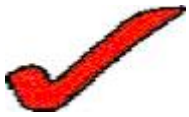
CERTIFICATE OF INSURANCE

Advantage PPO

Tufts Health Plan Network Plan
Underwritten by Tufts Insurance Company



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

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

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

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MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

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

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

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

TUFTS HEALTH PLAN Address And Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
P.O. Box 9170
Watertown, Massachusetts 02471-9170

Hours: Monday through Thursday 8:00 a.m.-7:00 p.m.
Friday 8:00 a.m-5:00 p.m.

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

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

Liability Recovery
Call the TUFTS HEALTH PLAN Liability and Recovery Department at 1-888-880-8699, x. 21098 for questions about coordination of benefits and workers' compensation. For example, call the Liability and Recovery Department if you have any questions about how TUFTS HEALTH PLAN coordinates coverage with other health care coverage that you may have. The Liability and Recovery Department is available from 8:30 a.m. - 5:00 p.m. Monday through Thursday, and 10:00 a.m. - 5:00 p.m. on Friday.

For questions related to subrogation, call a MEMBER Specialist at 1-800-423-8080. If you are uncertain which department can best address your questions, call Member Services.

Member Services Department

Call the TUFTS HEALTH PLAN Member Services Department at 1-800-423-8080 for general questions, benefit questions, and information regarding eligibility for enrollment and billing.
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Mental Health Services
If you need assistance in receiving information regarding mental health benefits, please contact the Mental Health Department at 1-800-208-9565.

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

Telecommunications Device for the Deaf (TDD)
If you have access to a TDD phone, call 1-800-868-5850. You will reach our Member Services Department.

Massachusetts Relay (MassRelay)
1-800-720-3480

IMPORTANT ADDRESSES:
Appeals and Grievances Department
If you need to call us about a concern or appeal, contact a Member Specialist at 1-800-423-8080. To submit your appeal or grievance in writing, send your letter to:

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

Web site
For more information about TUFTS HEALTH PLAN and to learn more about the self-service options that are available to you, please see the TUFTS HEALTH PLAN Web site at www.tuftshealthplan.com.

Translating services for more than 200 languages

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.

Laotianສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

Navajo Doo b33h il7n7 da Din4 k'ehj7 1ln4ehgo, hodiilnih b44sh bee han7'4 bee n44 ho'd7lzingo nantin7g77 bik11'.

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.

DISCRIMINATION IS AGAINST THE LAW

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.

CERTIFICATE OF INSURANCE

This booklet is your CERTIFICATE OF INSURANCE for health benefits underwritten by Tufts Insurance Company ("TIC"). TIC has entered into an agreement with Tufts Benefit Administrators ("TBA") for TBA to administer the health benefits and make available a network of PROVIDERS described in this CERTIFICATE. Both TIC and Tufts Benefit Administrators ("TBA") do business under the name of TUFTS HEALTH PLAN ("TUFTS HP").

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

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

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.

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

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

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

PLEASE READ THIS CERTIFICATE OF INSURANCE CAREFULLY.

NOTICE TO SUBSCRIBERS ENROLLED IN INDIVIDUAL CONTRACTS (not applicable to plans obtained through an employer)

10-Day Right to Examine and Return this INDIVIDUAL CONTRACT

Please read this INDIVIDUAL CONTRACT. If you are not satisfied, you may return the INDIVIDUAL CONTRACT within 10 days after you received it. Mail or deliver it to TUFTS HEALTH PLAN. Any PREMIUMS you have paid will be refunded to you. This INDIVIDUAL CONTRACT will then be void from its EFFECTIVE DATE.

Contract and Benefit Information

This table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of COVERED SERVICES, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COINSURANCE
● **IN-NETWORK:** Except as described in the COVERED SERVICES section of Chapter 3, there is no COINSURANCE for COVERED SERVICES provided by a NETWORK PROVIDER.
● **OUT-OF-NETWORK:** Except as described in this Benefit Overview and the COVERED SERVICES section of Chapter 3, we pay 80% of the REASONABLE CHARGE for all COVERED SERVICES provided in the 50 United States by a NON-NETWORK PROVIDER. The MEMBER pays the remaining 20%. The MEMBER is also responsible for any charges in excess of the REASONABLE CHARGE.

COPAYMENTS	
● **EMERGENCY Care (IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS):**	
● EMERGENCY room	$300.00 COPAYMENT

Note:

- An EMERGENCY Room COST SHARING AMOUNTS may apply if you register in an EMERGENCY room but leave that facility without receiving care.
- A DAY SURGERY COPAYMENT may apply if DAY SURGERY services are received.

● **Other COVERED SERVICES (IN-NETWORK LEVEL OF BENEFITS only)**	
● Office Visit (per visit)	$45.00 COPAYMENT

Note: Applies to IN-NETWORK Office Visits for preventive care*, diagnostic cytological exams (Pap Smears), non-routine immunizations, and diagnostic mammograms for the diagnosis and treatment of illness or injury; mental health and substance use disorders; family planning services; diabetes self-management training and educational services; nutritional counseling; health education; visits to a LIMITED SERVICE MEDICAL CLINIC; non-routine OUTPATIENT maternity care (pre-natal and post-partum)**,

and routine eye exam and other vision care.

*including diagnostic tests associated with periodic health exams .

**includes routine laboratory tests associated with routine prenatal care are covered in full, as required by the Affordable Care Act.

● INPATIENT Services	DEDUCTIBLE then $500.00 COPAYMENT
● DAY SURGERY	DEDUCTIBLE then $300.00 COPAYMENT

Notes:

For certain OUTPATIENT services listed as "covered in full" at the IN-NETWORK-LEVEL OF BENEFITS in the table below, you may be charged an Office Visit COPAYMENT when these services are provided in conjunction with an office visit.

In addition, please note that in accordance with the Affordable Care Act (ACA), certain services , including women's preventive health care services, are not subject at the IN-NETWORK-LEVEL OF BENEFITS to a COPAYMENT or DEDUCTIBLE. Please see the following Benefit Overview chart for more information. Also, please note that COPAYMENTS for URGENT CARE services vary depending upon type of PROVIDER (PCP vs. Specialist) and location in which services are rendered (for example, PROVIDER's office, LIMITED SERVICE MEDICAL CLINIC, URGENT CARE CENTER, or EMERGENCY room).

DEDUCTIBLE	
IN-NETWORK:	
● Individual DEDUCTIBLE	$2,500.00 per CALENDAR YEAR.
An Individual DEDUCTIBLE of $2,500.00 applies to each MEMBER for COVERED SERVICES received at the IN-NETWORK LEVEL OF BENEFITS per CALENDAR YEAR.	
● Family DEDUCTIBLE	$5,000.00 per CALENDAR YEAR.
All amounts any enrolled MEMBERS in a family pay toward their Individual DEDUCTIBLES are applied toward the $5,000.00 Family DEDUCTIBLE.	
Once the Family DEDUCTIBLE has been met during a CALENDAR YEAR, all enrolled MEMBERS in a family will thereafter have satisfied their Individual DEDUCTIBLES for the remainder of that CALENDAR YEAR.	
Note: Any amount paid by the MEMBER for a COVERED SERVICE rendered during the last 3 months of a CALENDAR YEARshall be carried forward to the next CALENDAR YEAR's DEDUCTIBLE. However, any DEDUCTIBLE amount carried forward will not be applied to the next CALENDAR YEAR OUT-OF-POCKET MAXIMUM.	

DEDUCTIBLE	
OUT-OF-NETWORK	
● Individual DEDUCTIBLE	$5,000.00 per CALENDAR YEAR.
An Individual DEDUCTIBLE of $5,000.00 applies to each MEMBER for COVERED SERVICES per CALENDAR YEAR.	
● Family DEDUCTIBLE	$10,000.00 per CALENDAR YEAR.
All amounts any enrolled MEMBERS in a family pay toward their Individual DEDUCTIBLES are applied toward the $10,000.00 Family DEDUCTIBLE.	
Once the Family DEDUCTIBLE has been met during a CALENDAR YEAR, all enrolled MEMBERS in a family will thereafter have satisfied their Individual DEDUCTIBLES for the remainder of that CALENDAR YEAR.	
Notes	
● Any amount paid by the MEMBER for a COVERED SERVICE rendered during the last 3 months of a CALENDAR YEAR shall be carried forward to the next CALENDAR YEAR's DEDUCTIBLE. However, any DEDUCTIBLE amount carried forward will not be applied to the next CALENDAR YEAR OUT-OF-POCKET MAXIMUM.	
● A separate OUT-OF-NETWORK DEDUCTIBLE applies to certain pediatric dental care services for MEMBERS under age 19. For more information, see "Pediatric Dental Care Services for MEMBERS under age 19" in Chapter 3.	

OUT-OF-POCKET MAXIMUM

IN-NETWORK:

Individual OUT-OF-POCKET MAXIMUM

An individual OUT-OF-POCKET MAXIMUMS of $7150.00 applies to each MEMBER per CALENDAR YEAR for COVERED SERVICES received at the IN-NETWORK LEVEL OF BENEFITS.

FamilyOUT-OF-POCKET MAXIMUM

All amounts any enrolled MEMBERS in a family pay toward their Individual OUT-OF-POCKET MAXIMUM are applied toward the $14300.00 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 will thereafter have satisfied their Individual OUT-OF-POCKET MAXIMUMS for the remainder of that CALENDAR YEAR.

OUT-OF-POCKET MAXIMUM

OUT-OF-NETWORK

Individual OUT-OF-POCKET MAXIMUM

An individual OUT-OF-POCKET MAXIMUM of $14300.00 applies to each MEMBER per CALENDAR YEAR received at the OUT-OF-NETWORK Level of Benefits.

Family OUT-OF-POCKET MAXIMUM

All amounts any enrolled MEMBERS in a family pay toward their Individual OUT-OF-POCKET MAXIMUMS are applied toward the $28600.00 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 will thereafter have satisfied their Individual OUT-OF-POCKET MAXIMUMS for the remainder of that CALENDAR YEAR.

NOTIFICATION PENALTY

You must pay the NOTIFICATION PENALTY listed below for failure to notify TUFTS HEALTH PLAN of an INPATIENT hospitalization or a tranfer to another hospital in accordance with Chapter 1.

IN-NETWORK LEVEL OF BENEFITS:

There is no NOTIFICATION PENALTY for an INPATIENT hospitalization or a tranfer to another hospital at the IN-NETWORK LEVEL OF BENEFITS. As long as your hospitalization is provided by a NETWORK PROVIDER you are not responsible for notifying TUFTS HEALTH PLAN of the hospitalization or transfer. Your NETWORK PROVIDER will notify TUFTS HEALTH PLAN of the INPATIENT admission or a tranfer for you.

OUT-OF-NETWORK LEVEL OF BENEFITS:

You must pay a NOTIFICATION PENALTY of $300.00 for failure to notify TUFTS HEALTH PLAN of a hospitalization or a tranfer to another hospital at the OUT-OF-NETWORK LEVEL OF BENEFITS in accordance with Chapter 1. For more information, please see "INPATIENT NOTIFICATION" in Chapter 1.

Note: This NOTIFICATION PENALTY cannot be used to meet the DEDUCTIBLES or OUT-OF-POCKET MAXIMUMS described above.

