been met during a CALENDAR YEAR, all enrolled Members in a family have thereafter satisfied their Individual **IN-**NETWORK OUT-OF-POCKET MAXIMUMs for the remainder of that CALENDAR YEAR.
- Amounts that cannot count towards the **IN-**NETWORK OUT-OF-POCKET MAXIMUM
  - Any amount paid for COVERED SERVICES received at the OUT-OF-NETWORK Level of Benefits.
  - Any amount paid for services, supplies or medications that are not COVERED SERVICES
  - Costs in excess of the REASONABLE CHARGE.

Important information about your
OUT-OF-NETWORK DEDUCTIBLE

The Schedule of Benefits later in this Benefit Overview states which COVERED SERVICES are subject to the DEDUCTIBLE.

- The Family DEDUCTIBLE applies to all enrolled MEMBERS of a family for COVERED SERVICES subject to the OUT-OF-NETWORK LEVEL OF BENEFITS.

  Important Note:
  - All amounts any enrolled MEMBERS in a family pay toward their Individual DEDUCTIBLES are applied toward their Family DEDUCTIBLE.
  - Once this Family DEDUCTIBLE has been met during a CALENDAR YEAR, all enrolled MEMBERS in a family have thereafter satisfied their Individual DEDUCTIBLES for the remainder of that CALENDAR YEAR.
- These amounts cannot count towards your OUT-OF-NETWORK NETWORK DEDUCTIBLE:
- Any amount you pay for COVERED SERVICES received at the OUT-OF-NETWORK Level of Benefits.
- Any amount paid for services, supplies or medications that are not COVERED SERVICES.
- Costs in excess of the REASONABLE CHARGE.
- Once you meet your OUT-OF-NETWORK NETWORK DEDUCTIBLE in a CALENDAR YEAR, you still pay the following for COVERED SERVICES:
- COINSURANCE
- Any amounts you pay for prescription drugs. For more information, see Prescription Drug Benefit in the Benefit Overview and Chapter 3, COVERED SERVICES.
- See the following OUT-OF-POCKET MAXIMUM for COVERED SERVICES chart for the most you pay for COVERED SERVICES.

- 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 YEARs DEDUCTIBLE. Any amount carried forward will not apply towards the next CALENDAR YEAR's IN-NETWORK OUT-OF POCKET MAXIMUM.

Important information about your
OUT-OF-NETWORK OUT-OF POCKET MAXIMUM

- Amounts that cannot count towards the OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM :
  - Any amount paid for COVERED SERVICES received at the IN-NETWORK LEVEL OF BENEFITS.
  - Any amount paid for services, supplies or medications that are not COVERED SERVICES
  - Costs in excess of the REASONABLE CHARGE.

PREVENTIVE CARE SERVICES

In accordance with the Affordable Care Act (ACA), this plan provides coverage for MEMBERS for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- Services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supports by the Health Resources and Services Administration (HRSA); and
- Preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

COST SHARING AMOUNTS are different for preventive services and diagnostic services.

- The preventive care services described in the ACA guidelines above are **covered in full when provided by IN-NETWORK PROVIDERS.**
  - This includes preventive screening procedures, for example, screening colonoscopies and sigmoidoscopies.
  - Other examples include womens preventive health services and preventive mammograms.
- Diagnostic procedures generally require you to pay a COST SHARING AMOUNT.
  - This includes, but is not limited to, diagnostic colonoscopies, endoscopies, and proctosigmoidoscopies.
  - Other examples include diagnostic mammograms and diagnostic prostate and colorectal exams.
- For more information about your coverage and COST SHARING AMOUNTS see the following sections in the Schedule of Benefits table later in this Benefit Overview
  - Preventive health care for MEMBERS through age 19
  - Preventive health care for MEMBERS age 20 and over
  - Preventive Screenings and Diagnostic Procedures and Exams
  - Preventive Screenings
  - Diagnostic Procedures & Exams

For a current list of preventive services, please see our Web site at:

https://www.tuftshealthplan.com/documents/employers/health-wellness/list-of-preventiveservices

OR

https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services

SCHEDULE OF BENEFITS

This Schedule of Benefits states your COST SHARING AMOUNTS for COVERED SERVICES. This includes when you must pay a DEDUCTIBLE. Please note the following:

- For certain OUTPATIENT services listed as covered in full, you may be charged COST SHARING AMOUNTS when these services are provided in conjunction with an office visit.
- COPAYMENTs for URGENT CARE services vary depending upon the location in which services are rendered. Examples include a PROVIDRERS office, LIMITED SERVICE MEDICAL CLININC, URGENT CARE CENTER, or EMERGENCY room.
- A Telemedicine services visit with a TUFTS HEALTH PLAN PROVIDER will apply the same COST SHARING AMOUNTS that applies to an in-person office visit with that PROVIDER.

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See "Benefit Limits" at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
EMERGENCY Care		
Treatment in an EMERGENCY room	$200.00 COPAYMENT. (not subject to DEDUCTIBLE)	$200.00 COPAYMENT. (not subject to DEDUCTIBLE)
	EMERGENCY Room COPAYMENT waived if admitted as an INPATIENT or for DAY SURGERY. Note: Observation services will take an EMERGENCY Room COST SHARING AMOUNT.	
We recommend that you call TUFTS HEALTH PLAN within 48 hours after EMERGENCY care is received. If you are admitted as an Inpatient after receiving EMERGENCY care, we recommend that you or someone acting for you, such as a family member or the attending PROVIDER, call TUFTS HEALTH PLAN within 48 hours.		

OUTPATIENT CARE		
Allergy testing	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Autism spectrum disorders - diagnosis and treatment **(PA)**	Applied behavioral analysis (ABA) services: • When provided by a PARAPROFESSIONAL: IN-NETWORK DEDUCTIBLE and then Covered in full. • When provided by a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA): IN-NETWORK DEDUCTIBLE then COINSURANCE • Prescription medications**:** See prescription drug benefit • Psychological and psychiatric care**:** See mental health andsubstance use disorder benefit • Physical, occupational and speech therapies*: See the Speech, physical and occupational therapy services” benefit . *Note: Refer to the “Speech, physical and occupational therapy services” benefit later in this Benefit Overview for visit limits and PRIOR AUTHORIZATION related to therapy services provided to treat conditions other than autism spectrum disorder.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Cardiac rehabilitation (**BL)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Chemotherapy	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.
(BL) - Benefit Limit applies. See "Benefit Limits" section following this section and "COVERED SERVICES" in Chapter 3

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Chiropractic care See "Spinal manipulation"		
Diabetes services and supplies	Diabetic test strips: Covered under the "Prescription Drug Benefit". For more information about your COST SHARING AMOUNT, please see that benefit in Chapter 3. Diabetes self-management education: $35.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
	Diabetes supplies covered as Durable MedicalEquipment: See Durable Medical Equipment later in this Benefit Overview Diabetes supplies covered as medical supplies: See Medical supplies later in this Benefit Overview for information about your cost for diabetes supplies covered as prescription medication please see the “Prescription Drug Benefit” later in this section.	

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See "Benefit Limits" at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Diagnostic Imaging **(PA)**	**General imaging:** IN-NETWORK DEDUCTIBLE then COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
• General imaging (such as x-rays and ultrasounds); and • MRI / MRA, CT/CTA, PET and nuclear cardiology.	**MRI/MRA:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **CT/CTA:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **PET:** IN-NETWORK DEDUCTIBLE and then COINSURANCE. **Nuclear cardiology:** IN-NETWORK DEDUCTIBLE and then COINSURANCE.	
Diagnostic testing **(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Early intervention services for a DEPENDENT CHILD	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Family planning (procedures, services and contraceptives) Note: Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.	**Office Visit**: $35.00 COPAYMENT (not subject to DEDUCTIBLE) **DAY SURGERY**: IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Hemodialysis	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Human leukocyte antigen testing or histocompatibility locus antigen testing	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	**YOUR COST**	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Immunizations Note: Preventive immunizations, including those for travel, that are recommended by the Center for Disease Control (CDC) are listed on their website at: http://www.cdc.gov/vaccines/schedules/index.htm	Routine preventive immunizations as recommended by the CDC**:** Covered in full. Travel vaccines as recommended by the CDC: Covered in full. All other immunizations: IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Infertility services **(PA)**	20% COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then 20% COINSURANCE
Laboratory tests (**PA**) Note: In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full.	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Lead screenings	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Lyme disease -MEDICALLY NECESSARY diagnosis and treatment of chronic Lyme disease	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Nutritional counseling Note: 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.	Covered in full for preventive nutritional counseling services provided in accordance with the ACA.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
	All other nutritional counseling services. $35.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Office visits to diagnose and treat illness and injury Note: A Telemedicine service visit with a TUFTS HEALTH PLAN PROVIDER will apply the same COST SHARING AMOUNT that applies to an in-person office visit with that PROVIDER.	$35.00 COPAYMENT (not subject to DEDUCTIBLE) Note: This includes visits to a LIMITED SERVICE MEDICAL CLINIC that participates with TUFTS HEALTH PLAN.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
OUTPATIENT surgery in a PROVIDER's office	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Preventive health care for MEMBERS age 19 and under (including hearing screenings) **Note:** Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Preventive health care for MEMBERS age 20 and older **Note:** Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Preventive Screenings and Diagnostic Procedures & Exams		
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full. Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of this routine annual exam is subject to COST SHARING AMOUNTS.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE Routine annual cytology (pap smear) screening: OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE Routine mammogram: OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE Routine prostate and colorectal exam: OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Diagnostic Procedures & Exams	Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): DEDUCTIBLE then COINSURANCE Diagnostic colon or colorectal **procedure only** (for example, colonoscopies associated with symptoms): IN-NETWORK DEDUCTIBLE and then COINSURANCE Diagnostic prostate and colorectal exam: IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
	Diagnostic cytology (pap smear) examination: IN-NETWORK DEDUCTIBLE and then COINSURANCE	
	Diagnostic mammograms: IN-NETWORK DEDUCTIBLE and thenCOINSURANCE	
Radiation therapy	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Respiratory therapy and pulmonary rehabilitation services	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Smoking cessation counseling services	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Speech, Physical and Occupational therapy services **(PA) (BL)** (including rehabilitation and HABILITATION Services)	IN-NETWORK DEDUCTIBLE and then COINSURANCE per visit.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See "Benefit Limits" at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Telemedicine services **Note:** This COST SHARING AMOUNT applies to telemedicine services obtained through the TUFTS HEALTH PLAN designated telemedicine vendor. See "Office visits to diagnose and treat illness or injury" for the COST SHARING AMOUNT that applies to telemedicine visits with a NETWORK PROVIDER.	$35.00 COPAYMENT	See "Office visits to diagnose and treat illness or injury" for cost sharing that applies to telemedicine visits with NON-NETWORK PROVIDERS.
URGENT CARE in an URGENT CARE CENTER	$35.00 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