PRE-EXISTING CONDITION LIMITATION

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

Important Note about your coverage under the Affordable Care Act ("ACA"): Under the ACA, preventive care services -- including women's preventive health care services, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription -- are now covered in full. These services are listed in the following Benefit Overview. For more information on what services are now covered in full, please see our Web site at www.tuftshealthplan.com.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
EMERGENCY Care		
Treatment in an EMERGENCY room	$300.00 COPAYMENT	$300.00 COPAYMENT .
You should call TUFTS HEALTH PLAN within 48 hours after EMERGENCY care is received. If you are admitted as an INPATIENT, you or someone acting for you must call your PCP or TUFTS HEALTH PLAN within 48 hours in order to be covered at the IN-NETWORK LEVEL OF BENEFITS. Note: A Day Surgery Copayment may apply if Day Surgery services are rendered.		
Allergy testing and treatment	IN-NETWORK DEDUCTIBLE and then covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Autism spectrum disorders - diagnosis and treatment **(AR)**	Habilitative or rehabilitative care (including applied behavioral analysis): 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 and then Covered in full When provided by a licensed physical or occupational therapist: $45.00 COPAYMENT. (not subject to DEDUCTIBLE) When provided by a licensed speech-language therapist or audiologist: $45.00 COPAYMENT. (not subject to DEDUCTIBLE) Prescription medications: Covered as described under "Prescription Drug Benefit" in Chapter 3.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Cardiac rehabilitation services	IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Chemotherapy	IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Cleft lip and cleft palate treatment and services for CHILDREN See “Cleft lip and cleft palate treatment and services for CHILDREN, under “Other Health Services” later in this table.		
Chiropractic care See "Chiropractic medicine "		
Cytology examinations (Pap smears)	**Routine annual cytology screenings:** Covered in full. (not subject to DEDUCTIBLE) **Diagnostic cytology examinations**: IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Diabetes self-management training and educational service	$45.00 COPAYMENT. (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Diagnostic Imaging **(AR)**	**General imaging:** IN-NETWORK DEDUCTIBLE and $50 COPAYMENT.	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 $250 COPAYMENT. **CT/CTA:** IN-NETWORK DEDUCTIBLE and $250 COPAYMENT. **PET:** IN-NETWORK DEDUCTIBLE and $250 COPAYMENT. **Nuclear cardiology**: IN-NETWORK DEDUCTIBLE and $250 COPAYMENT. **Note:** Diagnostic imaging, except for general imaging, will be covered in full when the imaging is required as part of an active treatment plan for a cancer diagnosis.	
Diagnostic or preventive screening procedures (for example, proctosigmoidoscopies, colonoscopies and sigmoidoscopies are covered under this benefit.)	**Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention:** Covered in full. (not subject to DEDUCTIBLE) **Diagnostic procedure only (for example, colonoscopies associated with symptoms):** IN-NETWORK DEDUCTIBLE and then Covered in full **Diagnostic procedure accompanied by treatment/ surgery (for example, polyp removal)**: IN-NETWORK DEDUCTIBLE and $300 COPAYMENT.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Diagnostic testing **(AR)**	IN-NETWORK DEDUCTIBLE and $50 COPAYMENT.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Early intervention services	Covered in full. (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Family planning (procedures, services and contraceptives)	**Office Visit**: $45.00 COPAYMENT (not subject to DEDUCTIBLE) **Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full. To determine whether a specific family planning service is covered in full or subject to a COST SHARING AMOUNT, please see http://tuftshealthplan.com/employers/pdf/preventive_services_listing.pdf, or call Member Services. **DAY SURGERY**: IN-NETWORK DEDUCTIBLE and $300 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Hemodialysis	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Human leukocyte antigen (HLA) testing	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Immunizations	**Routine preventive immunizations:** Covered in full. (not subject to DEDUCTIBLE) **All other immunizations:** IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Infertility services (AR)	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Laboratory tests **(AR)** Note: In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full at the IN-NETWORK LEVEL OF BENEFITS.	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Lead screenings	Covered in full. (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Lyme disease MEDICALLY NECESSARY diagnosis and treatment of chronic Lyme disease	$45.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Mammograms **(BL)**	**Routine mammograms:** Covered in full. (not subject to DEDUCTIBLE) **Diagnostic mammograms**: IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Nutritional counseling Note: Nutritional counseling services are covered in full at the IN-NETWORK LEVEL OF BENEFITS when they are provided as preventive services, as defined by the U.S. Preventive Services Task Force. Please see "Nutritional Counseling" in Chapter 3 for more information.	$45.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Office visits to diagnose and treat illness and injury **Note:** This includes consultations as well as visits to a LIMITED SERVICE MEDICAL CLINIC that participates with TUFTS HEALTH PLAN.	$45.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Oral health services **(AR)**	**EMERGENCY care in an EMERGENCY room**: $300 COPAYMENT **Office visit:** $45.00 COPAYMENT (not subject to DEDUCTIBLE) **INPATIENT SERVICES**: IN-NETWORK DEDUCTIBLE and $500 COPAYMENT per INPATIENT admission. **DAY SURGERY**: IN-NETWORK DEDUCTIBLE and $300 COPAYMENT	**EMERGENCY care in an EMERGENCY room**: $300 COPAYMENT . **All other services:** OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
OUTPATIENT surgery in a PROVIDER's office	IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions	IN-NETWORK DEDUCTIBLE and then Covered in full.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE.
Pediatric dental care for MEMBERS up to age 19	Please see the "Pediatric dental care for MEMBERS up to age 19" benefit in Chapter 3 for your COST SHARING AMOUNTS.	
Preventive health care for MEMBERS under age 6	Covered in full. (not subject to DEDUCTIBLE) **Note:** ● Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS. ● Member cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your Cost Sharing Amounts for these services, and see our website at www.tuftshealthplan.com for more information about which laboratory services are considered preventive.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Preventive health care for MEMBERS over age 6	Covered in full. (not subject to DEDUCTIBLE) **Note:** ● Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS. ● Member cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your Cost Sharing Amounts for these services, and see our website at www.tuftshealthplan.com for more information about which laboratory services are considered preventive.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Routine annual gynecological exams	Covered in full. (not subject to DEDUCTIBLE) **Note:** ● Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine exam is subject to COST SHARING AMOUNTS. ● Member cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your Cost Sharing Amounts for these services, and see our website at tuftshealthplan.com for more information about which laboratory services are considered preventive.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Radiation therapy	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Respiratory therapy and pulmonary rehabilitation services	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Short term rehabilitative and habilitative physical and occupational therapy services **(BL)** Note: Visits limits do not apply to the treatment of autism spectrum disorders.	$45.00 COPAYMENT per visit.(not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Therapy for speech, hearing and language disorders	$45.00 COPAYMENT per visit.(not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Chiropractic medicine	$45.00 COPAYMENT per visit.(not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Smoking cessation counseling services	Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Vision care services		
Routine eye examination **(BL)**	$45.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Other vision care services	Care provided by an optometrist $45.00 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.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
	Care provided by an ophthalmolgist IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
DAY SURGERY		
DAY SURGERY	IN-NETWORK DEDUCTIBLE and $300 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
INPATIENT CARE		
Bone marrow transplants for breast cancer, hematopoietic stem cell transplants and human solid organ transplants **(AR)**	IN-NETWORK DEDUCTIBLE and $500 COPAYMENT per INPATIENT admission.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Cleft lip and cleft palate treatment and services for CHILDREN See “Cleft lip and cleft palate treatment and services for CHILDREN, under “Other Health Services” later in this table.		
Extended Care **(AR) (BL)**	IN-NETWORK DEDUCTIBLE and then Covered in full Covered up to 100 days per CALENDAR YEAR.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Hospital services (acute care) **(AR)**	IN-NETWORK DEDUCTIBLE and $500 COPAYMENT per INPATIENT admission.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions	IN-NETWORK DEDUCTIBLE and $500 COPAYMENT per INPATIENT admission.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Reconstructive surgery and procedures **(AR)**	IN-NETWORK DEDUCTIBLE and $500 COPAYMENT per INPATIENT admission.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Maternity Care		
Routine OUTPATIENT Maternity care	Covered in full. NOTE: MEMBER COST SHARING will apply to diagnostic tests or diagnostic laboratory tests when they are ordered during a routine maternity care visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Non-Routine OUTPATIENT Maternity care	**Office Visit** $45.00 COPAYMENT per visit (not subject to DEDUCTIBLE) **All other services:** IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
INPATIENT Maternity care	IN-NETWORK DEDUCTIBLE and $500 COPAYMENT per INPATIENT admission.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Mental Health and Substance Use Disorder Services		
To contact the TUFTS HEALTH PLAN Mental Health Department, call 1-800-208-9565.		
OUTPATIENT services **(AR)**	$45.00 COPAYMENT (not subject to DEDUCTIBLE)	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Medication assisted treatment, including methadone maintenance	$5 COPAYMENT when provided by a medication assisted treatment clinic.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
INPATIENT services including MEDICALLY NECESSARY treatment in a mental health residential treatment facility **(AR)**	IN-NETWORK DEDUCTIBLE and $500 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Intermediate care **(AR)**	IN-NETWORK DEDUCTIBLE then Covered in full	OUT-OF-NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Other Health Services		
Ambulance services **(AR)**	IN-NETWORK DEDUCTIBLE and $50 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Cleft lip and cleft palate treatment and services for CHILDREN	**Medical or facial surgery:** DAY SURGERY: Covered as described under "DAY SURGERY". INPATIENT SERVICES: Covered as described under "Acute Hospital Services" or "Reconstructive Surgery". **Oral surgery:** Covered as described under "Oral Health Services". **Dental surgery or orthodontic treatment and management:** Covered in full **Preventive and restorative dentistry:** Covered in full (see "Cleft lip and cleft palate treatment and services for CHILDREN" in Chapter 3 for more information about what is covered under this benefit). **Speech therapy and audiology services:** Covered as described under "Therapy for speech, hearing and language disorders". **Nutrition services:** Covered as described under "Nutritional counseling".	**Dental surgery or orthodontic treatment and management:** Covered in full **Preventive and restorative dentistry:**Covered in full **All other services:** OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
DURABLE MEDICAL EQUIPMENT **(AR)**	MEMBER pays IN-NETWORK DEDUCTIBLE and then 30% COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then 30% COINSURANCE
Hearing aids **(BL)**	Hearing aids for CHILDREN age 21 and under: MEMBER pays IN-NETWORK DEDUCTIBLE and then 30% COINSURANCE.	Hearing aids for CHILDREN age 21 and under: OUT-OF NETWORK DEDUCTIBLE then 30% COINSURANCE
Home health care	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Hospice	IN-NETWORK DEDUCTIBLE and thenCovered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Injectable, infused, or inhaled medications **(AR)**	IN-NETWORK DEDUCTIBLE and $50 COPAYMENT	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	
	IN-NETWORK LEVEL OF BENEFITS	**OUT-OF-NETWORK LEVEL OF BENEFITS**
Medical Supplies	IN-NETWORK DEDUCTIBLE and then Covered in full	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Oral medications for the treatment of cancer	$50 COPAYMENT for up to a 30-day supply.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Prosthetic devices **(AR)**	MEMBER pays IN-NETWORK DEDUCTIBLE and then 20% COINSURANCE.	OUT-OF NETWORK DEDUCTIBLE then COINSURANCE
Scalp hair prostheses or wigs for cancer or leukemia patients	MEMBER pays IN-NETWORK DEDUCTIBLE and then 30% COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then 30% COINSURANCE
Special medical formulas		
Low protein foods	IN-NETWORK DEDUCTIBLE then 30% COINSURANCE	OUT-OF NETWORK DEDUCTIBLE then 30% COINSURANCE
Nonprescription Enteral Formulas **(AR)**	Covered in full.	Covered in full.
Special medical formulas **(AR)**	Covered in full.	Covered in full.
Prescription Drug Benefit		
For information about your COPAYMENTS and/or COINSURANCE for covered prescription drugs, see the "Prescription Drug Benefit" section in Chapter 3.		
TUFTS HEALTH PLAN MEMBER Discounts		
For information on how you can take advantage of discounts on a variety of health products, services, and treatments, such as acupuncture, massage therapy, and wellness programs, see "TUFTS HEALTH PLAN MEMBER Discounts" in Chapter 3.		

(AR) - These services may require approval by an AUTHORIZED REVIEWER. At the IN-NETWORK LEVEL OF BENEFITS, your PROVIDER will obtain this approval for you. At the OUT-OF-NETWORK LEVEL OF BENEFITS, you are responsible for obtaining this approval. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Benefit Limits

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

Hearing Aids
Hearing aids for CHILDREN age 21 and under are covered up to $2,000 per ear every 36 months. This includes both the amount TUFTS HEALTH PLAN pays and the MEMBER's COST SHARING AMOUNT. (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Short-term physical and occupational rehabilitation and habilitation therapy
The maximum benefit payable per CALENDAR YEAR is 2 evaluation(s) for short term occupational rehabilitation therapy services.

The maximum benefit payable per CALENDAR YEAR is 2 evaluation(s) for short term occupational habilitation therapy services.

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

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

The maximum benefit payable per CALENDAR YEAR is 2 evaluation(s) for short term physical rehabilitation therapy services.

The maximum benefit payable per CALENDAR YEAR is 2 evaluation(s) for short term physical habilitation therapy services.

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

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

Chiropractic medicine
The maximum benefit payable in each CALENDAR YEAR is 1 chiropractic evaluation per PROVIDER and 12 visits.

Vision Care Services
Coverage is provided for one routine eye examination every 24 months (IN-NETWORK and OUT-OF-NETWORK LEVELS combined).

Chapter 1
How Your Preferred PROVIDER Plan Works

Eligibility for Benefits

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

Important Notes:

- There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your EFFECTIVE DATE.
- In accordance with federal law (45 CFR § 148.180), TUFTS HEALTH PLAN does not:
  - adjust PREMIUMS based on genetic information;
  - request or require genetic testing; or
  - collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.
- If you live outside of Massachusetts and are a MEMBER under a GROUP CONTRACT, your benefits under this plan may also include benefits required under applicable state law. For more information, please call a Member Services Coordinator.

IN-NETWORK LEVEL OF BENEFITS

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

IN-NETWORK LEVEL OF BENEFITS

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

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

(There are special rules for INPATIENT mental health and INPATIENT substance use disorder services. Those rules are described under "INPATIENT Mental Health and Substance Use Disorders" later in this chapter.)

Selecting a PROVIDER

In order to receive coverage at the IN-NETWORK LEVEL OF BENEFITS you must receive care from a NETWORK PROVIDER listed in the DIRECTORY OF NETWORK PROVIDERS. You should choose a PROVIDER who is in a location convenient to you.

Notes:

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

No INPATIENT NOTIFICATION by You

As long as your INPATIENT procedure hospitalization is provided by a NETWORK PROVIDER, you are not responsible for notifying us of the INPATIENT hospitalization or transfer to another hospital. Your NETWORK PROVIDER will notify us of the hospitalization or transfer for you. See “INPATIENT NOTIFICATION ” in Chapter 1 for more information.

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

Changes to PROVIDER network

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

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

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

OUT-OF-NETWORK LEVEL OF BENEFITS

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

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

COVERED SERVICES Not Available from a NETWORK PROVIDER
If a COVERED SERVICES is not available from a NETWORK PROVIDER, as determined by TUFTS HEALTH PLAN, with TUFTS HEALTH PLAN's approval you may go to a NON-NETWORK PROVIDER. We will pay up to the REASONABLE CHARGE for these services. You will be responsible for any charges in excess of the REASONABLE CHARGE (as well as any applicable COST SHARING AMOUNT). You may receive a bill for these services. If you receive a bill, please see "Bills from PROVIDERS" later in this document or call Member Services for more information about what to do if you receive a bill.

INPATIENT NOTIFICATION by You
If you receive INPATIENT services which are not provided by a NETWORK PROVIDER, you must notify TUFTS HEALTH PLAN of these services. If you do not notify TUFTS HEALTH PLAN of these services, you will be subject to a NOTIFICATION PENALTY. See "INPATIENT NOTIFICATION" later in Chapter 1 for more information.

COVERED SERVICES Outside of the 50 United States

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

Continuity of Care

If you are an existing MEMBER

If your PROVIDER is involuntarily disenrolled from TUFTS HEALTH PLAN for reasons other than quality or fraud, you may continue to see your PROVIDER for COVERED SERVICES at the IN-NETWORK LEVEL OF BENEFITS in the following circumstances:

- Pregnancy. If you are in your second or third trimester of pregnancy, you may continue to see your PROVIDER through your first postpartum visit.

- Terminal Illness. If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your PROVIDER as long as necessary.

If you are enrolling as a new MEMBER

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

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

Conditions for coverage of continued treatment

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

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

INPATIENT Mental Health/Substance Use Disorder Services

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

OUT-OF-NETWORK LEVEL OF BENEFITS: If you wish to receive INPATIENT or intermediate mental health or substance use disorder services at a PROVIDER that is not a NETWORK PROVIDER, your coverage will be at the OUT-OF-NETWORK LEVEL OF BENEFITS. Coverage at the OUT-OF-NETWORK LEVEL OF BENEFITS means that you pay a DEDUCTIBLE and COINSURANCE and are responsible for notifying TUFTS HEALTH PLAN of your admission. In order to receive care for INPATIENT or intermediate mental health or substance use disorder services at the OUT-OF-NETWORK LEVEL OF BENEFITS, you must receive authorization from an AUTHORIZED REVIEWER. Please call the TUFTS HEALTH PLAN Mental Health Department at 1-800-208-9565 for more information on how to receive this authorization.

EMERGENCY Admission to a NON-NETWORK PROVIDER

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

EMERGENCY Care

EMERGENCY CARE

To receive EMERGENCY CARE

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

OUTPATIENT EMERGENCY CARE

If you receive EMERGENCY services but are not admitted as an INPATIENT, you will be covered at the IN-NETWORK LEVEL OF BENEFITS. You will be required to pay COST-SHARING for each EMERGENCY room visit. For more information about your MEMBER costs for medical services, see "Benefit Overview" at the front of this CERTIFICATE.

If you receive EMERGENCY COVERED SERVICES from a NON-NETWORK PROVIDER,we will pay up to the REASONABLE CHARGE. You will be responsible for any charges in excess of the REASONABLE CHARGE (as well as any applicable COST SHARING AMOUNT). You may receive a bill for these services. If you receive a bill, please see "Bills from Providers" later in this Certificate or call Member Services for more information about what to do if you receive a bill.

INPATIENT EMERGENCY care

If you receive EMERGENCY services and are admitted as an INPATIENT, you or someone acting for you must notify TUFTS HEALTH PLANwithin 48 hours of seeking care in order to be covered at the IN-NETWORK LEVEL OF BENEFITS. (Notification from the attending PROVIDER satisfies this requirement.) Otherwise, coverage for these services will be provided at the OUT-OF-NETWORK LEVEL OF BENEFITS.

Also, if you are admitted as an INPATIENT to a hospital that is a NON-NETWORK PROVIDER, you must notify TUFTS HEALTH PLAN of the admission or you will be charged a NOTIFICATION PENALTY. NPATIENT NOTIFICATION guidelines are described later in this chapter.

Financial Arrangements between TUFTS HEALTH PLAN and TUFTS HEALTH PLAN PROVIDERS

Methods of payment to TUFTS HEALTH PLAN PROVIDERS

TUFTS HEALTH PLAN's goal in compensation of PROVIDERS is to encourage preventive care and active management of illnesses. TUFTS HEALTH PLAN strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards PROVIDERS for providing high quality care to our MEMBERS. TUFTS HEALTH PLAN uses a variety of mutually agreed upon methods to compensate NETWORK PROVIDERS .

THE DIRECTORY OF HEALTH CARE PROVIDERS indicates the method of payment for each PROVIDER. Regardless of the method of payment, TUFTS HEALTH PLAN expects all participating PROVIDERS to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of MEDICALLY NECESSARY care and reduces the number of unnecessary medical tests and procedures which can be both harmful and costly to MEMBERS.

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

Member Identification Card

Introduction

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

Reporting errors

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

Identifying yourself as a TUFTS HEALTH PLAN MEMBER

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

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

When you receive services, you must tell the office staff that you are a TUFTS HEALTH PLAN MEMBER.

> **IMPORTANT NOTE:** If you do not identify yourself as a TUFTS HEALTH PLAN MEMBER, then:
>
> - we may not pay for the services provided; and
> - you would be responsible for the costs.

Membership requirement

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

Membership identification number

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

Utilization Management

Utilization management

The purpose of the utilization management program is to control health care costs by evaluating whether health care services provided to MEMBERS are MEDICALLY NECESSARY and provided in the most appropriate and efficient manner. This program sometimes includes prospective, concurrent, and retrospective review of health care services.

Prospective review is used to determine whether proposed treatment is MEDICALLY NECESSARY before that treatment begins. It is also referred to as "Pre-Service Review".

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

Retrospective review is used to evaluate care after the care has been provided. In certain circumstances, retrospective review is used to more accurately determine the appropriateness of health care services provided to MEMBERS. It is also referred to as "Post-Service Review".

TIMEFRAMES FOR TUFTS HEALTH PLAN TO REVIEW YOUR REQUEST FOR COVERAGE

Type of Review	Timeframe for Determinations*
Prospective (Pre-service) review	Within 2 working days of receiving all necessary information but no later than 15 days from receipt of the request.
Concurrent review	Within 1 working day of receiving all necessary information.
Retrospective (Post-service) review	30 days

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

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

We make coverage determinations. You and your PROVIDER make all treatment decisions.

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

- Mental health or substance use disorder utilization review decisions – 1-800-208-9565;
- All other utilization review decisions - 1-800-423-8080.

Case Management

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

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

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

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

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

Individual case management (ICM)

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

As a part of the ICM plan, we may authorize coverage for certain alternative services and supplies that do not otherwise constitute COVERED SERVICES for that MEMBER. This will occur only if TUFTS HEALTH PLAN determines, in its sole discretion, that all of the following conditions are satisfied:

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

TUFTS HEALTH PLAN will periodically monitor the appropriateness of the alternative services and supplies provided to the MEMBER. If, at any time, these services and supplies fail to satisfy any of the conditions described above, TUFTS HEALTH PLAN may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan at our sole discretion. Please note that ICM plans are not used to authorize services or supplies that are specifically excluded under the MEMBERS’s plan or that fall within the parameters of the Utilization Review program described above and do not meet the relevant MEDICALLY NECESSARY criteria for authorization.

AUTHORIZED REVIEWER

AUTHORIZED REVIEWER Approval

Prior approval by an AUTHORIZED REVIEWER is required for certain COVERED SERVICES. COVERED SERVICES that require this approval are identified by (AR) in the "Benefit Overview".

If you receive these services from a NETWORK PROVIDER, the PROVIDER is responsible for obtaining approval from TUFTS HEALTH PLAN.

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

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

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

Services that you receive in an EMERGENCY do not require the prior approval of an AUTHORIZED REVIEWER.

INPATIENT NOTIFICATION (formerly known as PREREGISTRATION)

INPATIENT NOTIFICATION is a process that makes TUFTS HEALTH PLAN aware of for all INPATIENT admissions and transfers to another hospital. We will evaluate the anticipated length-of-hospital stay, your proposed medical care, verify MEDICAL NECESSITY, and assess the need for a care management program after discharge or recommend an alternative treatment setting.

The INPATIENT NOTIFICATION to TUFTS HEALTH PLAN by your PROVIDER does not guarantee payment. We are not obligated to pay claims for persons who fail to meet eligibility criteria, who receive care that is determined not to be MEDICALLY NECESSARY, or if the claim is not for a COVERED SERVICE.

When Care is Provided by a NETWORK PROVIDER
When a NETWORK PROVIDER is directing your care, he or she is responsible to notify TUFTS HEALTH PLAN for your INPATIENT admission or transfer. In this case, you do not need to notify us of the admission or transfer.

When Care is Not Provided by a NETWORK PROVIDER
When your care is not authorized by a NETWORK PROVIDER, you the MEMBER are responsible to notify TUFTS HEALTH PLAN any INPATIENT admission or transfer.

If you do not notify TUFTS HEALTH PLAN, you will have to pay a NOTIFICATION PENALTY in addition to the DEDUCTIBLE and COINSURANCE. (Please see "Benefit Overview" at the front of the Certificate for the amount of the NOTIFICATION PENALTY.) Please read carefully the following description of the INPATIENT NOTIFCATION process that you must complete when a NETWORK PROVIDER is not directing your care.

> Note: If the GROUP does not have a NOTIFICATION PENALTY, this provision does not apply to you. Please see "Benefit Overview" at the front of the CERTIFICATE to determine if an INPATIENT NOTIFICATION PENALTY applies to you.

How to Notify TUFTS HEALTH PLAN of a Hospital Admission

Call the Member Services number on your ID card to report your hospital admission. The Precertification Department is available at 617-972-9550 or 1800-672-1515 Monday through Friday from 8:30 a.m. to 5:00 p.m. to accept hospital admission information. You, or someone acting on your behalf, will need be asked to provide the following information:

- Patient name, address and phone number (work and home)
- Hospital name, address and phone number
- MEMBER identification number (from your MEMBER ID card)
- Employer
- Diagnosis and proposed procedure
- Proposed admission and discharge dates
- Admitting PROVIDER's name, address and phone number

When to Notify TUFTS HEALTH PLAN for Elective Hospitalization or Transfers
Notification to TUFTS HEALTH PLAN for elective hospitalizations or transfers must occur at least five (5) days prior to hospitalization. After you call TUFTS HEALTH PLAN, we may consult with your PROVIDER and will notify you or your PROVIDER of the determination of the admission and the anticipated hospital stay or will recommend an alternative treatment setting.

When to Notify TUFTS HEALTH PLAN for an Urgent or Emergeny Admission
Notification to TUFTS HEALTH PLAN for an urgent admissions should be completed as soon as possible, but no later than one business day after the admission. An urgent admission is one which requires prompt medical intervention but one in which there is a reasonable opportunity to notify TUFTS HEALTH PLAN prior to, or at the time of, admission. Notification for an EMERGENCY admission should be completed within one business day following the admission. For a definition of EMERGENCY, see Appendix A.

When to Notify TUFTS HEALTH PLAN for Deliveries
Notification to TUFTS HEALTH PLAN for delivery of your newborn CHILD should occur within 30 days of your due-date.

When to Notify TUFTS HEALTH PLAN for a Newborn CHILD
- In cases where the newborn CHILD leaves the hospital with the mother after delivery, there is no need to notify TUFTS HEALTH PLAN of that newborn CHILD's hospital stay.
- In cases where the newborn CHILD remains in the hospital after the mother is discharged after delivery and the newborn CHILD's care is not provided by NETWORK PROVIDER, you must notify TUFTS HEALTH PLAN immediately of your newborn CHILD's hospital stay. (In order to be covered for any MEDICALLY NECESSARY care, the newborn CHILD must be enrolled under the GROUP CONTRACT within 30 days after birth. See Chapter 2 for more information. For a description of the Level of Benefits applicable to the newborn CHILD's care, see Chapter 1.)

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After You Notify TUFTS HEALTH PLAN of a Hospital Admission
After you call us with the necessary admission information, your PROVIDER or the hospital will be notified of the decision made by TUFTS HEALTH PLAN.

Changes to Hospital Admission Information
Notification of your hospital admission is valid only for the diagnosis, procedure, admission date and medical facility specified at the time of the notification. We must be notified of any delays, changes or cancellations of your proposed admission. A separate notification to TUFTS HEALTH PLAN must be obtained for a new admission date, readmission, hospitalization, transfer or surgery for conditions other than those designated during the initial hospital admission.

If you do not notify us of changes, you will be required to pay a NOTIFICATION PENALTY for that admission. See “Benefit Overview” at the front of the CERTIFICATE for the amount of the NOTIFICATION PENALTY.

Extension of Hospitalization
All (INPATIENT hospitalizations are monitored. When it is MEDICALLY NECESSARY to extend hospitalization beyond the originally determined-stay, TUFTS HEALTH PLAN staff will request additional clinical information from your attending PROVIDER or hospital for additional MEDICALLY NECESSARY hospital days.

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

Information Resources for MEMBERS

Obtaining information about TUFTS HEALTH PLAN

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

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

How to obtain this information about TUFTS HEALTH PLAN

Contact the Massachusetts Health Policy Commission’s Office of Patient Protection.

- Phone: 1-800-436-7757.
- Fax #: 1-617-624-5046.
- Web site: www.mass.gov/hpc.opp.
- Write a letter to the Office:
- Email to HPC-OPP@state.ma.us

Health Policy Commission
Office of Patient Protection
Two Boylston Street, 6th Floor
Boston, MA 02116

Chapter 2 - Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule under GROUP CONTRACTS

SUBSCRIBERS

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

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

DEPENDENTS

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

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

  Notes:

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

IMPORTANT NOTE;
If you live, work or reside outside the NETWORK CONTRACTING AREA

If you live, work or reside outside the NETWORK CONTRACTING AREA, you can be covered only if:

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

Eligibility rule under INDIVIDUAL CONTRACTS

You are eligible as a SUBSCRIBER only if you:

- meet the eligibility rules of TUFTS HEALTH PLAN and your INDIVIDUAL CONTRACT and;
- live, work or reside in the NETWORK CONTRACTING AREA.

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

- qualifies as a DEPENDENT, as defined in this CERTIFICATE; and
- meet the eligibility rules of TUFTS HEALTH PLAN and your INDIVIDUAL CONTRACT and;
- lives, works or resides in the NETWORK CONTRACTING AREA.

Note:

In some cases, DEPENDENTS who live, work or reside outside the NETWORK CONTRACTING AREA can be eligible for coverage under this plan. Please see "If you live, work or reside outside the NETWORK CONTRACTING AREA" below for more information.

If You Live, Work or Reside Outside the NETWORK CONTRACTING AREA

If you live, work or reside outside the NETWORK CONTRACTING AREA, you can be covered only if:

- you are a CHILD attending school full-time outside of the NETWORK CONTRACTING AREA;
- you are a DEPENDENT subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced SPOUSE for whom TUFTS HEALTH PLAN is required to provide coverage.

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.

Enrollment

When to enroll

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

- during the annual OPEN ENROLLEMENT PERIOD; or
- within the 30 days of the date you or your DEPENDENT is first eligible for this coverage.
  Note: If you fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible DEPENDENTS, if any, at a later date. This will apply only if you:
  - declined this coverage when you were first eligible because you or your eligible DEPENDENT were covered under another group health plan or other health care coverage at that time; or
  - declined this coverage when you were first eligible, and you have acquired a DEPENDENT through marriage, birth, adoption, or placement for adoption.

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

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

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

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

EFFECTIVE DATE of coverage

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

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

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

Adding DEPENDENTS under FAMILY COVERAGE

When DEPENDENTS may be added

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

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

How to add DEPENDENTS

If you have FAMILY COVERAGE, fill out a membership application form listing the DEPENDENTS. Give the form to your GROUP (if you are enrolled in a GROUP CONTRACT) or to TUFTS HEALTH PLAN (if you have an INDIVIDUAL CONTRACT), whichever applies, either during your OPEN ENROLLMENT PERIOD or within 30 days after the date of an event listed above, under "When DEPENDENTS may be added."

If you don't have FAMILY COVERAGE, ask your GROUP or TUFTS HEALTH PLAN, whichever applies, to change your INDIVIDUAL COVERAGE to FAMILY COVERAGE and then follow the procedure above.

EFFECTIVE DATE of DEPENDENTS' coverage

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

EFFECTIVE DATES will be no later than:

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

Availability of benefits after enrollment

COVERED SERVICES for an enrolled DEPENDENT are available as of the DEPENDENT's EFFECTIVE DATE. There are no waiting periods. Maternity benefits are available even if the pregnancy began before your EFFECTIVE DATE.

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

Newborn CHILDREN and ADOPTIVE CHILDREN

Importance of enrolling and choosing a PCP for newborn CHILDREN and ADOPTIVE CHILDREN

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

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

Continuing Eligibility for DEPENDENTS

Introduction

This topic explains continuing eligibility for DEPENDENTS.

When Coverage ends

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

Coverage after termination

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

What the SUBSCRIBER must do to continue coverage for DISABLED DEPENDENTS

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

When coverage ends

DISABLED DEPENDENT coverage ends when:

- the DEPENDENT no longer meets the definition of DISABLED DEPENDENT, or
- the SUBSCRIBER fails to give us proof of the DEPENDENT's continued disability.