Vision care services		
Routine eye examination **(BL)**	$35.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Other vision care services	Care from an optometrist $35.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
	Note: Eyeglass lenses and frames following cataract surgery or other surgery to replace the natural lens of the eye are covered in full. See Chapter 3 for more information.	Note: Eyeglass lenses and frames following cataract surgery or other surgery to replace the natural lens of the eye are subject to OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE. See Chapter 3 for more information.
	Care from an ophthalmologist IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
DAY SURGERY		
Facility	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Physician/surgeon	IN-NETWORK DEDUCTIBLE then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See "Benefit Limits" at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
INPATIENT CARE		
Physician/surgeon	IN-NETWORK DEDUCTIBLE then COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Acute hospital services (Facility) **(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Extended Care **(PA) (BL)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE . Covered up to 100 days per CALENDAR YEAR.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Gender reassignment surgery	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Hematopoietic stem cell transplants, and human solid organ transplants **(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Reconstructive surgery and procedures, mastectomy surgeries, surgical treatment of functional deformity or impairment **(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Maternity Care		
INPATIENT care	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
OUTPATIENT	Routine maternity care Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Note: Routine laboratory tests associated with maternity care are covered in full at the IN-NETWORK LEVEL OF BENEFITS, in accordance with the ACA.	Non-Routine Maternity care Office Visit $35.00 COPAYMENT per visit (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
	All other services: IN-NETWORK DEDUCTIBLE and then COINSURANCE	

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
BEHAVIORAL HEALTH CARE (OUTPATIENT , INPATIENT and Intermediate)		
To contact the TUFTS HEALTH PLAN Behavioral Health Department, call 1-800-208-9565.		
OUTPATIENT behavioral health treatment services (PA)	Individual session $35.00 COPAYMENT per visit. (not subject to DEDUCTIBLE) Group session: $35.00 COPAYMENT per visit. (not subject to DEDUCTIBLE)	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
INPATIENT behavioral health treatment services, including MEDICALLY NECESSARY services in a residential treatment facility**(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Intermediate behavioral health care (PA)	IN-NETWORK DEDUCTIBLE and then covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Substance Use Disorder (OUTPATIENT, INPATIENT and Intermediate)		
To contact the TUFTS HEALTH PLAN Behavioral Health Department, call 1-800-208-9565.		
OUTPATIENT substance use treatment services	Individual session $35.00 COPAYMENT per visit. (not subject to DEDUCTIBLE) Group session: $35.00 COPAYMENT per visit. (not subject to DEDUCTIBLE)	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
INPATIENT substance use treatment services **(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Intermediate substance use treatment services	IN-NETWORK DEDUCTIBLE and then covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
COMMUNITY RESIDENTIAL care **(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Medication assisted treatment, including methadone maintenance	Covered in full when provided by a NETWORK medication assisted treatment clinic.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Other Health Services		
Ambulance services **(PA)**		
Ground ambulance services	DEDUCTIBLE and then $50.00 COPAYMENT per visit.	DEDUCTIBLE and then $50.00 COPAYMENT per visit.
All other covered ambulance services	DEDUCTIBLE and then $50.00 COPAYMENT per visit.	DEDUCTIBLE and then $50.00 COPAYMENT per visit.
DURABLE MEDICAL EQUIPMENT **(PA)**	MEMBER pays 30% COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then 30% COINSURANCE
Hearing Aids **(PA)**	Covered in full.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Home health care (**PA**)	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Hospice care services	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Injectable, infused, or inhaled medications **(PA)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Medical Supplies	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
New cancer therapies	**OUTPATIENT** IN-NETWORK DEDUCTIBLE and then COINSURANCE **INPATIENT** IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.
(BL) - Benefit Limit applies. See "Benefit Limits" section following this section and "COVERED SERVICES" in Chapter 3

Benefit Overview, continued

This section provides basic information about your benefits and COST SHARING AMOUNTS under this plan. See “Benefit Limits” at the end of this section for benefit limitations such as visit and day maximums. Chapter 3 provides additional detail about COVERED SERVICES.

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Oral health services **(PA)**	**EMERGENCY Services:** See EMERGENCY Care listed at the beginning of this section **INPATIENT services:** See INPATIENT Care listed earlier in this section **DAY SURGERY:** See DAY SURGERY listed earlier in this section.	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Orthoses and prosthetic devices **(PA)**	MEMBER pays 20% COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Scalp hair prostheses or wigs for cancer or leukemia patients **(BL)**	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Special Medical Formulas		
Low Protein Foods	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE
Nonprescription Enteral Formulas (**PA**)	IN-NETWORK DEDUCTIBLE and then COINSURANCE	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(PA) - PRIOR AUTHORIZATION 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 Important Information about PRIOR AUTHORIZATION and Inpatient Notification at the beginning of Chapter 3.

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

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:	$15.00 COPAYMENT for up to a 30-day supply.
	$30.00 COPAYMENT for a 31-60-day supply.
	$45.00 COPAYMENT for a 61-90-day supply.
TIER-2 drugs:	$35.00 COPAYMENT for up to a 30-day supply.
	$70.00 COPAYMENT for a 31-60-day supply.
	$105.00 COPAYMENT for a 61-90-day supply.
TIER-3 drugs:	$60.00 COPAYMENT for up to a 30-day supply.
	$120.00 COPAYMENT for a 31-60-day supply.
	$180.00 COPAYMENT for a 61-90-day supply.

- 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 Web site 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.

DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a TUFTS HEALTH PLAN designated mail services pharmacy.	
TIER-1 drugs:	$30.00 COPAYMENT for up to a 90 day supply.
TIER-2 drugs:	$70.00 COPAYMENT for up to a 90 day supply.
TIER-3 drugs:	$120.00 COPAYMENT for up to a 90 day supply.

Benefit Limits

Cardiac Rehabilitation Services
Covered up to 36 visits per CALENDAR YEAR. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Extended Care Services
Covered up to 100 days per CALENDAR YEAR. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Hearing Aids
Coverage is limited to:

- one hearing aid per ear every three (3) years for MEMBERS up to age 19. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined) 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. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined) Coverage is provided up to $700 for each individual hearing aid.

Human Leukocyte Antigen Testing
Coverage limited to one testing per lifetime. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined)

Infertility Services
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.

Physical, occupational and speech therapy

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).

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).

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

Vision Care Services
Coverage is provided for one routine eye examination for MEMBERS every 01 year (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

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.

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.

IN-NETWORK LEVEL OF BENEFITS

You may choose to receive COVERED SERVICES from a NETWORK PROVIDER. If you do, COVERED SERVICES are provided at the IIN-NETWORK LEVEL OF BENEFITS. Note that care includes;

- Behavioral health and substance use disorder services; and
- Services at a LIMITED SERVICES MEDICAL CLINIC or 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

In order to receive coverage at the IN-NETWORK LEVEL OF BENEFITS, you must receive care from a NETWORK PROVIDER. NETWORK PROVIDERS are listed in the DIRECTORY OF HEALTH CARE PROVIDERS. Choose a PROVIDER who is in a location near to you.

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. Call Member Services for more information.

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.

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.

Changes to PROVIDER NETWORK

CARELINK 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 PROVIDERmay 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.