Coverage after termination

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

Rule for former SPOUSES for GROUP CONTRACT (Also see Chapter 5)

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

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

How to continue coverage for former SPOUSES for GROUP CONTRACT

Follow these steps to continue coverage for a former SPOUSE:

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

Keeping our records current

You must notify us of any changes that affect you or your DEPENDENTS' eligibility. Examples of these changes are:

- birth, adoption, changes in marital status, or death;
- your remarriage or the remarriage of your former SPOUSE, when the former SPOUSE is an enrolled DEPENDENT under your FAMILY COVERAGE;
- moving out of the NETWORK CONTRACTING AREA or temporarily residing out of the NETWORK CONTRACTING AREA for more than 90 consecutive days;
- address changes; and
- changes in an enrolled DEPENDENT's status as a CHILD or DISABLED DEPENDENT.

If you enrolled for coverage directly with TUFTS HEALTH PLAN, forms to report these changes are available from your GROUP (only if your coverage is under a GROUP CONTRACT) or from the Member Services Department.

Chapter 3 - COVERED SERVICES

When health care services are COVERED SERVICES

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

- listed as COVERED SERVICES in this chapter;
- MEDICALLY NECESSARY;
- consistent with applicable state or federal law;
- consistent with the Medical Necessity Guidelines in effect at the time the services or supplies are provided. This information is available to you on our Web site at www.tuftshealthplan.com or by calling Member Services;
- obtained within the 50 United States. The only 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;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- approved by an AUTHORIZED REVIEWER*,* in some cases.

Important Notes:

- AUTHORIZED REVIEWER approval: All claims for services (whether or not the services were provided by a NETWORK PROVIDER) are subject to retrospective review by an AUTHORIZED REVIEWER. AUTHORIZED REVIEWERS review claims to be sure that the claims are for COVERED SERVICES only. A COVERED SERVICE is one that is described in this chapter. We will only pay claims that are for COVERED SERVICES.
- Certain services require the prior approval of an AUTHORIZED REVIEWER at both the IN-NETWORK and OUT OF NETWORK LEVEL OF BENEFITS (see "Benefit Overview" to determine which services require this type of prior approval). Please see Chapter 1 for more information about how this prior approval is obtained at the IN-NETWORK LEVEL OF BENEFITS. If you wish to receive these services at the OUT OF NETWORK LEVEL OF BENEFITS, you are responsible for obtaining prior approval from TUFTS HEALTH PLAN. If prior approval is not received, TUFTS HEALTH PLAN will not cover those services. Please contact Member Services, or, for mental health and substance use disorder services, the TUFTS HEALTH PLAN Mental Health Department at 1-800-208-9565, for more information.
- INPATIENT NOTIFICATION: You must notify TUFTS HEALTH PLAN of any INPATIENT admissions or hospital transfers provided at the OUT OF NETWORK LEVEL OF BENEFITS. Please see Chapter 1 - INPATIENT NOTIFICATION for more information

COVERED SERVICES

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

Notes:

- For information about your costs for the COVERED SERVICES listed below (for example, COPAYMENTS , DEDUCTIBLES and COINSURANCE), see the "Benefit Overview" section at the beginning of this document.
- Information about the day, dollar, and visit limits under this plan are listed in certain COVERED SERVICES in this chapter.

EMERGENCY CARE

Notes:

- The EMERGENCY Room COST-SHARING AMOUNT is waived if the EMERGENCY room visit results in immediate hospitalization or DAY SURGERY.
- If you receive EMERGENCY COVERED SERVICES from a NON-NETWORK PROVIDER, we will pay the PROVIDER up to the REASONABLE CHARGE. You will be responsible for any charges in excess of the REASONABLE CHARGE, (as well as any you pay the applicable COST-SHARING AMOUNT). You may receive a bill for these services. If you receive a bill, please see "Bills from Providers" later in this document or call Member Services for more information about what to do if you receive a bill.

- An EMERGENCY Room COST-SHARING AMOUNT may apply if you register in an EMERGENCY room but leave that facility without receiving care.
- Observation services will take an EMERGENCY Room COPAYMENT.

Outpatient care

Allergy testing

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

Autism spectrum disorders – diagnosis and treatment

(prior approval by an AUTHORIZED REVIEWER is required)

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

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

TUFTS HEALTH PLAN provides coverage for the following COVERED SERVICES:

- habilitative or rehabilitative care, which are professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA)* supervised by a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA). For more information about these programs, call the TUFTS HEALTH PLAN Mental Health Department at 1-800-208-9565.
- services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers. **Note**: Visit limits for services described under the “Short term rehabilitative or habilitative physical or occupational therapy” benefit do not apply to coverage for autism spectrum disorders.
- prescription drugs, covered under your "Prescription Drug Benefit, described in Chapter 3;
- psychiatric and psychological care, covered under your "Mental Health and Substance Abuse Services" benefit, described in Chapter 3;

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

Cardiac rehabilitation services

Services for OUTPATIENT treatment of documented cardiovascular disease that:

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

We cover only the following services:

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

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

Chemotherapy

Chiropractic care

See "Spinal manipulation".

Cytology examinations (Pap Smears)

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

Diabetes self-management training and educational services

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

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

Diagnostic imaging

Includes:

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

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

Diagnostic or preventive screening procedures

Includes, for example, proctosigmoidoscopies, colonoscopies and sigmoidoscopies.

Prior approval by an AUTHORIZED REVIEWER is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS OF BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval.

Diagnostic testing

Examples include, but are not limited to, ambulatory EKG testing, sleep studies, and diagnostic audiological testing. Prior approval by an AUTHORIZED REVIEWER may be required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS. Please call Member Services with questions about specific tests.

Early intervention services

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

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

Family planning

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

- Procedures:
  - sterilization; and
  - pregnancy terminations only as permitted under Massachusetts law (no PCP referral required).
- Services:
  - medical examinations;
  - consultations;
  - birth control counseling; and
  - genetic counseling.
- Contraceptives:
  - cervical caps;
  - implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants).
  - intrauterine devices (IUDs);
  - Depo-Provera or its generic equivalent; and
  - any other MEDICALLY NECESSARY contraceptive device that has been approved by the United States Food and Drug Administration*.

  *Note:

Please note that we cover certain contraceptives, such as oral contraceptives, over-the-counter female contraceptives, and diaphragms, under your Prescription Drug Benefit. If those contraceptives are covered under that 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

For use in bone marrow transplantation when necessary to establish a MEMBER's bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens or any combination consistent with the rules and criteria established by the Department of Public Health.

Immunizations

Infertility services

Diagnosis and treatment of Infertility* in accordance with Massachusetts law.

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

Infertility services include:

(I).the following services and supplies provided in connection with an infertility evaluation:

- diagnostic procedures and tests;
- procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.

(II).the following procedures when approved in advance by an AUTHORIZED REVIEWER:

- artificial insemination (intrauterine or intracervical) ;
- cryopreservation of eggs (up to 90 days); and
- procurement and processing of eggs or inseminated eggs and banking of inseminated eggs when associated with active infertility treatment.
  *Note: Donor sperm is only covered when the partner has a diagnosis of male factor infertility.

(III).the following Assisted Reproductive Technology ("ART") procedures when approved in advance by an AUTHORIZED REVIEWER**:

- I.V.F. (in-vitro fertilization and embryo transfer);
- D.O. (donor oocyte);
- F.E.T. (frozen embryo transfer);
- G.I.F.T. (gamete intra-fallopian transfer);
- assisted hatching;
- Z.I.F.T. (zygote intra-fallopian transfer);
- I.C.S.I. (intracytoplasmic sperm injection).

***Note: Artificial insemination and these ART procedures described above will only be considered COVERED SERVICES for MEMBERS with Infertility:

- who meet our eligibility requirements, which are based on the MEMBER's medical history;
- who meet the eligibility requirements of our contracting Infertility Services Providers;
- when approved in advance by an AUTHORIZED REVIEWER at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS. (see "Important Notes" earlier in this Chapter for more information about when you are responsible for obtaining this approval); and
- with respect to the procurement and processing of donor sperm, eggs, or inseminated eggs or banking of donor sperm or inseminated eggs, to the extent such costs are not covered by the donor's health care coverage, if any.

*Infertility is defined as the condition of a MEMBER who has been unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35.

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

Laboratory tests

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

Important Note: Laboratory tests must be ordered by a licensed PROVIDER and be performed at a licensed laboratory. Some laboratory tests (e.g., genetic testing) may require the approval of an AUTHORIZED REVIEWER at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval. Also, please note that in accordance with the ACA, laboratory tests associated with routine preventive care are covered in full at the IN-NETWORK LEVEL OF BENEFITS.

Lead Screenings

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. Treatments for Lyme disease otherwise not eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, Experimental or Investigative.

Mammograms

Provided at the following intervals:

- one baseline at 35-39 years of age;
- one every year at age 40 and older; or
- as otherwise MEDICALLY NECESSARY.

Nutritional counseling

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

When MEDICALLY NECESSARY, for the purpose of treating an illness. Please see “Nutritional Counseling” in the “Benefit Overview” for the applicable Cost Sharing Amount; or

As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, and behavior change and counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full at the IN-NETWORK LEVEL OF BENEFITS.

Note: Weight loss programs and clinics are not covered.

Office visits to diagnose and treat illness or injury

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

Oral health services

The services described in this section are in addition to services described under "Pediatric dental care for MEMBERS under age 19" earlier in this chapter.

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

- **Except as specified below,** and for services provided under the "Pediatric dental care for MEMBERS up to age 19" described later in this chapter, **all Non-EMERGENCY oral health services performed in an INPATIENT or DAY SURGERY setting must be approved in advance by an AUTHORIZED REVIEWER at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS and meet MEDICAL NECESSITY guidelines in order to be covered.**
- **Non-EMERGENCY oral health services are not covered when performed in an office setting.**

- Hospital, PROVIDER, and surgical charges are covered for the following conditions:
  - Surgical treatment of skeletal jaw deformities;
  - Surgical treatment of cleft lip or cleft palate for CHILDREN under the age of 18 (prior approval by an AUTHORIZED REVIEWER is not required).
  - Surgical treatment for Temporomandibular Joint Disorder (TMJ).
- The costs of INPATIENT services and DAY SURGERY for certain additional oral health services are covered in certain specifc instances. For these services (chart below) to be covered, all of the following clinical criteria must be met:
  - the MEMBER cannot safely and effectively receive oral health services in an office setting (1) due to being of young age or (2) because of a specific and serious nondental organic impairment (for example, hemophilia)
  - the MEMBER requires these services in order to maintain his/her health.
  - the services are not 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 go to our Web site at www.tuftshealthplan.com to view the complete guidelines for determining Medical Necessity for these services, entitled "Dental Procedures Requiring Hospitalization". You may also call Member Services for additional information.

OUTPATIENT surgery in a PROVIDER'S office

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

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

Pediatric dental care for MEMBERS up to age 19

Introduction

This pediatric dental benefit is administered by Delta Dental.

Participating network dentists will file claims for you and Delta Dental will pay the dentist directly. To check if your child's dentist is in the network, or to find a new dentist, visit www.deltadentalma.com/DDPremier-find-a-dentist. If you have any questions about what your pediatric dental benefit covers or how a claim was paid, call Delta Dental at 1-844-260-6095. Customer service representatives are available Monday-Thursday from 8:30 am-8:00 pm and on Fridays from 8:30 am-4:30 pm.

Dental claims and any written correspondence should be sent to:

Delta Dental PO Box 2907, Milwaukee, WI 53201-290

Coverage

The following table explains your COST SHARING AMOUNTS and benefit limits for pediatric dental care coverage.

COVERED SERVICES	MEMBER COST SHARING AMOUNTS	
	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Type I Services: Preventive & Diagnostic ● Comprehensive Evaluation - Once per lifetime per patient per provider or location. ● Periodic Oral Exams - 2 per 12 months per patient.* ● Limited Oral Evaluation - 2 per 12 months per patient.* ● Full Mouth X-Rays - Once per 36 months per patient per provider or location. * ● Panoramic X-Rays - Once every 36 months per patient per provider or location. * ● Bitewing X-Rays - 2 per 12 months per patient. * ● Single Tooth X-Rays - Maximum of one per visit. ● Teeth Cleaning - 2 per 12 months per patient, includes minor scaling procedures. * ● Fluoride Treatments - Once per day per patient per provider per location. ● Space Maintainers. ● Sealants - Once per 3 years per patient per tooth per provider or location. * Sealants are not covered on previously restored tooth.	Covered in full.	20% COINSURANCE.

*Time limits on services (e.g. 6, 12, 24, 36 or 60 months) are computed to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Pediatric dental care for MEMBERS up to age 19 , continued

COVERED SERVICES	MEMBER COST SHARING AMOUNTS	
	IN-NETWORK LEVEL OF BENEFITS	OUT-OF-NETWORK LEVEL OF BENEFITS
Type II Services: Basic Covered Services ● Amalgam Restorations - Once per 12 months per tooth surface per patient.* ● Composite Resin Restorations - Once per 12 months per tooth surface per patient. For primary, posterior teeth reimbursement for a composite restoration should not exceed the reimbursement for an amalgam restoration.* ● Root canals on permanent teeth - Once per lifetime per tooth.* ● Prefabricated Stainless Steel Crowns - Once per lifetime per tooth.* ● Periodontal Scaling and Root Planing - Once per 36 months per patient.* ● Simple Extractions - Once per lifetime per tooth, erupted or exposed root.* ● Surgical Extractions - Once per lifetime per tooth. Removal of completely bony impacted tooth requires prior authorization.*	Subject to 25% COINSURANCE.	Subject to DEDUCTIBLE (listed below) and then 45% COINSURANCE.
Type III Services: Major Restorative ● Crown, resin - Once per 60 months per tooth.* ● Porcelain/ceramic crowns - Once per 60 months per tooth.* ● Porcelain fused to metal/noble/high noble crowns - Once per 60 months per tooth.* ● Partial & complete dentures - Once per 84 months.* ● Reline or rebase partial or complete denture - Once per 24 months per patient.*	Subject to 50% COINSURANCE.	Subject to DEDUCTIBLE (listed below) and then 70% COINSURANCE.
Type IV Services: Orthodontia (must be approved in advance by an AUTHORIZED REVIEWER) Braces and related services. Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifiers.	Subject to 50% COINSURANCE.	70% COINSURANCE.

*Time limits on services (e.g. 6, 12, 24, 36 or 60 months) are computed to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Annual DEDUCTIBLE - applies to Type II and Type III services only (per CHILD)	N/A	$50

Preventive health care for MEMBERS under age 6

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

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

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to an COST SHARING AMOUNTS at the In-Network Level of Benefits. Member cost-sharing will also apply at the In-Network Level of Benefits to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see our website at www.tuftshealthplan.com for more information about which laboratory services are considered preventive.

Preventive health care for MEMBERS age 6 and older

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

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to an COST SHARING AMOUNTS at the In-Network Level of Benefits. Member cost-sharing will also apply at the In-Network Level of Benefits to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see our website at www.tuftshealthplan.com for more information about which laboratory services are considered preventive.

Radiation therapy

Respiratory therapy and pulmonary rehabilitation services

Routine annual gynecological exam

Includes any follow-up obstetric or gynecological care determined to be MEDICALLY NECESSARY as a result of that exam.

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

Short term rehabilitative and habilitative physical and occupational therapy services

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

Short-term habilitative physical and occupational therapy services are covered only when provided to keep, learn, or improve skills and functioning for daily living never learned or acquired due to a disabling condition. For these services to be covered, we must determine that the MEMBER's condition is subject to improvement within a period of 60 days from the initial treatment as a direct result of these therapies.

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

- provided by a licensed physical therapist; and
- in compliance with TUFTS HEALTH PLAN's MEDICALLY NECESSITY guidelines, and, if applicable, prior authorization guidelines.

Note: Benefit limits do not apply to the treatment of autism spectrum disorders.

Smoking cessation counseling services

Including individual, group, and telephonic smoking cessation counseling services that:

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

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

Chiropractic medicine

Coverage is provided for MEDICALLY NECESSARY visits for the purpose of chiropractic treatment or diagnosis, regardless of the place of service (no PCP referral required).

During each visit, MEMBERs are covered for spinal manipulation, therapeutic exercise, and attended electrical stimulation (EMS).

(Note: Covered up to 1 evaluation per PROVIDER and 12 visits per CALENDAR YEAR.)

Therapy for speech, hearing and language disorders

Diagnosis and treatment when MEDICALLY NECESSARY. Short-term cognitive retraining or cognitive rehabilitation services are covered under this benefit only when provided to restore function lost or impaired as the result of an accidental injury or sickness. In order for these services to be covered, measurable improvement must be anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery.

URGENT CARE in an URGENT CARE CENTER

Vision care services

- Routine eye examination: Coverage is provided for one routine eye examination every 24 months (IN-NETWORK and OUT-OF-NETWORK LEVELS combined)

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

DAY SURGERY

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

INPATIENT Care

Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants

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

- Bone marrow transplants for MEMBERS diagnosed with breast cancer that has progressed to metastatic disease who meet the criteria established by the Massachusetts Department of Public Health.
- Hematopoietic stem cell transplants and human solid organ transplants provided to MEMBERS. These services must be provided at a designated transplant facility that is a NETWORK PROVIDER. We pay for charges incurred by the donor in donating the stem cells or solid organ to the MEMBER, but only to the extent that charges are not covered by any other health care coverage. This includes:
  - evaluation and preparation of the donor, and
  - surgery and recovery services when those services relate directly to donating the stem cells or solid organ to the MEMBER.

  Notes:

  - 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. Additional donor search expenses for unrelated donors must be approved by an AUTHORIZED REVIEWER.
  - We cover a MEMBER's human leukocyte antigen (HLA) testing. See "OUTPATIENT medical care" earlier in this chapter for more information.
  - Prior approval by an AUTHORIZED REVIEWER is required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS. See "Important Note"earlier in the chapter for more information about when you are responsible for obtaining this approval.

Extended care

In each CALENDAR YEAR, INPATIENT extended care services are covered up to the maximum benefit listed under “Benefit Overview” at the front of this CERTIFICATE. Extended care services are SKILLED nursing, rehabilitation or chronic disease hospital services which are provided in a Medicare-certified:

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

Notes:

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

Hospital services (acute care)

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

*Prior approval by an AUTHORIZED REVIEWER is required at both the IN-NETWORK and OUT-OF-NETWORK LEVEL OF BENEFITS.

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

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

Reconstructive surgery and procedures

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

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

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

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

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

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

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

Notes:

- Cosmetic surgery is not covered.
- Except as described above in connection with a mastectomy, AUTHORIZED REVIEWER approval is required before you receive any reconstructive surgery or procedure (regardless of whether the procedure is provided by a NETWORK PROVIDER or a NON-NETWORK PROVIDER). Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval.

Maternity Care

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

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

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

Maternity Care (INPATIENT)

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

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

Notes:

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

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

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

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

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

When newborn CHILD is enrolled:

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

TUFTS HEALTH PLAN will pay for Routine Nursery Care at the IN-NETWORK LEVEL OF BENEFITS; and

TUFTS HEALTH PLAN will pay for MEDICALLY NECESSARY care other than Routine Nursery Care: (1) at the IN-NETWORK LEVEL OF BENEFITS, if that care is provided by a NETWORK PROVIDER, and (2) at the OUT OF NETWORK LEVEL OF BENEFITS, if that care is not provided by a NETWORK PROVIDER (You are required to notify TUFTS HEALTH PLAN immediately of your newborn CHILD's hospital stay).

When newborn CHILD is not enrolled:

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

2. Non-MEMBER's Delivery

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

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

TUFTS HEALTH PLAN will pay for Routine Nursery Care (1) at the IN-NETWORK LEVEL OF BENEFITS, if that care is provided by a NETWORK PROVIDER, and (2) at the OUT OF NETWORK LEVEL OF BENEFITS, if that care is not provided by a NETWORK PROVIDER You are required to notify TUFTS HEALTH PLAN immediately of your newborn CHILD's delivery).; and

TUFTS HEALTH PLAN will pay for MEDICALLY NECESSARY care other than Routine Nursery Care (1) at the IN-NETWORK LEVEL OF BENEFITS, if that care is provided by a NETWORK PROVIDER, and (2) at the OUT OF NETWORK LEVEL OF BENEFITS, if that care is not provided by a NETWORK PROVIDER You are required to notify TUFTS HEALTH PLAN immediately of your newborn CHILD's hospital stay)..

When newborn Child is not enrolled:

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

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

OUTPATIENT mental health and substance use disorder services for MENTAL DISORDERS

Services to diagnose and treat MENTAL DISORDERS (including diagnosis, detoxification, and treatment of substance use disorders) given by the following PROVIDERS:

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

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

Notes:

- Prior approval by a TUFTS HEALTH PLAN Mental Health AUTHORIZED REVIEWER is required for psychological testing and neuropsychological assessment services at both the IN-NETWORK and OUT OF NETWORK LEVEL OF BENEFITS combined. Please contact the TUFTS HEALTH PLAN Mental Health Department at 1-800-208-9565 for more information on how to obtain this approval.

INPATIENT and intermediate mental health and substance use disorder services for MENTAL DISORDERS

INPATIENT and intermediate mental health and substance use disorder services for MENTAL DISORDERS

- INPATIENT mental health and substance use disorder services for Mental Disorders in a facility that is licensed as a general hospital, a mental health hospital, or a substance use disorder facility, or mental health residential treatment facility.
- Intermediate mental health and substance use disorder services. MEDICALLY NECESSARY mental health and substance use disorder services that are more intensive than traditional OUTPATIENT mental health and substance use disorder services, but less intensive than 24-hour hospitalization. Some examples of covered intermediate mental health and substance use disorder services are:

  - level III community-based detoxification;
  - intensive outpatient programs;
  - crisis stabilization;
  - partial hospital programs

INPATIENT and Intermediate mental health and substance use disorder services must be obtained at a NETWORK PROVIDER in order to receive benefits at the IN-NETWORK LEVEL OF BENEFITS. See "INPATIENT Mental Health and Substance Use Disorder Services" in Chapter 1 for more information. Please contact the TUFTS HEALTH PLAN Mental Health Department at 1-800-208-9565 for more information on how to receive this authorization.

Other Health Services

Ambulance services

- Ground, sea, and helicopter ambulance transportation for EMERGENCY care.
- Airplane ambulance services (e.g., Medflight) when approved by an AUTHORIZED REVIEWER
- Non-EMERGENCY, MEDICALLY NECESSARY ambulance transportation between covered facilities.
- Non-EMERGENCY ambulance transportation for MEDICALLY NECESSARY care when the medical condition of the MEMBER prevents safe transportation by any other means. Prior approval by an AUTHORIZED REVIEWER may be required.
  *Approval by an AUTHORIZED REVIEWER may be required at both the In-Network and Out-of-Network Levels of Benefits. Please see "Important Notes" for more information about when you are responsible for obtaining this approval.

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

Cleft lip or cleft palate treatment and services for CHILDREN

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

- Medical and facial surgery: Covered as described under "DAY SURGERY", "Acute hospital services", and "Reconstructive surgery and procedures" earlier in this chapter. This includes surgical management and follow-up care by plastic surgeons;
- Oral surgery: Covered as described under "Oral health services" earlier in this chapter. This includes surgical management and follow-up care by oral surgeons;
- Dental surgery or orthodontic treatment and management;
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy;
- Speech therapy and audiology services: Covered as described under "Therapy for speech, hearing and language disorders" earlier in this chapter;
- "Nutrition services: Covered as described under "Nutritional counseling" earlier in this chapter.

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

Equipment that TUFTS HEALTH PLAN determines to be non-medical in nature and used primarily for non-medical purposes (even though that equipment may have some limited medical use) will not be considered DURABLE MEDICAL EQUIPMENT and will not be covered under this benefit.

Note: Certain DURABLE MEDICAL EQUIPMENT may require AUTHORIZED REVIEWER approval. This prior approval is required at both the IN-NETWORK and OUT OF NETWORK LEVEL OF BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval.

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

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

Below are examples of commonly covered items (this list is not all-inclusive):

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

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

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

DURABLE MEDICAL EQUIPMENT,

continued

Below are examples of non-covered items (this list is not all-inclusive). Please call Member Services for all questions regarding coverage of DURABLE MEDICAL EQUIPMENT:

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

Hearing Aids

Coverage is provided for:

- hearing aids (one per ear per prescription change) for CHILDREN age 21 or younger, including hearing aid evaluations, the fitting and adjustment of hearing aids, and supplies, including ear molds, as required under Massachusetts law. Coverage for hearing aids is provided up to $2,000 per ear every 36 months. This includes both the amount TUFTS HEALTH PLAN pays and the MEMBER’s COST SHARING AMOUNT. (IN-NETWORK and OUT-OF-NETWORK LEVELS of BENEFITS combined).

Home health care

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

- home visits by a PROVIDER;
- SKILLED nursing care and physical therapy; and
- the following services, if determined to be a MEDICALLY NECESSARY component of SKILLED nursing or physical therapy:
  - speech therapy,
  - occupational therapy,
  - medical/psychiatric social work,
  - nutritional consultation,
  - the use of DURABLE MEDICAL EQUIPMENT (coverage is not subject to limits described in the "DURABLE MEDICAL EQUIPMENT" benefit in this chapter), and
  - the services of a part-time home health aide.

*To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Note:

- Home health care services for physical and occupational therapies following an injury or illness are only covered to the extent that those services are provided to restore function lost or impaired, as described under "Short term rehabilitative or habilitative physical and occupational therapy services" earlier in this Chapter 3. However, those home health care services are not subject to the 60-day period for significant improvement requirement or the visit limits listed under "Short term rehabilitative or habilitative physical and occupational therapy services".

Hospice care services

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

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

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

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

Injectable, infused, or inhaled medications

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

Notes:

- Prior authorization and quantity limitations may apply.
- There are designated home infusion PROVIDERS for a select number of specialized pharmacy products and drug administration services. These PROVIDERS offer clinical managements of drug therapies, nursing support, and care coordination to MEMBERS with acute and chronic conditions. Medications offered by these PROVIDERS include, but are not limited to medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. Please contact Member Services or see our Web site for more information on these medications and PROVIDERS.
- Coverage includes the components required to administer these medications, including, but not limited to, hypodermic needles and syringes, DURABLE MEDICAL EQUIPMENT, supplies, pharmacy compounding, delivery of drugs, and supplies.
- Medications that are 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 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

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.

Prosthetic devices

TUFTS HEALTH PLAN covers the cost (including repairs) of breast prostheses and prosthetic arms and legs. Coverage is provided for the most appropriate MEDICALLY NECESSARY model that adequately meets the MEMBER's needs. Prior approval by an AUTHORIZED REVIEWER is required at both the IN-NETWORK and OUT-OF-NETWORK LEVELS of BENEFITS. Please see "Important Notes" at the start of this chapter for more information about when you are responsible for obtaining this approval*.

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

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Scalp hair prostheses or wigs for cancer or leukemia patients

Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. (Please also see "DURABLE MEDICAL EQUIPMENT" earlier in this Chapter.)

Special Medical Formulas

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

Low protein foods:

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

Nonprescription enteral formulas:
(prior approval by an AUTHORIZED REVIEWER may be required)

Coverage is provided:

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

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

Special Medical Formulas:
(prior approval by an AUTHORIZED REVIEWER may be required)

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

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

TUFTS HEALTH PLAN MEMBER Discounts

In addition to your covered benefits, as a MEMBER you may take advantage of TUFTS HEALTH PLAN MEMBER Discounts. These include discounts on:

- fitness center memberships;
- nutritional supplements;
- mind and body treatments; and
- a variety of services related to good health.

This list of MEMBER discounts is effective January 1, 2016 and may change during the year. Please see our Web site at www.tuftshealthplan.com for the most current list or call a Member Specialist.

Current examples of these discounts include:

- Fitness discounts
  - Save 20% on all varieties of annual memberships and pay no initiation fee at TUFTS HEALTH PLAN network fitness centers in Massachusetts, New Hampshire, and Rhode Island.
  - As an alternative to annual memberships, you and your family can visit a fitness center in the TUFTS HEALTH PLAN network and pay a small copayment ($6-$10) for each visit, up to five visits a month.
  - Save 50% off the joining/initiation fee when you join a participating New England Curves® club.
  - Save 10% on personal training packages at Fitness Together and receive a free initial fitness evaluation.
  - Save 20% on Appalachian Mountain Club membership rates and receive discounts on accommodations, subscriptions and programs.
  - Members 18 and younger pay no membership, joining, or initiation fee to enroll at participating Boys & Girls Clubs in Massachusetts and Rhode Island. Young members also receive a 20% discount on the cost of programs with fees. Day care, summer camp and preschool are excluded from the discount.

- Fitness Club Rebate*
  You may be eligible for a rebate for the cost of 3 months of fitness club fees for using a qualified fitness club. If you are eligible for this rebate, just complete at least four consecutive months of membership in TUFTS HEALTH PLAN. Then, submit the Fitness Rebate Form, along with proof of fitness center membership and proof of payment, and we will reimburse up to 3 months of your fitness club fees for the year.

*Notes:

- Certain GROUPS may not offer this fitness rebate. If you are enrolled in a GROUP plan, check with your employer or contact TUFTS HEALTH PLAN to confirm whether you are eligible for this rebate.
- The rebate applies up to 3 months of fitness club dues per family, per year, after you have incurred up to up to 3 months of fitness club membership fees and have met the eligibility requirements. The fitness reimbursement is paid to the TUFTS HEALTH PLAN SUBSCRIBER.