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

PRIOR AUTHORIZATION and INPATIENT NOTIFICATION
PRIOR AUTHORIZATION

COVERED SERVICES that require PRIOR AUTHORIZATION are identified by (PA) in the Benefit Overview at the beginning of this document.

- **When you receive services from NETWORK PROVIDER:**

They are responsible for obtaining PRIOR AUTHORIZATION on your behalf for COVERED SERVICES they provide to you.

- **When you receive services from NON-NETWORK PROVIDER:**

You are responsible for making sure PRIOR AUTHORIZATION is obtained when PA is required. If you receive services that we (or our designee) determine are not COVERED SERVICES, you will be responsible for the cost of these services.

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

INPATIENT NOTIFICATION

INPATIENT NOTIFICATION is a process that makes TUFTS HEALTH PLAN aware of all INPATIENT admissions and transfers to another hospital. We will evaluate the anticipated hospital stay. We may also review your proposed medical care and/or verify MEDICAL NECESSITY. We 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 on your behalf.

- **When you receive services from a NON-NETWORK HOSPITAL:**

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

If you are admitted as an INPATIENT after receiving EMERGENCY care: **We ask that you or someone acting for you (such as a family member or the attending PROVIDER) call us within 48 hours.**

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.

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 all INPATIENTand /or intermediate behavioral health and substance use disorder services. You are not responsible for Precertifying your admission at a NETWORK PROVIDER.

OUT-OF NETWORK LEVEL OF BENEFITS: You may want to receive INPATIENT behavioral health or INPATIENT substance use disorder services from a NON-NETWORK PROVIDER. If so, your coverage and cost sharing will be at the OUT-OF-NETWORK LEVEL OF BENEFITS. PRIOR AUTHORIZATION may be required for certain services. Please call or ask your NON-NETWORK PROVIDER to call us. We can let you know in advance whether the services you want to receive are COVERED SERVICES. Contact the TUFTS HEALTH PLAN BehavioralHealth department at 1-800-208-9565.

EMERGENCY Care

To receive EMERGENCY care

If you have an EMERGENCY, seek care at the nearest EMERGENCY facility. If needed, call 911 for EMERGENCY medical assistance. 911 services may not be available in your area. In this event, call the local number for EMERGENCY medical services.

OUTPATIENT EMERGENCY care

If you receive EMERGENCY care at a NETWORK HOSPITAL, you will pay the EMERGENCY room COST SHARING AMOUNT for each visit.

If you receive EMERGENCY care from a hospital that is a NON-NETWORK PROVIDER, you will pay the EMERGENCY room COST SHARING AMOUNT for each visit. TUFTS HEALTH PLAN will pay up to the REASONABLE CHARGE. If you receive a bill, please see "Bills from PROVIDERS/Member Reimbursement Process" in Chapter 6 or call Member Services.

INPATIENT EMERGENCY care

If you receive EMERGENCY care at a NETWORK HOSPITAL and are admitted as an INPATIENT, the NETWORK HOSPITAL will notify us. You will pay the INPATIENT Hospital COST SHARING AMOUNT for a NETWORK HOSPITAL.

If you receive EMERGENCY care at a hospital that is a NON-NETWORK PROVIDER, and are admitted as an INPATIENT:

- We ask that you or someone acting for you (such as a family member or the attending PROVIDER) notify us within 48 hours.
- You will be covered at the IN-NETWORK LEVEL OF BENEFITS. TUFTS HEALTH PLAN will pay up to the REASONABLE CHARGE. If you receive a bill, please see "Bills from PROVIDERS/ Member Reimbursement Process" in Chapter 6 or call Member Services for more information about what to do when you receive a bill.
- You will be covered at the OUT-OF-NETWORK LEVEL OF BENEFITS **IF**:
  - we determine that transfer to a NETWORK HOSPITAL is medically appropriate; and
  - you refuse the transfer and decide to remain at the NON-NETWORK PROVIDER.

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. 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

CARELINK gives each MEMBER a member identification card (Member ID card).

Reporting errors

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

Identifying yourself as a CARELINK MEMBER

Your Member ID card is important; it identifies you as a CARELINK 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 CARELINK 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 CARELINK Member Specialist.

Utilization Review

Utilization review

The purpose of the CARELINK utilization review program is to control health care costs. It does this by evaluating whether health care services provided to MEMBERS are: (1) MEDICALLY NECESSARY; and (2) provided in the most appropriate and efficient manner. This program sometimes includes prospective, concurrent, and retrospective review of health care services.

We use prospective review to determine if proposed treatment is MEDICALLY NECESSARY. This review happens before that treatment begins. It is also called “pre-service review”.

We use concurrent review to: (1) monitor the course of treatment as it occurs: and (2) to determine when that treatment is no longer MEDICALLY NECESSARY.

We use retrospective review 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 FOR TUFTS HEALTH PLAN 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; and prior to the expected date of service. Non-urgent: Within 15 business days of receiving all necessary information; and prior to the expected date of service.
Concurrent review.	Prior to the end of the current certified period.
Retrospective (Post-service) review.	Within 30 business 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.

We may deny your coverage request. If this happens, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal.

Coverage determinations are made under this CARELINK plan. You and your PROVIDER make all treatment decisions.

IMPORTANT NOTE:

Members can call 1-800-232-1164 for mental health or substance abuse utilization review decisions. Members can call 1-866-352-9114 to determine the status or outcome of all other utilization review decisions.

Specialty case management

Some MEMBERS with Severe Illnesses or Injuries may warrant case management intervention under a specialty case management program. Under this program, we: (1) encourage the use of the most appropriate and cost-effective treatment; and the MEMBER's (2) support the treatment and progress.

We may contact the MEMBER and his or her NETWORK PROVIDER. We do this to discuss a treatment plan and establish short and long term goals. A Specialty Case Manager may suggest alternative treatment settings available to the MEMBER.

We may periodically review the MEMBER's treatment plan. We will contact the MEMBER and the MEMBER's NETWORK PROVIDER if we identify alternatives to the MEMBER's current treatment plan that:

- qualify as COVERED SERVICES;
- are cost effective; and
- are appropriate for the MEMBER.

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

- high-risk pregnancy and newborn CHILDREN;
- serious heart or lung disease;
- cancer;
- certain neurological diseases;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- severe traumatic injury.

Individual case management (ICM)

In certain circumstances, CARELINK may approve an individual case management ("ICM") plan for a MEMBER with a Severe Illness or Injury. 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, CARELINK may approve coverage for alternative services and supplies that do not otherwise qualify as COVERED SERVICES for that MEMBER. This will occur only if TUFTS HEALTH PLAN determines, in its sole discretion, that all of the following conditions are satisfied:

- the MEMBER's condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are MEDICALLY NECESSARY;
- the alternative services and supplies are provided directly to the MEMBER with the condition;
- the alternative services and supplies are in place of more expensive treatment that qualifies as COVERED SERVICES;
- the MEMBER and an AUTHORIZED REVIEWER agree 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.

We may approve an ICM plan. If this happens, CARELINK will also indicate the COVERED SERVICE that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the MEMBER would have received for the COVERED SERVICE.

TUFTS HEALTH PLAN will periodically monitor the appropriateness of the alternative services and supplies provided to the MEMBER. We may decide, at any time that these services and supplies fail to satisfy any of the conditions described above. In this event, CARELINK may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.

Preadmission Certification and Continued Stay Review

What is Preadmission Certification and Continued Stay Review (PAC/CSR)?
Preadmission Certification/Continued Stay Review is a program designed to help you and your DEPENDENTS choose the most appropriate facility for your medical care and to avoid unnecessary or excessively long INPATIENT hospital admissions. As part of the PRECERTIFICATION process, CARELINK will determine an appropriate length for your INPATIENT hospital admission. Remember, your PROVIDER will handle PAC/CSR for you when you use a NETWORK PROVIDER. If you use a NON-NETWORK PROVIDER, we recommend that you have your INPATIENT hospital admission PRECERTIFIED PAC and CSR are performed for CARELINK through a utilization review program by a REVIEW ORGANIZATION.

Pre-Admission Certification/Continued Stay Review for Hospital Confinement
Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the MEDICAL NECESSITY and length of an INPATIENT hospital admission when a MEMBER requires treatment in a Hospital:

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

We recommend that you or your DEPENDENT contact the REVIEW ORGANIZATION to request PAC:

- prior to any non-EMERGENCY treatment in a hospital, as described above;
- in the case of an EMERGENCY admission
- for an admission due to pregnancy, or
- prior to the end of the certified length of stay, for continued hospital confinement.

Changes to PRECERTIFICATION Information
PRECERTIFICATION is valid only for the diagnosis, procedure, admission date and medical facility specified at the time of PRECERTIFICATION. We recommend that you provide notification of any delays, changes or cancellations of your proposed admission. When you use a NETWORK PROVIDER, your PROVIDER must obtain a separate PRECERTIFICATION for a new admission date, readmission, hospitalization, transfer or surgery for conditions other than those designated during the initial PRECERTIFICATION.

Chapter 2--Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule

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 CERTIFICATE; and
- Meets your GROUP's and TUFTS HEALTH PLAN's eligibility rules; and
- Lives, works or resides in the NETWORK CONTRACTING AREA.

*Notes

- In some 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.
- CHILDREN are not required to live, work or reside in the NETWORK CONTRACTING AREA. However, coverage outside of the NETWORK CONTRACTING AREA is limited to the OUT-OF-NETWORK LEVEL OF BENEFITS only.

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

You can be covered ONLY if:

- You are a Spouse or Dependent of a Subscriber, or
- 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.
  Note: Coverage outside of the NETWORK CONTRACTING AREA is limited to the OUT-OF-NETWORK LEVEL OF BENEFITS.

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.

Eligibility Requirements under Rhode Island and Federal Law

An eligible CHILD is defined based on his or her relationship with the participant.

- Limiting eligibility is prohibited based on: financial dependency on the SUBCRIBER; residency; student status; employment; eligibility for other insurance; or marital status.
- The terms of coverage for a CHILD under this GROUP CONTRACT do not vary based on the age of that CHILD.

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.

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

- You or your eligible DEPENDENT were covered under another group health plan or other health care coverage at that time; or
- 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

We may accepts your application and receive the needed PREMIUM. When this happens, coverage starts on the date your GROUP chooses. Enrolled DEPENDENTS' coverage starts when the SUBSCRIBER's coverage starts, or at a later date if the DEPENDENT becomes eligible after the SUBSCRIBER became eligible for coverage. A DEPENDENT's coverage cannot start before the SUBSCRIBER's coverage starts.

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.

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 FAMILY COVERAGE. 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".

You may not have FAMILY COVERAGE. In this case, ask your GROUP to change your INDIVIDUAL COVERAGE to FAMILY COVERAGE.Then, follow the above procedure.

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.

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 CERTIFICATE. 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.

Continuing Eligibility for DEPENDENTS, continued

Rule for former SPOUSES (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.

Note: 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.

How to continue coverage for former SPOUSES

To continue coverage for a former SPOUSE, 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.

Chapter 3--COVERED SERVICES

When health care services are COVERED SERVICES.

Health care services and supplies are COVERED SERVICES only if they are:

- Listed as COVERED SERVICES in this chapter;
- Determined to be MEDICALLY NECESSARY by us or our designee;
- Consistent with applicable state or federal law;
- Consistent with MEDICAL NECESSITY Guidelines in effect at the time the services or supplies are provided.
- 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;

.

Our MEDICAL NECESSITY Guidelines are available on our Web site at:
https://tuftshealthplan.com/provider/resource-center#///Commercial//

- Click on the category you are looking for, such as "Behavioral Health" or "Guidelines".
- Resource documents in these categories are listed alphabetically.

If you prefer, call Member Services at 1-800-682-8059, Or call our Behavioral Health Department at 1-800-208-9565.

PRIOR AUTHORIZATION

COVERED SERVICES that require **PRIOR AUTHORIZATION** are identified by (PA) in the Benefit Overview at the beginning of this document.

- **When you receive services from NETWORK PROVIDERS:** They are responsible for obtaining **PRIOR AUTHORIZATION** on your behalf for COVERED SERVICES they provide to you.

- **When you receive services from Non-NETWORK PROVIDERS:** You are responsible for making sure PRIOR AUTHORIZATION is obtained when PA is required. If you receive services that we (or our designee) determine are not COVERED SERVICES, you will be responsible for the cost of these services.

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

INPATIENT NOTIFICATION

INPATIENT NOTIFICATION is a process that makes TUFTS HEALTH PLAN aware of all INPATIENT admissions and transfers to another hospital. We will evaluate the anticipated hospital stay. We may also review your proposed medical care and/or verify Medical Necessity. We 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 PROVIDERS is responsible for notifying TUFTS HEALTH PLAN on your behalf.

- **When you receive services from a Non-NETWORK HOSPITAL:** You are responsible for making sure that TUFTS HEALTH PLAN is notified when you have an inpatient admission or transfer. If you receive services that we (or our designee) determine are not COVERED SERVICES, you will be responsible for the cost of these services.

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

We ask that you or someone acting for you (such as a family member or the attending PROVIDER) call us within 48 hours.

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.

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

- 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.

COVERED SERVICES

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

<u>**Notes**</u>:

- For information about your COST SHARING AMOUNTS (DEDUCTIBLE, COPAYMENTS and/or COINSURANCE) see the “Benefit Overview”. See “Benefit Limits” for any benefit limitations. Both sections can be found at the beginning of this document.
  - Please note that your coverage level for **preventive services** will be different from **diagnostic procedures**:
  - **Preventive care services** described in the ACA guidelines, including women’s preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the In-Network Level of Benefits. For more information, see “Preventive screenings” in the Benefit Overview at the beginning of this document.
  - You may need to pay a COST SHARING AMOUNT for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic procedures & exams" in the Benefit Overview at the beginning of this document.

EMERGENCY care

- Care for an EMERGENCY in an EMERGENCY room;
- Care for an EMERGENCY in a PROVIDER's office.

<u>Notes</u>:

- 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-TUFTS HEALTH PLAN PROVIDER. If you receive a bill, please call Member Services or see "Bills from Providers" later in this CERTIFICATE OF INSURANCE for more information on what to do if you receive a bill.

OUTPATIENT care

Allergy testing, treatment, and allergy injections

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

Autism spectrum disorders - diagnosis and treatment for CHILDREN under age 15

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:

- Applied behavioral analysis services (ABA)*, supervised by a Board-Certified Behavior Analyst (BCBA) who is a licensed health care clinician. For more information about these services, call the TUFTS HEALTH PLAN Behavioral Health Department at 1-800-208-9565.
- Prescription medications: See the prescription drug benefit later in this chapter.
- Psychological and psychiatric care: See the behavioral health and substance use disorder benefit for COVERED SERVICES.
- Speech, physical and occupational therapy services are provided by licensed or certified therapists. There are no visit limits when services are provided under this autism spectrum disorders benefit..*

Note: Refer to the "Speech, physical and occupational therapy services" benefit later in this chapter for therapy services provided to treat conditions other than autism spectrum disorder.

*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.

Cardiac rehabilitation services

OUTPATIENT treatment of documented cardiovascular disease.

We cover only the following services:

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

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

Chemotherapy

Also see “Injectable, infused or inhaled medications” listed later in this chapter.

Diabetes 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 “DURABLE MEDICAL EQUIPMENT under "Other Health Services" 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 (PA)

Coverage includes

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

Diagnostic Tests (PA)

Diagnostic tests, including but are not limited to ambulatory EKG testing, sleep studies, and diagnostic audiological testing, are covered. Please call Member Services with questions about specific tests.

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.

Family planning

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.

Hemodialysis

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

Human leukocyte antigen testing or histocompatibility locus antigen testing

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. Includes costs of testing for A, B or DR antigens. 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.

Covered Services, continued

Infertility services

Rhode Island law mandates coverage for the diagnosis and treatment of Infertility, as well as standard fertility-preservation services when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

(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. 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)

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.

For more information, please call Member Services and see the Medical Necessity Guideline "Infertility Services-Rhode Island" on our Web site

(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 and see the Medical Necessity Guideline for "Preimplantation Genetic Diagnosis" on our Web site

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. Your plan includes prescripttion drug coverage. See the "Prescription Drug Benefit" section in this chapter for information about drug therapy benefit levels.

Laboratory tests

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

Important notes:

- Lab tests must be ordered by licensed physician, physician assistant, or nurse practitioner; and
- Lab tests must be performed at a licensed laboratory.
- Prior authorization (PA) is required for certain laboratory tests (e.g., genetic testing).).
- 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.
- Member cost-sharing will apply to diagnostic laboratory tests when they are ordered as part of a preventive services visit. For more information about which laboratory services are considered preventive, please see our website at: http://www.tuftshealthplan.com/providers/pdf/payment_policies/preventive_services.pdf.

Lead Screenings

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

Lyme Disease

MEDICALLY NECESSARY diagnostic testing and, to the extent not covered under a Prescription Drug Benefit, long-term antibiotic treatment of chronic Lyme disease. Treatment for Lyme disease otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, EXPERIMENTAL or INVESTIGATIVE.

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.

Notes:

- See **"Important note about Preventive Services"** later in this chapter for more information about preventive services.
- Weight loss programs and clinics are not covered

Office visits to diagnose and treat illness or injury

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

Note: See “Diagnostic imaging” and “Diagnostic tests and laboratory services” for coverage of services associated with these office visits.

Oral health services

The following oral services are covered. 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

Important Note: PRIOR AUTHORIZATION is required for Non-EMERGENCY oral health services performed in an INPATIENT or DAY SURGERY setting.