- Nutritional Services
  - Nutritional Counseling - In addition to your health plan coverage for MEDICALLY NECESSARY counseling, you can receive 25% off the cost of unlimited visits with a registered dietitican or licensed nutritionist in our network. Learn more about diets that promote good health.
  - Dietary and Nutrition Supplements -- Save 15% or more off of the manufacturers' suggested retail price on a wide variety of vitamins, supplements, and popular energy and protein bars through ChooseHealthy.com. Standard shipping is also free for Members.
  - iDiet: Members can receive a 15% discount for enrolling in the iDiet, an easy-to-follow 12-week program for healthy, long-term weight loss. For more information or to register for the plan and automatically save 15%, go to https://www.myidiet.com/hi/tuftshealth/.

- Weight Loss Program Rebate -
  TUFTS HEALTH PLAN will reimburse up to 3 months (12 weeks) of membership fees for the Jenny Craig All Access program.

  TUFTS HEALTH PLAN will reimburse up to 50% of the initial evaluation fee for the following medical facility-based weight loss programs:
  - Health Management Resources (HMR) Weight-Loss Programs, limited to: HMR Program at MetroWest Medical Center (Natick, MA), HMR Program for Weight Management (Auburndale, MA), Harvard Vanguard Medical Associates (Boston, MA), Winchester Hospital (Medford, MA), Derry Medical Center (Derry, NH);
  - Brigham & Women's Hospital - Program for Weight Management;
  - Anna Jacques Hospital - Medical Weight Loss Center.

  Important Notes:
  - The reimbursement applies once per year, per family.
  - The reimbursement applies to Jenny Craig programs, OR 50% of the initial evaluation fee for specified medical facility-based weight loss programs.
  - The reimbursement does not apply to the cost of food.
  - MEMBERs would have the option to submit for one of the above options, no combination of reimbursements would be permitted.

- Mind and Body
  - Save 25 % off of the usual and customary rates on acupuncture treatments. On massage therapy, you will either save 25% off of the usual and customary rates, or pay $15 per 15 minutes of massage therapy, whichever is less.. To find a participating provider, click on Member Discounts at tuftshealthplan.com.
  - Natural Therapies - Learn more about aromatherapy, homeopathic remedies, meditation, yoga, and other natural remedies at ChooseHealthy.com.
  - Mindfulness Stress Reduction Program - Members can Ssave 15% on cost of tuition for the 8-week program for stress reduction program at UMass Medical School's Center for Mindfulness in Medicine, Health Care and Society. The program takes place at the Shrewsbury campus. The Center for Mindfulness is a leader in mind-body medicine and mindfulness-based treatment and research, being among the first to integrate meditation and mindfulness into mainstream medicine and health care. Members can access the discount through the following link: http://www.umassmed.edu/cfm/stress-reduction/tufts-health-plan/.
  - Memory Fitness Activities Discount Program: MEMBERS can save 17% on a subscription to the BrainHQ application offered by Posit Science. BrainHQ is an application that is designed to increase the speed at which we can reliably process information, improve the brain's ability to make clear and strong representations of information and stimulate the machinery that produces brain chemicals that strengthen memory and enable learning. MEMBERS can access the discount through the following link: http://www.brainhq.com/reg/thp.

- Eyewear
  - With the EyeMed Vision Care program, MEMBERS can receive 35% off the retail price of frames, along with discounts on lenses and lens options, with the purchase of a complete pair of eyeglasses from a participating EyeMed provider.
  - EyeMed Vision Care also offers a contact lens replacement program, 20% off the retail price of nonprescription sunglasses, and 15% off the retail price (or 5% off the promotional price) of LASIK and PRK laser vision correction.

- Home Instead Senior Care
  - Provides home support services you or an elderly family MEMBER, such as light housekeeping or meal preparation. Receive a $100 one-time credit towards charges for these and other non-medical home care services through participating offices.

- A free home-safety inspection is also provided once you contract for services. It includes a review of the home entrance, kitchen, bathrooms, and more.

- Other discounts
  - CVS Caremark ExtraCare health card - Receive 20% off of the price of certain CVS/pharmacy-brand, non-prescription health related items by using your ExtraCare health card offered by CVS Caremark (in conjunction with Tufts Health Plan).
  - Jenny Craig - Get 50% off of the Jenny Craig AllAccess program enrollment fee, plus 5% off of all Jenny Craig food. The 50% discount is on the $99 enrollment fee. Enrollment and monthly fees of $19 are required, plus the cost of food, and shipping (if applicable). The Member is responsible for all payments for the Jenny Craig program. The food discount is not applicable to shipping cost and is only valid for personal consumption. Please call Member Services for more information about this discount and its limitation.
  - Nutrisystem - Save 12% off every 28-day Nutrisystem My Way® program order. My Way is a metabolism and lifestyle based weight loss program. Members also receive a free Fast 5TM kit.
  - The Original Healing ThreadsTM Designer Wear - Save 15% off the cost of machine washable , microfiber tops and breakaway pants, treated to allow liquids to roll off of the fabric.
  - iDiet: Members can receive a 15% discount for enrolling in the iDiet, an easy-to-follow 12-week program for healthy, long-term weight loss. For more information or to register for the plan and automatically save 15%, go to https://www.myidiet.com/hi/tuftshealth/.

These discounts and savings may change over time without notice to MEMBERS. To check on current TUFTS HEALTH PLAN MEMBER Discounts:

- call Member Services at the number listed on your MEMBER ID card, or
- go to www.tuftshealthplan.com

Prescription Drug Benefit

Introduction
This section describes the Prescription Drug Benefit. The following topics are included in this section to explain your prescription drug coverage:

- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- TUFTS HEALTH PLAN Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered
Prescription drugs will be considered COVERED SERVICES only if they comply with the "TUFTS HEALTH PLAN Pharmacy Management Programs" section described below and are:

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

For a current list of covered drugs, please go to our Web site at www.tuftshealthplan.com, or call a Member Specialist.

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

- Tier-1 drugs have the lowest level COST SHARING AMOUNT; many generic drugs are on tier-1.
- Tier-2 drugs have the middle level COST SHARING AMOUNT.
- Tier-3 drugs have a higher level COST SHARING AMOUNT.
- Tier-4 drugs have the highest COST SHARING AMOUNT.

Notes:

- Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered subject to a $50 Copayment for up to a 30-day supply in full. These medications are not subject to any prescription drug deductible, if one applies to your plan.
- Smoking cessation agents (both prescription and generic over-the-counter agents when prescribed by a Provider) are covered in full.
- Certain drugs on our formulary are designated as part of our low cost drug program. Your retail pharmacy Copayments for these low cost drugs are $5 for up to a 30-day supply and $10 for a 31-90 day supply. Please see the website at www.tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy or call Member Services for more information.

Prescription Drug CoverageTable

DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs) .	
TIER-1 drugs:	$30.00 COPAYMENT for up to a 30-day supply. $60.00 COPAYMENT for a 31-60-day supply. $90.00 COPAYMENT for a 61-90-day supply.
TIER-2 drugs:	$85.00 COPAYMENT for up to a 30-day supply. $170.00 COPAYMENT for a 31-60-day supply. $255.00 COPAYMENT for a 61-90-day supply.
TIER-3 drugs:	$100.00 COPAYMENT for up to a 30-day supply. $200.00 COPAYMENT for a 31-60-day supply. $300.00 COPAYMENT for a 61-90-day supply.
TIER-4 drugs:	10% COINSURANCE with a COST SHARING AMOUNT of no less than $100.00 and up to a maximum of $250.00 for up to a 30-day supply.
Important Note: If you choose to obtain a covered prescription drug at a retail pharmacy which is not a TUFTS HEALTH PLAN designated pharmacy, you will be required to pay for the entire cost of the drug up front. You will then need to contact TUFTS HEALTH PLAN in order to be reimbursed. You will be responsible only for the MEMBER COST SHARING AMOUNT listed above.	
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: ● Coverage When Drugs Are Obtained Through a TUFTS HEALTH PLAN Designated Mail Services Pharmacy: Most maintenance medications, when mailed to you through a TUFTS HEALTH PLAN designated mail services pharmacy.	
TIER-1 drugs:	$60.00 COPAYMENT for up to a 90 day supply.
TIER-2 drugs:	$170.00 COPAYMENT for up to a 90 day supply.
TIER-3 drugs:	$300.00 COPAYMENT for up to a 90 day supply.
TIER-4 drugs:	10% COINSURANCE with a COST SHARING AMOUNT of no less than $100.00 and up to a maximum of $250.00 for up to a 30-day supply.
● Coverage When Drugs Are Not Obtained Through a TUFTS HEALTH PLAN Designated Mail Services Pharmacy: If you choose to obtain a covered prescription drug through a mail service pharmacy which is not a TUFTS HEALTH PLAN designated pharmacy, you pay 20% COINSURANCE for that drug. *Note: COINSURANCE is calculated based on TUFTS HEALTH PLAN's contracted rate at the time the prescription is filled and does not reflect any rebates that TUFTS HEALTH PLAN may receive at a later date. Rebates, if any, are reflected in your GROUP's PREMIUM.	

Notes

- If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorized the generic equivalent, you will pay the applicable tier COST SHARING AMOUNT plus the difference in cost between the brand-name drug and the generic drug.

What is Covered

We cover the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under "What is Not Covered" (see "Important Notes" later in this "Prescription Drug Benefit").
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.

- 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” earlier in this chapter for information about other contraceptive drugs and devices that qualify as COVERED SERVICES.
- Fluoride for CHILDREN.
- Injectables and biological serum included on the list of covered drugs on our Web site. MEDICALLY NECESSARY hypodermic needles and syringes required to inject these medications are also covered. For more information, call Member Services or see our Web site at www.tuftshealthplan.com.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, in the medical literature, or by the Commissioner of Insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law and is FDA-approved. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call Member Services.
- Over-the-counter drugs included in the list of covered drugs on our Web site. For more information, call Member Services or see our Web site at www.tuftshealthplan.com.
- Certain medications used for bowel preparation in colonoscopy procedures are covered in full for Members ages 50 through 74. For more information, please call Member Services or see the formulary on our Web site at www.tuftshealthplan.com.
- Prescription smoking cessation agents.

What is not Covered

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

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act and fluoride for CHILDREN).
- Topical and oral fluorides for adults.
- Medications for the treatment of idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants, Depo-Provera or its generic equivalent (these are covered under your OUTPATIENT care benefit earlier in this Chapter)
- 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" earlier in this chapter.
- Prescriptions written by PROVIDERS who do not participate in TUFTS HEALTH PLAN, 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 or check our Web site at www.tuftshealthplan.com.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. Some examples of these excluded medications are: topical acne medications with benzoyl peroxide ≤ 10%; H2 blockers with nizatidine, famotidine, cimetidine, or ranitidine; and oral non-sedating antihistamines. For a complete list of these excluded medications, call Member Services or check our Web site at www.tuftshealthplan.com.
- Prescription medications when packaged with non-prescription products.
- oral non-sedating antihistamines.

TUFTS HEALTH PLAN Pharmacy Management Programs

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

Quantity Limitations Program

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

Prior Authorization Program:

We restrict the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing PROVIDER to obtain prior approval from us for such drugs. Step therapy is a type of prior authorization program which allows coverage for certain drugs only after specific preferred medications are tried first.

Step Therapy PA Program

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

Designated Specialty Pharmacy Program (Mail Order):

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

Split Fill Program

This program applies only to certain medications. Medications in the Split Fill Program are dispensed in split fills with less than a month's supply of the medication filled at a time. You will be responsible for paying a pro-rated Cost Sharing Amount instead of the full 1-30 day supply Cost Sharing Amount. For more information about this program, please call Member Services, or see the Web site at www.tuftshealthplan.com.

Non-Covered Drugs With Suggested Alternatives:

While TUFTS HEALTH PLAN covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. These non-covered drugs are listed in Appendix C.

All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered.

New-To-Market Drug Evaluation Process:

New-To-Market drug products are reviewed for safety, clinical effectiveness, and cost by the TUFTS HEALTH PLAN's Pharmacy and Therapeutics Committee. 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 – usually within 6 months of the drug product's availability.

IMPORTANT NOTES:

- If your PROVIDER feels it is MEDICALLY NECESSARY for you to take medications that are restricted under any of the Tufts Health Plan Pharmacy Management Programs described above, he or she may submit a request for coverage. We will review the request and provide you with notification of our coverage determination within 72 (seventy-two) hours after receiving the request. We will approve the request if it meets our guidelines for coverage. For more information, call Member Services. Please note: You or your prescribing PROVIDER may request an expedited exception process based on exigent circumstances. We will notify you and your prescribing PROVIDER of our determination no later than 24 hours after receving such a request. Exigent circumstances exists when a MEMBER: is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function; or is undergoing a current course of treatment using a non-formulary drug.
  Additionally, if Tufts Health Plan denies a standard or expedited exception request for a drug not covered by the plan, you have the option of requesting an external review at the same time as filing an internal appeal. The external review determination must be made within 72 hours for standard requests and 24 hours for expedited requests. Please contact the Tufts Health Plan Appeals and Grievances Department at 888-880-8699, x. 59674 for more information regarding this external option.
- If a request is made to cover medications that are part of the "New-to-Market Drug Evaluation Process" program or the "Non-Covered Drugs with Suggested Alternatives" program, and that request is approved by Tufts Health Plan, the medications will generally be covered on the highest tier (e.g., Tier 3 on a 3-tier formulary, Tier-4 on a 4-tier formulary), with some exceptions. Please call Member Services for more information about on which tier your medication is covered.
- The TUFTS HEALTH PLAN Web site has a list of covered drugs with their tiers. We may change a drug's tier during the year. For example, if a brand drug's patent expires, we may change the drug's status by moving the brand drug from Tier-2 to Tier-3 .
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check our Web site at **www.tuftshealthplan.com** , or call a Member Specialist.

Filling Your Prescription
Where to Fill Prescriptions:

- You can fill your prescriptions at any pharmacy; however, TUFTS HEALTH PLAN designated pharmacies will only charge you the MEMBER COST SHARING AMOUNT at the time you fill your prescription. If you choose to fill your prescription at a non-TUFTS HEALTH PLAN designated pharmacy, you will be responsible for paying the entire cost of the medication up front. Please see the Prescription Drug Coverage Table earlier in this chapter for more information. TUFTS HEALTH PLAN designated pharmacies include:
- for the majority of prescriptions, most of the pharmacies in Massachusetts, New Hampshire and Rhode Island and additional pharmacies nationwide; and
- for a select number of drug products, a small number of designated specialty pharmacy providers. (For more information about TUFTS HEALTH PLAN's designated specialty pharmacy program, see "TUFTS HEALTH PLAN Pharmacy Management Programs" earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the TUFTS HEALTH PLAN Member Services Department.