- Hospital, PROVIDER, and surgical charges for the following conditions:
  - Surgical treatment of skeletal jaw deformities; or
  - Surgical treatment for Temporomandibular Joint Disorder (TMJ).
- In certain specific instances, the costs of INPATIENT services and DAY SURGERY for certain additional oral health services are covered. For these services (see chart below) to be covered, the following clinical criteria must be met:
  - the MEMBER cannot safely and effectively receive oral health services in an office setting because of a specific and serious nondental organic impairment (An example of this is hemophilia.), AND
  - the MEMBER requires these services in order to maintain his/her health (Also, the services cannot be cosmetic or EXPERIMENTAL).

If you meet the criteria above and require these services	**THEN you are covered for:**
Surgical removal of impacted teeth when embedded in bone.	Hospital, PROVIDER, and surgical charges.
Extraction of 7 or more permanent teeth during one visit.	Hospital, PROVIDER, and surgical charges.
Surgical removal of unerupted teeth when embedded in bone.	Hospital, PROVIDER, and surgical charges.
Any other non-covered dental procedure that meets the above criteria.	Hospital charges only.

Please see instructions at the beginning of this chapter about how to view go to our Web site at to view Medical Necessity guidelines on our Web site. See guideline “Dental Procedures Requiring Hospitalization.” Or, you may call Member Services.

OUTPATIENT surgery in a PROVIDER'S office

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 and as required by Rhode Island General Laws Section § 27-38.1. This includes coverage for hearing screenings in accordance with state and federal law.

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 AMOUNT.

Preventive Screenings and Diagnostic Procedures & Exams

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 Web site at:

https://www.tuftshealthplan.com/documents/employers/health-wellness/list-of-preventive-services
OR
https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services

- Diagnostic services are subject to MEMBER COST SHARING AMOUNTS.

For these Cost Sharing Amounts, see the Benefit Overview at the beginning of this document.

Preventive screenings compared to diagnostic procedures & exams

Coverage for preventive screenings:

The following routine screenings and exams are covered in full when provided by a NETWORK PROVIDER. For more information about preventive services, see "**Important Information about Preventive Services"** above.

- Preventive screenings for colon or colorectal cancer. (Examples include colonoscopy and sigmoidoscopy screenings).
- Routine annual cytology (Pap smear) examinations.
- Routine mammograms.
- Routine prostate and colorectal examinations and laboratory.

Coverage for diagnostic procedures & exams:

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.

Radiation therapy

Respiratory therapy and pulmonary rehabilitation services

Speech, Physical and Occupational therapy services

(including rehabilitative services and HABILITATIVE Services)
Coverage is also provided for HABILITATIVE services that are MEDICALLY NECESSARY as required by state and federal law. Coverage is provided for rehabilitative services when provided to restore function lost or impaired as the result of an accidental injury or sickness and include cognitive rehabilitation and retraining.

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

- provided by a licensed physical therapist; and
- in compliance with TUFTS HEALTH PLAN's MEDICAL NECESSITY guidelines.

Notes:

- The COST SHARING AMOUNT and coverage limits for this benefit are included in the Benefit Overview and Benefit Limit sections earlier in this CERTIFICATE OF INSURANCE.
- This benefit limit does not apply to speech, physical or occupational therapy provided in conjunction with a PROVIDER's approved home health care plan

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 within the “Prescription Drug Benefit” section later in this chapter.

Spinal manipulation

Manual manipulation of the spine.

Telemedicine services

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

Telemedicine Services may be obtained from a TUFTS HEALTH PLAN NETWORK PROVIDER with real-time interactive capabilities or through TUFTS HEALTH PLAN's designated telemedicine vendor. For additional information on the TUFTS HEALTH PLAN telemedicine vendor and how to access those services please visit teladoc.com/tuftshealthplan or contact Member Services.

When you obtain Telemedicine Services from a TUFTS HEALTH PLAN NETWORK PROVIDER you will pay the same COST SHARING AMOUNT that applies to an in-person office visit with that PROVIDER. When you access Telemedicine Services through the TUFTS HEALTH PLAN telemedicine vendor, you will pay the COST SHARING AMOUNT for Telemedicine Services listed in the Schedule of Benefits.

Additionally, at your choice, audio only consultation services may be available to you when obtained through the TUFTS HEALTH PLAN telemedicine vendor. If you access such audio only consultation services, the same COST SHARING AMOUNT as indicated for Telemedicine services in the Schedule of Benefits will apply.

URGENT CARE in an urgent care center

Vision care services

- Routine eye examination for MEMBERS : Coverage is provided for one routine eye examination every 01 year .
  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: Coverage is provided for eye examinations and necessary treatment of a medical condition. Note: Eyeglass lenses and standard frames will be covered following a MEMBER's cataract surgery or other surgery to replace the natural lens of the eye, when the MEMBER does not receive an intraocular implant. See the Benefit Overview at the beginning of this document for any Cost Sharing Amount applicable to these lenses and frames.

DAY SURGERY

Also called ambulatory surgery or surgical day care.

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

INPATIENT Care

Note: For all Inpatient care, see **Important Information about PRIOR AUTHORIZATION and INPATIENT NOTIFCATION** at the beginning of this chapter.

Acute Hospital services

(PA)

- 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

Extended Care Services

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

- SKILLED nursing services;
- Rehabilitative services; or
- Chronic disease services.

Note: CUSTODIAL CARE is not covered.

Gender reassignment surgery and related services

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.

Hematopoietic stem cell transplants, and human solid organ transplants

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 up to 10 searches for donors not related by blood. PRIOR AUTHORIZATION is required for additional donor search expenses for unrelated donors.
- We cover a MEMBER's human leukocyte antigen (HLA) testing. See “OUTPATIENT medical care” for more information.

Reconstructive surgery and procedures and mastectomy surgeries, surgery to treat functional deformity or impairment
(PA)
Coverage is provided for the cost of:
- Services required to relieve pain or to restore a bodily function impaired as a result of: a congenital defect; birth abnormality; traumatic injury; or a covered surgical procedure;
- the following services in connection with mastectomy:
  - Surgical procedures known as a mastectomy;
  - 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).

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.

Note: Breast prostheses are covered as described under “Prosthetic devices” in this chapter.
- Removal of a breast implant. This is covered when:
  - the implant was placed post-mastectomy;
  - there is documented rupture of a silicone implant;
  - there is documented evidence of auto-immune disease or infection.

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

Note: Cosmetic surgery is not covered.

Maternity Care

(No PCP referral required.)

- 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.

Notes:

  - No prior authorization is needed for the minimum hospital stay. There is no requirement that the mother give birth in a hospital to qualify for this minimum stay. Hospital length of stay begins at the time of delivery if childbirth occurs in the hospital. For childbirth that occurs outside the hospital, the length of stay begins at time of admission.
  - 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

Upon discharge:

  - COVERED SERVICES includes: one home visit by a registered nurse, physician, or certified nurse midwife; and additional MEDICALLY NECESSARY home visits, when provided by a licensed health care provider. This 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

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.

Note: 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.

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.

Behavioral Health Services (OUTPATIENT, INPATIENT, and Intermediate)

OUTPATIENT behavioral health treatment services

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

Notes:

- Psychopharmacological services and neuropsychological assessment services are covered under "Office visits to diagnose and treat illness or injury" .
- PRIOR AUTHORIZATION is required for psychological testing and neuropsychological assessment services

.

Behavioral Health Services (OUTPATIENT, INPATIENT, and Intermediate), continued

Note: See **Important Information about PRIOR AUTHORIZATION and INPATIENT NOTIFICATION** at the beginning of this chapter.

INPATIENT and intermediate behavioral health treatment services

(PA)

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 mental health care 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;
- intensive OUTPATIENT programs;
- acute residential treatment* (longer term residential treatment is not covered);
- adult intensive services (AIS)*.
- crisis stabilization;
- day treatment/partial hospital programs;

Note: *TUFTS HEALTH PLAN covers adult intensive services approved by us and that meet our criteria for participation. AIS is a facility-based behavioral health care program. Adult intensive services are primarily based in the home for qualifying adults with moderate to severe psychiatric conditions. This program must consist of, but is not limited to, the following:

- ongoing EMERGENCY or crisis evaluations available 24 hours a day, 7 days a week;
- psychiatric assessment;
- medication evaluation and management;
- case management;
- psychiatric nursing services; and
- individual, group, and family therapy.

Under this AIS program, a PROVIDER must provide a minimum of six contact hours per week.

Important Note: Intermediate mental health care services must be obtained at a NETWORK PROVIDER to be covered at the IN-NETWORK LEVEL OF BENEFITS. See “INPATIENT Mental Health and Substance use disorder services” for more information.

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

(Note: Treatment for the use of tobacco or caffeine is not covered under these substance use disorder services benefits.)

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

(PA)

Note: See I**mportant Information about PRIOR AUTHORIZATION and INPATIENT NOTIFICATION** at the beginning of this chapter.

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

Intermediate services for substance use disorder services that are more intensive than traditional OUTPATIENT substance use disorder services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate substance abuse services are partial hospital programs intensive OUTPATIENT programs.