How to Fill Prescriptions:

- When you fill a prescription, provide your Member ID to any TUFTS HEALTH PLAN designated pharmacy and pay your COST SHARING AMOUNT.
- If the cost of your prescription is less than your Copayment, then you are only responsible for the actual cost of the prescription.
- If you have any problems using this benefit, call the TUFTS HEALTH PLAN Member Services Department.

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

Filling Prescriptions for Maintenance Medications:

If you are required to take a maintenance medication, we offer you two choices for filling your prescription:

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

The following may not be available to you through a TUFTS HEALTH PLAN designated mail services pharmacy:

- Medications for short term medical conditions;
- Certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- Medications that are part of our Quantity Limitations program; or
- Medications that are part of our Special Designated Pharmacy program.

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

Exclusions

We 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 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 SERVCIES.
- A drug, device, medical treatment or procedure (collectively "treatment") that is EXPERIMENTAL OR INVESTIGATIVE.
  This exclusion does not apply to:
  - bone marrow transplants for breast cancer;
  - long-term antibiotic treatment of chronic Lyme disease;
  - patient care services provided as part of a qualified clinical trial conducted to prevent, detect or treat cancer or other life-threatening diseases or conditions;
  - Off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS, if you have a Prescription Drug Benefit.
    which meet the requirements of Massachusetts and federal law.

    If the treatment is EXPERIMENTAL or INVESTIGATIVE, we will not pay for any related treatments which are provided to the MEMBER for the purpose of furnishing the EXPERMENTAL 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 yoursel or for 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: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which we determine that benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a PROVIDER may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the DIRECTORY OF HEALTHCARE PROVIDERS to determine if your PROVIDER charges such a fee.
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated).
- Facility charges or related services if the procedure being performed is not a COVERED SERVICE, except as provided under "Oral health services" earlier in this chapter.
- Preventive dental care , except as provided under “Pediatric dental care for MEMBERS up to age 19” earlier in this chapter.
- 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" , 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. This exclusion does not apply to the treatment of cleft lip or cleft palate for CHILDREN under the age of 18, as described under “Cleft lip or cleft palate treatment and services for CHILDREN” earlier in this chapter. Please note that this bulleted exclusion does not apply for Covered Services described under the “Pediatric dental care for MEMBERS up to age 19”, described earlier in this chapter.

- The following pediatric dental care services, treatments, and supplies:
  - Services that are not dentally necessary and appropriate according to Delta Dental review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; and, oral surgery. These guidelines help Delta Dental in making decisions about whether services are covered; and, whether a given service is the least costly, clinically acceptable method of prevention, diagnosis or treatment. A service may not be covered under these guidelines even if it was recommended by a dentist.
    . You can have your dentist send Delta Dental a request for a Pre-treatment
    Estimate in advance of the service to see if the service meets the review guidelines.
  - Services received from a dental or medical department maintained by or on behalf of an employer; a mutual benefit association; labor union; trustee; or, similar person or group.
  - An illness or injury that we decide is employment-related.
  - Services you would not have to pay for if you did not have thishealth insurance plan.
  - Services or supplies that are experimental in terms of generally accepted dental standards.
  - Services done by a dentist who is a member of your immediate family.
  - Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.
  - Exams by specialists except for periodic oral exams.
  - Consultations.
  - Disorders related to the temporomandibular joints - (TMJ), including night guards and surgery.
  - Services to increase the height of teeth or restore occlusion.
  - Restorations needed because you grind your teeth or due to erosion, abrasion, or attrition.
  - Services done mainly to change or to improve your appearance.
  - Orthodontics except for medically necessary orthodontics for patients under age 19.
  - Occlusal guards.
  - Implants.
  - Bone grafts.
  - Splinting and other services to stabilize teeth.
  - Laboratory or bacteriological tests or reports.
  - Temporary, complete dentures or temporary, fixed bridges or crowns.
  - Prescription drugs.
  - General anesthesia or intravenous sedation given by anyone other than a dentist.

  We can adopt and apply policies that we deem reasonable when we approve the eligibility of MEMBERS; and, the appropriateness of treatment plans and related charges.

  This exclusion does not apply to the treatment of cleft lip or cleft palate for CHILDREN under the age of 18, as described under “Cleft lip or cleft palate treatment and services for CHILDREN” earlier in this chapter.

- Surgical removal or extraction of teeth, except as provided under "Oral health services" and “Pediatric dental care for MEMBERS up to age 19” earlier in this chapter
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under "Reconstructive surgery and procedures" earlier in this chapter.
- Rhinoplasty, except as provided under "Reconstructive surgery and procedures" earlier in this chapter; liposuction; the removal of tattoos; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.
- Hair removal, except when MEDICALLY NECESSARY to treat an underlying skin condition.
- 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 PROVIDERS 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, oocytes or embryos for certain medical conditions that may impact a MEMBER's future fertility. Prior approval by an AUTHORIZED REVIEWER is required.

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

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

A gestational carrier is a surrogate with no biological connection to the embryo/child.

- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an AUTHORIZED REVIEWER and the MEMBER is the sole recipient of the donor's eggs.
- 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" (to the extent such costs are not covered by the donor's health coverage, if any).
- Acupuncture; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; neuromuscular stimulators and related supplies; electrolysis; INPATIENT and OUTPATIENT weight-loss programs and clinics except as described earlier in this chapter ; relaxation therapies; massage therapies, except as described under "Short term physical and occupational therapy services" earlier in this chapter; services by a personal trainer; exercise classes; cognitive rehabilitation programs or cognitive retraining programs except as described earlier in this chapter . Also excluded are diagnostic services related to any of these procedures or programs.
- Multi-purpose general electronic devices including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electronic devides including USB devides and direct connect devices (e.g., speaker, microphone, cables, cameras, batteries, etc.). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet, and all related accessories.
- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies, or procedures, and all services, procedures, labs and supplements associated with this type of medicine.
- Any service, program, supply or procedure performed in a non-conventional setting (including, but not limited to, spas/ resorts; educational, vocational, or recreational settings; Outward Bound; or wilderness, camp, or ranch programs), even if performed or provided by licensed PROVIDERS (including, but not limited to, mental health professionals, nutritionists, nurses or physicians). Examples of services provided in a non-conventional setting that are excluded from coverage include, but are not limited to, psychotherapy, ABA services, and nutritional counseling.
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the "Note" below.

  Note: The following blood services and products are covered:

  - blood processing;
  - blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval by an AUTHORIZED REVIEWER is required);
  - intravenous immunoglobulin for treatment of severe immune disorders,certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an AUTHORIZED REVIEWER is required).
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational purposes including 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, behavioral problems, and services to treat speech, hearing and language disorders in a school-based setting.

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

  Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a MEMBER with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the MEMBER'S treating doctor, the shoes or inserts are prescribed by a PROVIDER who is a podiatrist or other qualified doctor and are furnished by a PROVIDER who is a podiatrist, orthotist, prosthetist, or pedorthist.
- Transportation, including, but not limited to, ansportation by chair car, taxi, or wheelchair van, except as described in "Ambulance services" in this chapter.
- Lodging related to receiving any medical service, including lodging related to obtaining gender reassignment surgery or related services.
- Private duty nursing (block or non-intermittent nursing).

Chapter 4 - When Coverage Ends

Reasons coverage ends

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

- you lose eligibility because you enrolled under a GROUP CONTRACT and no longer meet your GROUP's or TUFTS HEALTH PLAN'S eligibility rules; or
- you enrolled under an INDIVIDUAL and no longer meet your INDIVIDUAL CONTRACT's or TUFTS HEALTH PLAN's eligibility rules; or
- you are a SUBSCRIBER or a SPOUSE and you no longer live, work or reside in the NETWORK CONTRACTNG AREA; or
- you choose to drop coverage; or
- you commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to any PROVIDER, any TUFTS HEALTH PLAN MEMBER, TUFTS HEALTH PLAN or any TUFTS HEALTH PLAN employee; or
- you commit an act of misrepresentation or fraud; or
- your GROUP CONTRACT or INDIVIDUAL CONTRACT (whichever applies) with TUFTS HEALTH PLAN ends. (For more information, see "Termination of a GROUP CONTRACT and Notice" or "Termination of an INDIVIDUAL COVERAGE" 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. Please see "If you live, work or reside outside of the NETWORK CONTRACTING AREA" in Chapter 2 for more information.

Benefits after termination

TUFTS HEALTH PLAN 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 conversion

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

When a Member is No Longer Eligible

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

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

If you no longer live, work or reside in the NETWORK CONTRACTING AREA
If you 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 when the SUBSCRIBER's coverage ends or when the DEPENDENT no longer meets the definition of DEPENDENT, whichever occurs first. Coverage of any CHILD of an enrolled DEPENDENT CHILD ends when the enrolled DEPENDENT CHILD's coverage ends.

You choose to drop coverage
Coverage ends if you decide you no longer want coverage and you meet any qualifying event your GROUP requires. To end your coverage, notify your GROUP (or TUFTS HEALTH PLAN if covered under an INDIVIDUAL CONTRACT) at least 30 days before the date you want your coverage to end. You must pay PREMIUMS up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

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

- are unrelated to your physical or mental condition;
- pose a threat to any PROVIDER, any TUFTS HEALTH PLAN MEMBER, or TUFTS HEALTH PLAN or any TUFTS HEALTH PLAN employee.

Membership Termination for Misrepresentation or Fraud

Policy
TUFTS HEALTH PLAN may terminate your coverage for misrepresentation or fraud. If your coverage is terminated for misrepresentation or fraud, TUFTS HEALTH PLAN may not allow you to re-enroll for coverage with TUFTS HEALTH PLAN under any other plan (such as a non-group or another employer's plan) or type of coverage (for example, coverage as a DEPENDENT or SPOUSE).

Acts of misrepresentation or fraud
Examples of misrepresentation or fraud include:

- false or misleading information on your application;
- enrolling as a SPOUSE someone who is not your SPOUSE;
- receiving benefits for which you are not eligible;
- keeping for yourself payments made by TUFTS HEALTH PLAN that were intended to be used to pay a PROVIDER; or
- allowing someone else to use your Member ID;
- submission of any false paperwork, forms, or claims information.

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

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

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

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

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

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

If the PREMIUM is more than is needed to pay for COVERED SERVICES you received after your termination date, TUFTS HEALTH PLAN will refund the excess to your GROUP (or TUFTS HEALTH PLAN if covered under an INDIVIDUAL CONTRACT) .

Voluntary and Involuntary Disenrollment Rates for MEMBERS
As required by Massachusetts law, TUFTS HEALTH PLAN conducts an annual disenrollment study. Annually, the study looks at the reasons MEMBERS leave TUFTS HEALTH PLAN, in order to track voluntary and involuntary disenrollment rates.

> **Voluntary Disenrollment Rate** - The number of MEMBERS we disenrolled because they ceased to pay PREMIUMS. This is the voluntary disenrollment rate. For the year 2014, less than one percent of MEMBERS voluntarily disenrolled by ceasing to pay their PREMIUMS.
>
> **Involuntary Disenrollment Rate** - The number of MEMBERS that we disenrolled because of fraud or acts of physical or verbal abuse. This is the involuntary disenrollment rate. For the year 2014, less than one percent of MEMBERS were involuntarily disenrolled as a result of fraud or abuse.

For additional information about the voluntary and involuntary disenrollment rates among TUFTS HEALTH PLAN MEMBERS, call Member Services.

Termination of a GROUP CONTRACT and Notice

End of TUFT HP and GROUP's relationship
If you enrolled under a GROUP's coverage will terminate if the relationship between your GROUP and TUFTS HEALTH PLAN ends for any reason, including:

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

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

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

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

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

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

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

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

Transfer to Other Employer GROUP Health Plans

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

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

Termination of an INDIVIDUAL CONTRACT

End of TUFTS HEALTH PLAN and SUBSCRIBER's relationship under an INDIVIDUAL CONTRACT
If you enrolled under an INDIVIDUAL CONTRACT, coverage will terminate if your relationship with TUFTS HEALTH PLAN ends for any reason, including:

- your INDIVIDUAL CONTRACT with TUFTS HEALTH PLAN terminates;
- you fail to pay PREMIUMS on time*; or
- TUFTS HEALTH PLAN stops operating.

*If the SUBSCRIBER is terminated, he or she cannot then reinstate coverage under this plan for a period of at least one year from his or her original enrollment date.

Chapter 5 - Continuation of GROUP CONTRACT Coverage

31-Day Continuation Coverage When MEMBER Leaves GROUP

Under Massachusetts law, a MEMBER who leaves a GROUP shall be able to continue his or her coverage under the

GROUP CONTRACT for a period of 31 days. If that MEMBER becomes entitled to other health insurance coverage during that 31-day period, this continuation coverage shall end as of the date he or she becomes entitled to the other health insurance coverage. For more information about this continuation coverage, please call your GROUP or Member Services.

Federal Continuation Coverage (COBRA)

Rules for federal COBRA continuation

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

Qualifying Events

A MEMBER's GROUP coverage under the GROUP CONTRACT may end because he or she experiences a qualifying event. A qualifying event is defined as:

- the SUBSCRIBER’s death;
- termination of the SUBSCRIBER’s employment for any reason other than gross misconduct;
- reduction in the SUBSCRIBER’s work hours;
- the SUBSCRIBER’s divorce or legal separation;
- the SUBSCRIBER’s entitlement to Medicare; or
- the SUBSCRIBER’s or SPOUSE’s enrolled DEPENDENT ceases to be a DEPENDENT CHILD.

If a MEMBER experiences a qualifying event, he or she may be eligible to continue GROUP coverage as a SUBSCRIBER or an enrolled DEPENDENT under federal COBRA law as described below.

When federal COBRA coverage is effective

A MEMBER who is eligible for federal COBRA continuation coverage is called a “qualified beneficiary.” A qualified beneficiary must be given an election period of 60 days to choose whether to elect federal COBRA continuation coverage. This period is measured from the later of the date the qualified beneficiary’s coverage under the GROUP CONTRACT ends (see the list of qualifying events described above) or the date the plan provides the qualified beneficiary with a COBRA election notice.

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

Cost of Coverage

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

Duration of Coverage

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

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

When coverage ends

Federal COBRA continuation coverage will end at the end of the maximum period of coverage. However, coverage may end earlier if:

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

Massachusetts Continuation Coverage

How to qualify for coverage

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 employment for any reason other than gross misconduct;
- reduction in the 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 Massachusetts continuation coverage as described below.