Other health services

Ambulance services

- Ground, sea, and helicopter ambulance transportation for EMERGENCY care.
- Airplane ambulance services (An example is Medflight,)*
- Non-EMERGENCY, MEDICALLY NECESSARY ambulance transportation between covered facilities. *
- Non-EMERGENCY ambulance transportation. This is covered for MEDICALLY NECESSARY care when the medical condition prevents safe transportation by any other means.*
  *Approval by an AUTHORIZED REVIEWER may be required for these services.

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.

DURABLE MEDICAL EQUIPMENT

Equipment must meet the following definition of "DURABLE MEDICAL EQUIPMENT":

DURABLE MEDICAL EQUIPMENT is a device or instrument of a durable nature that:

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

In order to be eligible for coverage, the equipment must also be the most appropriate 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.

TUFTS HEALTH PLAN may decide that equipment is: (1) non-medical in nature; and (2) used primarily for non-medical purposes. (This may occur even though that equipment has some limited medical use.) In this case, the equipment will not be considered DURABLE MEDICAL EQUIPMENT. It will not be covered under this benefit.

The following are examples of covered and non-covered items. They are for illustration only. Call a *CARELINK*Member Services to see if we cover a certain piece of equipment.

DURABLE MEDICAL EQUIPMENT, continued

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.

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;
- bed-related items, including bed trays, bed pans, bed rails, over-the-bed tables, and bed wedges;
- car seats;
- car/van modifications;
- comfort or convenience devices;
- dentures;
- ear plugs;
- exercise equipment and saunas;
- fixtures to real property. Examples are ceiling lifts, elevators, ramps, stair lifts, or stair climbers;
- orthoses and prosthetics devices (see "orthoses and prosthetics devices" for information about these COVERED SERVICES.) ;
- heating pads, hot water bottles, and paraffin bath units;
- 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;
-
- breast prostheses and prosthetic arms and legs. Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Orthoses and prosthetic devices" benefit.

Covered Services, continued

Hearing Aids

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

Home health care

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. Coverage includes:

- home visits by a CARELINK 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:

- Home health care services for speech, physical and occupational therapies may follow an injury or illness.
- The services are only covered to the extent provided to restore function lost or impaired. This is described under "Speech, physical and occupational therapy services." These home health care services are not subject to the rehabilitation visit limits listed under "Speech, physical and occupational therapy services"

Hospice care services

We will cover the following services for MEMBERS who are terminally ill (This means a life expectancy of 6 months or less.):

- PROVIDER services;
- Nursing care provided by or supervised by a registered professional nurse;
- Social work services;
- Volunteer services; and
- Counseling services (This includes bereavement counseling services for the MEMBER's family. This applies for up to one year after the MEMBER's death.)

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

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

Injectable, infused, or inhaled medications

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

Notes:

- 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 CARELINK Member Services or see our Web site 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 Web site as covered under a TUFTS HEALTH PLAN pharmacy benefit are not covered under this "Injectable, infused, or inhaled medications" benefit. For more information, call CARELINK Member Services. Or, check our Web site at **www.tuftshealthplan.com**.

Medical supplies

We cover the cost of certain types of medical supplies from an authorized vendor, including:

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

Notes:

- These medical supplies must be obtained from a vendor that has an agreement with us to provide such supplies. Contact a Member Specialist with coverage questions.

New therapies for cancer or other life-threatening diseases or conditions (approved clinical trials)

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 "Treatment in a Provider's office"
- For surgical procedures see "INPATIENT Services"
- For lab, radiology, and machine tests see "Laboratory Tests" and "Diagnostic Imaging".
- For prescription drugs, see "Prescription Drug Benefit"

In a clinical trial, this CERTIFICATE OF INSURANCE 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.

Orthoses and prosthetic devices

We cover the cost of orthoses and prosthetic devices (including repairs.) This includes coverage of breast prostheses as required by federal law. This includes 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.*

*Important Note: Breast prostheses provided in connection with a mastectomy are not subject to PRIOR AUTHORIZATION.

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. This benefit is limited. See Benefit Limits in the Benefit Overview at the beginning of this document.

Special medical formulas

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

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.

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;
- "CARELINK 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 "CARELINK Pharmacy Management Programs" section below and are:

- listed below under "What is Covered";
- provided to treat an injury, illness, or pregnancy;
- MEDICALLY NECESSARY; and

We have a current list of covered drugs. See our Web site 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 .

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 Web site. Also, see our Web site 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 Web site. Also, see our Web site 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 "CARELINK PHARMACY MANAGEMENT PROGRAMS" described below.

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 Web site at www.tuftshealthplan.com.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once the same 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 Web site at **www.tuftshealthplan.com**.
- Prescription medications when packaged with non-prescription products.
- Oral non-sedating antihistamines.

CARELINK 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:

CARELINK 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 AUTHORIZATION Program:

CARELINK 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 AUTHORIZATION 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:

CARELINK'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 web site at www.tuftshealthplan.com.

New-To-Market Drug Evaluation Process:

CARELINK'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.

IMPORTANT NOTES

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 "CARELINK's Pharmacy Management Programs" above.

Prescribers may submit a formulary exception request to CARELINK'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:

CARELINK's Pharmacy Utilization Management Department 705 Mt Auburn St Watertown, MA 02472.

An exception request may be submitted for any of our pharmacy programs: Prior Authorization, Step Therapy Prior Authorization, Quantity Limitations, New-to-Market, or Non-covered drugs with Suggested Alternatives.

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 Medical Necessity Guidelines. Please see the definition of MEDICAL NECESSITY in Appendix A: Glossary and Terms and Definitions for an explanation of how we develop our Guidelines.

We will notify you and your PROVIDER about our decision.

* If the request for a non-covered drug is approved, a tier-3 copayment for the medication will apply.
* If the request for coverage of a drug under another program is approved, a tier copayment will be assigned as appropriate.

* If the 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 705 Mt. Auburn St. P.O. Box 9193 Watertown MA 02471-9193

In person, come to Tufts Health Plan at the address above.

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 Web site 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 Web site at www.tuftshealthplan.com. You can also call Member Services at 1-800-682-8059.

Filling Your Prescription

Where to fill prescriptions:

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

- When you fill a prescription, provide your MEMBER ID to any CARELINK 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 CARELINK Member Services Department.

Important: If you fill a prescription at a non-CARELINK designated pharmacy, call CARELINK. 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, CARELINK 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 CARELINK designated mail services pharmacy.

*These drugs may not be available to you through a CARELINK 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.

Exclusions from Benefits

TUFTS HEALTH PLAN will not pay for the following services, supplies, or medications:

- A service, supply or medication which is not MEDICALLY NECESSARY.
- A service, supply or medication which is not a COVERED SERVICE.
- A service, supply or medication received outside the NETWORK CONTRACTING AREA, except as described under “How the Plan Works” in Chapter 1.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person’s, personal comfort or convenience.
- A service, supply, or medication that is obtained outside of the 50 United States. The only exception to this rule is for EMERGENCY care services, or Urgent Care services while traveling which qualify as COVERED SERVICES when provided outside of the 50 United States.
- CUSTODIAL CARE.
- Services related to non-COVERED SERVICES. This does not apply to complications related to pregnancy terminations.
- A drug, device, medical treatment or procedure (collectively "treatment") that is EXPERIMENTAL OR INVESTIGATIVE.

This exclusion does not apply to the following in accordance with requirements under Rhode Island and federal law:

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

A treatment may be EXPERIMENTAL OR INVESTIGATIVE. In this case, we will not pay for any related treatments provided to the MEMBER for the purpose of furnishing the EXPERIMENTAL OR INVESTIGATIVE treatment.

- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter. Laboratory tests ordered by a MEMBER (online or through the mail), even if performed at a licensed laboratory.
- The following exclusions apply to services provided by the relatives of a MEMBER
  - Services provided by a relative who is not a PROVIDER are not covered;
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a PROVIDER, are not covered.
  - If you are a PROVIDER, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise MEDICALLY NECESSARY. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay. Services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.

- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a PROVIDERS may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the DIRECTORY OF PROVIDERS to see if your PROVIDER charges such a fee.
- Charges incurred when the MEMBER, for his or her convenience, chooses to remain an INPATIENT beyond the discharge hour.
- Facility charges or related services if the procedure being performed is not a COVERED SERVICES, except as provided under “Oral health services” earlier in this chapter.
- Preventive dental care.
- The following dental care services, treatments, and supplies: periodontal treatment; orthodontia, even when it is an adjunct to other surgical or medical procedures; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under “Oral health services” earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea, as described in this chapter), including those for TMJ disorders. TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies, are not covered.
- Surgical removal or extraction of teeth, except as provided under "Oral health services" as described earlier in this chapter.
- Cosmetic (This means to change or improve appearance.) surgery, procedures, supplies, medications or appliances, except as provided under “Reconstructive surgery and procedures” earlier in this chapter.
- Rhinoplasty, except as provided under “Reconstructive surgery and procedures” earlier in this chapter; liposuction; the removal of tattoos and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.
- Hair removal (e.g., electrolysis, laser hair removal), except when MEDICALLY NECESSARY to treat an underlying skin condition,. or for skin preparation for gender reassignment genital surgery that has been approved by an AUTHORIZED REVIEWER.
- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcisions performed in any setting other than a hospital, DAY SURGERY, or a PROVIDER's office.
- 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; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days) sperm or embryo cryopreservation unless the MEMBER is in active infertility treatment; costs associated with donor recruitment and compensation; and 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.

Note: We may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a MEMBER's future fertility. PRIOR AUTHORIZATION is required for these services.

- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the MEMBER is the sole recipient of the donor’s eggs. PRIOR AUTHORIZATION is required for these services.
- Reversal of voluntary sterilization.
- Over-the-counter contraceptive agents except as described earlier in this chapter .

- the purchase of an electric hospital-grade breast pump; donor breast milk.
- Human organ transplants, except as described earlier in this chapter.
- Services provided to a non-MEMBER, except as described earlier in this chapter for:
  - organ donor charges under "Human organ transplants";
  - bereavement counseling services under “Hospice care services”; and
  - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs or banking of donor sperm or inseminated eggs under “Infertility services” (This is to the extent such costs are not covered by the donor’s health coverage, if any.)
- Acupuncture.
- Spinal manipulation services.
- Biofeedback, except for the treatment of urinary incontinence;
- hypnotherapy;
- psychoanalysis;
- TENS units or other neuromuscular stimulators and related supplies;
- INPATIENT and OUTPATIENT weight-loss programs and clinics; relaxation therapies; services by a personal trainer; exercise classes. Also excluded are diagnostic services related to any of these procedures or programs.
- Nutritional counseling, except as described earlier in this chapter.
- Massage therapies, cognitive rehabilitation programs and cognitive retraining programs are excluded except as described under "Speech, physical and occupational therapy services" earlier in this chapter.
- Any service, program, supply or procedure performed in a non-conventional setting (This includes, but is not limited to, spas/resorts, educational, vocational, or recreational settings, daycare or preschool settings, Outward Bound, or wilderness, camp or ranch programs). This is the case even if the services, programs, supplies or procedures are performed or provided by licensed PROVIDERS, such as mental health professionals, nutritionists, nurses or physicians. Some examples of services that may be excluded if they are performed in a non-conventional setting are psychotherapy, and nutritional counseling.
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the “Note” below.

  Note: The following blood services and products are covered:
  - blood processing;
  - blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (PRIOR AUTHORIZATION is required for these services.);
  - intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (PRIOR AUTHORIZATION is required for these services. See "Important Notes" earlier in this chapter).
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational purposes. 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.
- Eyeglasses, lenses or frames, except as described under "DURABLE MEDICAL EQUIPMENT" 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 HEALTH PLAN will not pay for contact lenses or contact lens fittings.

- 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.
- Transportation, including, but not limited to, transportation by chair car, taxi, or wheelchair van, except as described in “Ambulance services” in this chapter.
- Lodging related to receiving any medical service.
- Externally powered exoskeleton assistive devices and orthoses.
- All Non-Conventional Medicine services, provided independently or together with conventional medicine, AND all related testing, laboratory testing, services, supplies, procedures, and supplements associated with this type of medicine.
- Private duty nursing (block or non-intermittent nursing).

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; oryou lose eligibility because you no longer meet your GROUP's or TUFTS's HP 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.)

*Note: CHILDREN are not required to live, work or reside in the NETWORK CONTRACTNG AREA. In addition there are a few exceptions in which DEPENDENTS are still eligible for coverage even if they live, work or reside outside the NETWORK CONTRACTING AREA. However, coverage outside of the NETWORK CONTRACTING AREA is only covered at the OUT-OF-NETWORK LEVEL OF BENEFITS. 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 not 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 and converted plans

Once your coverage ends, you may be eligible to continue your coverage with your GROUP. Or, you may be able to enroll in a converted coverage plan. See Chapter 5 for more information.

When a MEMBER is No Longer Eligible

Loss of eligibility

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

Important Note: Your coverage will terminate retroactively. 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 AREA is only available at the OUT OF NETWORK LEVEL OF BENEFITS.

Before you no longer live, work or reside in the NETWORK CONTRATING AREA, tell your GROUP or call a Member Specialist before you no longer live, work or reside there to notify TUFTS HEALTH PLAN .

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.

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;
- 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

We will pay for all COVERED SERVICES you received between:

- 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.

The PREMIUM may be more than is needed to pay for COVERED SERVICES you received after your termination date. In this case, 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.

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

You may transfer from TUFTS HEALTH PLAN to any other health plan offered by your GROUP only:

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

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

Chapter 5--Continuation of GROUP CONTRACT Coverage 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.

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.

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 Web site (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 Web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact your GROUP.

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 CARELINK for you. CARELINK 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 CARELINK (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 CARELINK. If you are responsible for any portion of the hospital bill, CARELINK will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the Non-NETWORK HOSPITAL.

OUTPATIENT Medical Expenses

When you receive care from a NON-NETWORK PROVIDER, you are responsible for completing claim forms. (Check with the NON-NETWORK PROVIDER to determine if he or she will submit the claim directly to CARELINK. If not, you must submit the claim form directly to CARELINK yourself.)

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

If you do not sign the appropriate section on the claim form, CARELINK will make the appropriate payment directly to you. If you have not already 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, CARELINK will send you an explanation of benefits statement. The explanation of benefits statement will tell you how much you owe the NON-NETWORK PROVIDER.

To Get Claim Forms

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

Where to Forward Medical Claim Forms

Send completed claim forms to:

TUFTS HEALTH PLAN
Claims Department
P.O. Box 9185
Watertown, MA 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 CARELINK Member Specialist or through our web site at www.tuftshealthplan.com/cignathp.

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.

MEMBER Satisfaction Process

CARELINK has a multi-level MEMBER Satisfaction Process including:

- Internal Inquiry;
- MEMBER Grievance Process;
- Internal MEMBER Appeals; and
- External Review by an External Appeals Agency designated by the Rhode Island Office of the Health Insurance CommissionerDepartment

Mail all grievances and appeals to us at:

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

You can also call CARELINK Member Services at 1-866-352-9114 or submit your grievance or appeal in person at the address listed above.

Internal Inquiry:

Call a CARELINK 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 CAERLINK or a NETWORK PROVIDER. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact 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 CARELINK 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 CARELINK 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.

Administrative Grievances

An administrative grievance is a complaint about a CARELINK 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 CARELINK.

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 CARELINK 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.

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 CERTIFICATE.

It is important that you contact CARELINK as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage, claim payment. Appeals may be filed either verbally or in writing. You may file a verbal appeal. To do this, call a CARELINK 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 CARELINK MEMBER ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and PROVIDER names; and
- any supporting documentation.

MEMBER Satisfaction Process, continued

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
- We will review your appeal, make a decision, and send you a decision letter within thirty (30) calendar days of receipt.

Note: 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 CARELINK medical information relevant to your appeal. You must sign and return the form to us before CARELINK 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, CARELINK 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 CARELINK.

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 CARELINK 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; CARELINK 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

CARELINK recognize that there are circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. CARELINK will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. We may also process an appeal for a non-covered drug with a quicker turnaround.

Additionally, CARELINK 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 CARELINK Member Services. Under these circumstances, you will be notified of CARELINK's decision as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after the review is initiated.

External Review

CARELINK provides for an independent external review by an external appeal agency for final adverse determinations. These are decisions based on medical necessity. The Rhode Island Office of the Health Insurance Commissioner has designated two external appeal agencies who perform independent reviews of final adverse medical necessity decisions. These are not connected in any way with CARELINK. Note that appeals for coverage of services excluded from coverage under your plan are not eligible for review.

There is no fee for filing an external appeal and there is no minimum dollar amount of the claim in order to be afforded an external appeal. To initiate this external appeal, you must send a letter to us within four months of the receipt of your internal appeal adverse determination letter. In that letter, you must include any additional information that you would like the external review agency to consider.

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.

Within six (6) business 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 external appeal agency. The external appeal agency shall provide notice to you and your Provider of record of the outcome of the external appeal. within 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

The external review shall be based on the following:

- the review criteria used by CARELINK 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.

The decision of the external appeals agency is binding. However, any person who is aggrieved by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

If the external appeals agency overturns TUFTS HEALTH PLAN’s appeal decision, we will send you a written notice within five (5) business days of receipt of the written decision from the appeal agency. This notice will:

- include an acknowledgement of the decision of the agency;
- 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 the payment will be made or the authorization for services will be issued by CARELINK; and
- include the name and phone number of the person at CARELINK who will assist you with final resolution of the appeal.

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 CARELINK 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 web site. You can also get one by contacting the CARELINK 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 CARELINK regarding your bill(s) or send your bill(s) to CARELINK 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.

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.

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

Notice to Michigan Residents

Tufts Health Plan will promptly process a complete and proper claim for Covered Services made by a Member. However, in the event there are delays in processing claims, the Member shall have no greater rights to interest or other remedies against Tufts Health Plan's third party administrator, Tufts Benefit Administrators, Inc., than as otherwise afforded to him or her by law.

Limitation on Actions

You cannot 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.

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

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.

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.

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.

Coordination of This GROUP CONTRACT's Benefits with Other Benefits Applicability, continued

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.

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.

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*.* The benefits of the plan which covers the person as an employee, MEMBER or SUBSCRIBER (that is, other than as a DEPENDENT) are determined before those of the plan which covers the person as a DEPENDENT.

(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.

However, if the other plan does not have the rule described in (a) immediately above, but instead has the rule based upon the gender of the patient, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) DEPENDENT CHILD/Separated or Divorced. If two or more plans cover a person as a DEPENDENT CHILD of divorced or separated parents, benefits for the CHILD are determined in this order:

(a) First, the plan of the parent with custody of the CHILD;

(b) Then, the plan of the SPOUSE of the parent with the custody of the CHILD; and

(c) Finally, the plan of the parent not having custody of the CHILD.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the CHILD, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above in Paragraph B(2) of this section.

(5) 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.

(6) 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.

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. 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".

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.

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.

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 Web site 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 CERTIFICATE; or
- assume or create any obligation for TUFTS HEALTH PLAN.

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

Circumstances beyond TUFTS HEALTH PLAN's Reasonable Control

TUFTS HEALTH PLAN shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond 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 CERTIFICATE.

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.

Changes to this CERTIFICATE

We may change this CERTIFICATE. Changes do not require your consent.

An amendment to this CERTIFICATE 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

705 Mount Auburn Street

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 CERTIFICATE. This does not mean that we give up our rights to enforce those terms in the future.

When this CERTIFICATE Is Issued and Effective

This CERTIFICATE is issued and effective on your GROUP ANNIVERSARY DATE on or after January 1, 2019. It supersedes all previous CERTIFICATES.

Appendix A--Glossary of Terms and Definitions

This section defines the terms used in this CERTIFICATE.

ADOPTIVE CHILD

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

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

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

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.

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.

CALENDAR YEAR

The 12-month period in which benefit limits and COINSURANCE are calculated under this plan. Coverage based on a CALENDAR YEAR runs from January 1st through December 31st within a year.

CARELINK

CARELINK is an open access benefit plan insured by TUFTS HEALTH PLAN. In Rhode Island and Massachusetts, and its affiliate, Tufts Benefit Administrators, Inc., are responsible for participating PROVIDER network contracting and maintenance, certain credentialing, PROVIDER services and claims payment, and Member Services for CARELINK MEMBERS. Connecticut General Life Insurance Company and its affiliates, International Rehabilitation Associates, Inc. and CIGNA Behavioral Health, Inc. provide certain administrative services including participating PROVIDER network contracting and maintenance outside of Rhode Island and Massachusetts, medical management, and contracting and maintenance of a behavioral health PROVIDER network.

CERTIFICATE

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

CHILD

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

- The SUBSCRIBER's or SPOUSE's natural 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.

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.

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 CERTIFICATE.

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 (They are subject to the "Exclusions from Benefits" section in Chapter 3.);
- MEDICALLY NECESSARY; and
- provided or authorized by your PCP and in some cases, approved by TUFTS HEALTH PLAN or its designee.

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

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 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.

In cases of mental/behavioral health care or substance use disorder care, INPATIENT care or intermediate care provided primarily:

- for maintaining the MEMBER's or anyone else's safety; or
- for the maintenance and monitoring of an established treatment program,

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

Note: CUSTODIAL CARE is not covered by 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 CERTIFICATE.

(Any amount paid by the MEMBER for a COVERED SERVICE rendered during the last 3 months of a CALENDAR YEAR shall be carried forward to the next CALENDAR YEAR'S DEDUCTIBLE.) . See "Benefit Overview" at the front of this CERTIFICATE for more information.

Note: The amount credited towards the MEMBER's DEDUCTIBLE is based on the NETWORK PROVIDER negotiated rate at the time the services are rendered and does not reflect any later adjustments, payments, or rebates that are 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 separate booklet which lists NETWORK PROVIDERS. It also lists their affiliated NETWORK HOSPITAL(S), and certain other NETWORK PROVIDERS. Note: This directory is updated from time to time to reflect changes in NETWORK PROVIDERS. For information about the PROVIDERS listed in the DIRECTORY OF HEALTH CARE PROVIDERS, you can call CARELINK 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.

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.

HABILITATION

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.

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.

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.

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 COVERAGE

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.

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 CERTIFICATE and any amendments.

INDIVIDUAL COVERAGE

Coverage for a SUBSCRIBER only (no DEPENDENTS).

IN-NETWORK LEVEL OF BENEFITS

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

INPATIENT

A patient who is:

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

MEDICALLY NECESSARY

A service or supply that is:

- 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.

Our Medical Necessity Guidelines are available on our Web site at

https://tuftshealthplan.com/provider/resource-center#///Commercial//

Click on the category you are looking for, such as "Behavioral Health" or "Guidelines".

Resource documents in these categories are listed alphabetically.

Or if you prefer, 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 TUFTS HEALTH PLAN has developed or arranged for a network of PROVIDERS to afford MEMBERS with adequate access to COVERED SERVICES.

NETWORK HOSPITAL

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

NETWORK PROVIDER

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

NON-NETWORK PROVIDER

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 twenty-three (23) 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.

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 CERTIFICATE for detailed information about your OUT-OF-POCKET MAXIMUM.

OUTPATIENT

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

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

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

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.

PRECERTIFICATION

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

PRECERTIFICATION PENALTY

The amount a MEMBER will be required to pay if he or she does not follow the PRECERTIFICATION guidelines described in Chapter 1. The PRECERTIFICATION PENALTY amount does not count toward COINSURANCE, DEDUCTIBLES or the OUT-OF-POCKET MAXIMUM. The PRECERTIFICATION PENALTY is shown in "Benefit Overview" at the front of this CERTIFICATE.

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.

PRIOR AUTHORIZATION

A process we use to decide if a health care service or supply qualifies as a COVERED SERVICE and is MEDICALLY NECESSARY. PRIOR AUTHORIZATION is required before obtaining care for certain COVERED SERVICES. These COVERED SERVICES are identified by (PA) in the Benefit Overview at the beginning of this document. This process is handled by Tufts Health Plan's Chief Medical Officer or someone we designate.

NETWORK PROVIDERs who provide care to you are responsible for obtaining PRIOR AUTHORIZATION when it is required.

When you see a Non-NETWORK PROVIDER, you are responsible for making sure PRIOR AUTHORIZATION is obtained when it is required. If you receive services that we (or our designee) determine are not COVERED SERVICES, you will be responsible for the cost of these services.

To request PRIOR AUTHORIZATION or to confirm that your PROVIDER obtained PRIOR AUTHORIZATION, please call us. For behavioral health and/or substance use disorder services call our Behavioral Health Department 1-800-208-9565. For all other services, call Member Services at 1-800-682-8059.

Also see **Important Information about PRIOR AUTHORIZATION and Inpatient Notification** at the beginning of Chapter 3

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.

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.

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

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.

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.

URGENT CARE CENTER

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

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.

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the 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 publications hotline of 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 Specialist at 1-800-682-8059 for the specifics on how to appoint an authorized claimant.

Types of claims

There are several different types of claims that you may submit for review. TUFTS HEALTH PLAN's procedures for reviewing claims depends upon the type of claim submitted (URGENT CARE claims, pre-service claims, post-service claims, and concurrent care decisions).

URGENT CARE claim: An "URGENT CARE claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your PROVIDER's determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested. For URGENT CARE claims, 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. 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.

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 information on PRECERTIFICATION, contact your plan administrator.

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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

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

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

- Qualifying Exigency Leave: Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the SPOUSE, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
- Military Caregiver Leave: An eligible employee who is the SPOUSE, son, daughter, parent, or next of kin of a covered 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.

NOTICE OF PRIVACY PRACTICES

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

TUFTS HEALTH PLAN1 is committed to safeguarding the privacy of our members' protected health information ("PHI"). PHI is information which:

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

You are receiving this Notice as a member of CareLink. TUFTS HEALTH PLAN and Cigna2 have joined together to offer CareLink.

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

How We Obtain PHI

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

How We Use and Disclose Your PHI

We use and disclose PHI in a number of ways to carry out our responsibilities as a 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 somking 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.

- 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.

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 on 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
705 Mount Auburn Street

Watertown, MA 02472-1508

Effective Date of Notice

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

Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the 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 Web site at www.tuftshealthplan.com. In addition, we will use one of our periodic mailings to inform subscribers about the updated Notice.

Who to Contact for Questions or Complaints

If you would like more information or a paper copy of this Notice, please contact a Member Services Coordinator at the number listed above. You can also download a copy 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

705 Mount Auburn Street

Watertown, MA 02472-1508

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

1TUFTS HEALTH PLAN is the trade name for Tufts Associated Health Maintenance Organization, Inc. It is also a trade name for Total Health Plan, Inc. and Tufts Benefit Administrators, Inc. in each entity's capacity as an administrator for self-funded group health plans; and for Tufts Insurance Company.

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

© Tufts Associated Health Maintenance Organization, Inc. All rights reserved.