Note: Same-sex marriages legally entered into in Massachusetts are recognized under Massachusetts law. Therefore, Massachusetts continuation, 39-week continuation, and plant closing continuation provisions do apply to same-sex SPOUSES. Contact your employer for more information.

When coverage begins

Massachusetts continuation coverage is effective on the date following the day GROUP coverage ends, in most cases. Massachusetts continuation coverage would end, in most cases, 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.

Payment of PREMIUM

In most cases, you are responsible for payment of 102% of the GROUP PREMIUM for Massachusetts continuation coverage.

Rules for Massachusetts continuation

Under a Massachusetts law similar to COBRA, you may be eligible to continue coverage after GROUP coverage ends if: you were enrolled in TUFTS HEALTH PLAN through a Massachusetts GROUP which has 2 - 19 eligible employees and you experience a qualifying event which would cause you to lose coverage under your GROUP; and you elect this continuation coverage by following the procedure described below.

A MEMBER who is eligible for Massachusetts continuation of coverage (a "qualified beneficiary") must be given an election period of 60 days to choose whether to elect Massachusetts continuation of coverage. This period is measured from the later of the date the qualified beneficiary's coverage under the GROUP CONTRACT ends, or the date the GROUP provides the qualified beneficiary with a election notice. To elect this coverage, you must complete a Massachusetts continuation of coverage election form and return it to your GROUP within the 60 day period. Contact your GROUP for more information.

Coverage under an INDIVIDUAL CONTRACT

When your coverage under federal COBRA continuation or Massachusetts continuation ends, you and your enrolled DEPENDENTS may be eligible to apply for coverage under an INDIVIDUAL CONTRACT. See "COVERAGE under an INDIVIDUAL CONTRACT" at the end of this chapter for more information.

39-Week Continuation Coverage

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

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

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

Plant Closing

Description of continuation available under a GROUP CONTRACT.

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

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Under USERRA:

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

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

Coverage under an INDIVIDUAL CONTRACT

If GROUP coverage ends, the MEMBER may be eligible to enroll in coverage under an INDIVIDUAL CONTRACT offered either directly by TUFTS HEALTH PLAN or through the Commonwealth Health Insurance Connector Authority ("the Connector"). Please note that coverage under an INDIVIDUAL CONTRACT may differ from GROUP coverage. For more information, call TUFTS HEALTH PLAN Member Services or contact the Connector either by phone (1-877-MA-ENROLL) or on its Web site (www.mahealthconnector.org).

Chapter 6- How to File a Claim and MEMBER Satisfaction

How to File a Claim

NETWORK Providers
When you obtain care from a NETWORK PROVIDER you do not have to submit claim forms. The NETWORK PROVIDER will submit claim forms to TUFTS HEALTH PLAN for you. TUFTS HEALTH PLAN will make payment directly to the NETWORK PROVIDER.

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

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

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

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

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

To Obtain Claim Forms
Claim forms are available from the GROUP or by calling TUFTS HEALTH PLAN 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

Separate claim forms should be submitted for each family MEMBER.

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

MEMBER Satisfaction Process

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

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

All grievances and appeals should be sent to TUFTS HEALTH PLAN at the following address:

TUFTS HEALTH PLAN

Attn: Appeals and Grievances Dept.

705 Mt. Auburn Street

P.O. Box 9193

Watertown, MA 02471-9193

All calls should be directed to TUFTS HEALTH PLAN Member Services at1-800-423-8080. Alternatively, you may submit your grievance or appeal at the address listed above.

Internal Inquiry

Call a TUFTS HEALTH PLAN Member Specialist to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be explained or resolved within three (3) business days or if you tell a Member Specialist that you are not satisfied with the response you have received from TUFTS HEALTH PLAN we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

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

MEMBER Grievance Process

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

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

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

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

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

Administrative Grievance Timeline
- If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify TUFTS HEALTH PLAN that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your PROVIDERS to release medical information relevant to your grievance to TUFTS HEALTH PLAN. You must sign and return the form before TUFTS HEALTH PLAN can begin the review process. If you do not sign and return the form to TUFTS HEALTH PLAN within thirty (30) business days of the date you filed, TUFTS HEALTH PLAN may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance that are in the possession and control of TUFTS HEALTH PLAN.
- TUFTS HEALTH PLAN will review your grievance and will send you a letter regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and TUFTS HEALTH PLAN.

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

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

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

Internal Member Appeals

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 (an adverse determination) or a denial of coverage for a specifically excluded service or supply. The TUFTS HEALTH PLAN Appeals and Grievances Department will review all of the information submitted upon appeal, taking into consideration your benefits as detailed in this CERTIFICATE OF INSURANCE.

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

Your explanation should include:

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

Appeals Timeline

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

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

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

Health Care for All

30 Winter Street, Suite 1004

Boston, MA 02108

(800) 272-4232

http://www.hcfama.org/helpline

When Medical Records are Necessary

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

Who Reviews Appeals?

If the appeal involves a medical necessity determination, an actively practicing health care professional in the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment that is under review, and who did not participate in any of the prior decisions on the case, will take part in the review. In addition, a

committee made up of managers and clinicians from various TUFTS HEALTH PLAN departments will review your appeal. A committee within the Appeals and Grievances Department will review appeals involving non-COVERED SERVICES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Policy Commission

Office of Patient Protection

Two Boylston Street, 6th Floor

Boston, MA 02116

Phone: 1-800-436-7757

Fax: 1-617-624-5046

Internet: www.mass.gov/hpc.opp

Email: HPC-OPP@state.ma.us

Bills from Providers

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

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

- A completed, signed MEMBER Reimbursement Medical Claim Form, which can be obtained from the TUFTS HEALTH PLAN web site or by contacting the TUFTS HEALTH PLAN Member Services Department
- the documents listed on the MEMBER Reimbursement Medical Claim Form that are required for proof of service and payment.

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

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

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

IMPORTANT NOTE

Certain services you receive from most NON-NETWORK PROVIDERs at an IN-NETWORK setting may be reimburseable within our Network Contracting Area. Some examples of these types of PROVIDERS include

- radiologists, pathologists, and anesthesiologists who work in NETWORK Hospitals hospitals; and
- Emergency room specialists.

TUFTS HEALTH PLAN reserves the right to be reimbursed by the MEMBER for payments made due to TUFTS HEALTH PLAN's error.

Notice to Michigan Residents
A complete and proper claim for COVERED SERVICES made by a MEMBER will be promptly processed by TUFTS HEALTH PLAN. 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

Limitation on Actions
You cannot file a lawsuit against TUFTS HEALTH PLAN for failing to pay or arrange for COVERED SERVICES unless you have completed the TUFTS HEALTH PLAN MEMBER Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under this GROUP or INDIVIDUAL CONTRACT, you must first complete our MEMBER Satisfaction Process, and then file your lawsuit within two years after the date you were first sent a notice of the denial. Going through the TUFTS HEALTH PLAN MEMBER Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage. However, if you choose to pursue external review by the Office of Patient Protection, the days

from the date your request is received by the Office of Patient Protection until the date you receive the response are not counted toward the two-year limit.

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, 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.

Workers’ compensation

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

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

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

TUFTS HEALTH PLAN's right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for

expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- 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, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

Constructive Trust

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

MEMBER cooperation

You further agree:

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

Subrogation Agent

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

Coordination of Benefits

Benefits under other plans

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

TUFTS HEALTH PLAN has a coordination of benefits (COB) program that prevents duplication of payment for the same health care services. We will coordinate benefits payable for COVERED SERVICES with benefits payable by other plans, consistent with state law.

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

Primary and secondary plans

TUFTS HEALTH PLAN will coordinate benefits by determining which plan has to pay first when you make a claim and which plan has to pay second. TUFTS HEALTH PLAN will make these determinations according to applicable state law.

Right to receive and release necessary information

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

You agree to provide information about other coverage and cooperate with TUFTS HEALTH PLAN's COB program.

Right to recover overpayment

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

For more information

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

Medicare Eligibility

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

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;
- if you are a MEMBER who is enrolled under an INDIVIDUAL CONTRACT (meaning not covered through an employer under a GROUP CONTRACT); or
- if you are eligible for Medicare under age 65 due to disability, but are not actively working or are actively working for an employer with fewer than 100 employees.

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

Use and Disclosure of Medical Information

TUFTS HEALTH PLAN mails a separate “NOTICE OF PRIVACY PRACTICES” to all SUBSCRIBERS to explain how TUFTS HEALTH PLAN uses and discloses your medical information. If you have questions or would like another copy of our “Notice of Privacy Practices”, please call a Member Specialist. Information is also available on our Web site at **www.tuftshealthplan.com**.

Relationships between TUFTS HEALTH PLAN and PROVIDERS

TUFTS HEALTH PLAN arranges health care services. TUFTS HEALTH PLAN does not provide health care services. TUFTS HEALTH PLAN has agreements with PROVIDERS practicing in their private offices throughout the 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.

TUFTS HEALTH PLAN is not liable for acts, omissions, representations or other conduct of any PROVIDER.

Circumstances Beyond TUFTS HEALTH PLAN's Reasonable Control

Circumstances beyond TUFTS HEALTH PLAN's reasonable control

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

GROUP CONTRACT

Acceptance of the terms of the GROUP CONTRACT

By signing and returning the membership application form, you apply for GROUP coverage and agree, on behalf of yourself and your enrolled DEPENDENTS, to all the terms and conditions of the GROUP CONTRACT, including this CERTIFICATE.

Payments for coverage

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

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

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

Changes to this CERTIFICATE

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

An amendment to this CERTIFICATE describing the changes will be sent to you and 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, not just to you.

Notice

Notice to MEMBERS: When TUFTS HEALTH PLAN sends a notice to you, it will be sent to your last address on file with TUFTS HEALTH PLAN.

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

TUFTS HEALTH PLAN, 705 Mount Auburn Street, P.O. Box 9173, Watertown, MA 02471-9173.

Enforcement of terms

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

When this CERTIFICATE Is Issued and Effective

This CERTIFICATE is issued and effective on your GROUP ANNIVERSARY DATE on or after January 1, 2017 and supersedes all previous CERTIFICATES.

INDIVIDUAL CONTRACT

Acceptance of the terms of the INDIVIDUAL CONTRACT

By signing and returning the membership application form, you apply for coverage under an INDIVIDUAL CONTRACT and agree, on behalf of yourself and your enrolled DEPENDENTS, to all the terms and conditions of the INDIVIDUAL CONTRACT, including this CERTIFICATE.

Payments for coverage

TUFTS HEALTH PLAN will bill *y*ou for coverage under an INDIVIDUAL CONTRACT and you will be required to pay PREMIUMSto TUFTS HEALTH PLAN for that coverage. TUFTS HEALTH PLAN is not responsible if you fail to pay the PREMIUM.

Note: If you do not pay the PREMIUMS on time, TUFTS HEALTH PLAN may cancel your coverage in accordance with the INDIVIDUAL CONTRACT and applicable state law.

TUFTS HEALTH PLAN may change the PREMIUM. If the PREMIUM is changed, the change will apply to all MEMBERS under the INDIVIDUAL CONTRACT.

Changes to this CERTIFICATE.

TUFTS HEALTH PLAN may change this CERTIFICATE. Changes do not require your consent. Notice of changes in COVERED SERVICES will be sent to the SUBSCRIBER at least 60 days before the EFFECTIVE DATE of the modifications and will:

- include information regarding any changes in clinical review criteria; and
- detail the effect of such changes on a MEMBER's personal liability for the cost of such changes.

An amendment to this CERTIFICATE describing the changes will be sent to you and 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 under the INDIVIDUAL CONTRACT, not just to you.

Notice

Notice to MEMBERS: When TUFTS HEALTH PLAN sends a notice to you, it will be sent to your last address on file with TUFTS HEALTH PLAN.

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

TUFTS HEALTH PLAN
705 Mount Auburn Street
P.O. Box 9173
Watertown, MA 02471-9173

Enforcement of terms

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

When this CERTIFICATE Is Issued and Effective

This CERTIFICATE is issued and effective on your ANNIVERSARY DATE on or after January 1, 2017 and supersedes all previous CERTIFICATES.

Appendix A - Glossary of Terms And Definitions

This section defines the terms used in this CERTIFICATE.

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

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

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

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

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

AUTHORIZED REVIEWER
AUTHORIZED REVIEWERS review and approve certain services and supplies to MEMBERS. They are TUFTS HEALTH PLAN's Chief Medical Officer (or equivalent) or someone he or she names.

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

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

For more information, please call Member Services. If you are enrolled in a GROUP CONTRACT, you can also contact your employer.

CERTIFICATE OF INSURANCE (CERTIFICATE)
This document, and any future amendments, which describes the health benefits under the GROUP CONTRACT or INDIVIDUALI CONTRACT .

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

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

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

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

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

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

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

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

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 and costs in excess of the REASONABLE CHARGE for services received at the OUT OF NETWORK LEVEL OF BENEFITS are not included in the 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 TUFTS HEALTH PLAN will pay. They must be:

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

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

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

In cases of mental 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, and with an expected departure the same day, or in some instances, within 24 hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care".

DEDUCTIBLE
For each CALENDAR YEAR, the amount paid by the MEMBER for certain COVERED SERVICES before any payments are made under this CERTIFICATE.
(Any amount paid by the MEMBER for a COVERED SERVICE rendered during the last 3 months of a CALENDAR YEAR shall be carried forward to the next CALENDAR YEAR's DEDUCTIBLE.). However, any DEDUCTIBLE amount carried forward will not be applied to the next CALENDAR YEAR OUT-OF-POCKET MAXIMUM.

Costs in excess of the REASONABLE CHARGE for services do not count towards the DEDUCTIBLE. See "Benefit Overview" at the front of this CERTIFICATE for more information.

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

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

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

DIRECTORY OF HEALTH CARE PROVIDERS
A separate booklet which lists NETWORK physicians, 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 Member Services or check the Web site at www.tutftshealthplan.com.

DISABLED DEPENDENT
The SUBSCRIBER's CHILD who:

- became permanently physically or mentally disabled before the last day of the month in which their 26th birthday occurs;
- is incapable of supporting himself or herself due to disability;
- lives with the SUBSCRIBER or SPOUSE; and
- was covered under the SUBSCRIBER's FAMILY COVERAGE immediately before the last day of the month in which their 26th birthday occurs or has been covered by other GROUP health coverage since the disability began.

DURABLE MEDICAL EQUIPMENT
Devices or instruments of a durable nature that:

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

EFFECTIVE DATE
The date, according to TUFTS HEALTH PLAN's records, when you become a MEMBER and are first eligible for COVERED SERVICES.

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

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

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

EXPERIMENTAL OR INVESTIGATIVE
A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered EXPERIMENTAL OR INVESTIGATIVE 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; or
- reliable 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 and/or effective in improving health outcomes or that appropriate patient selection has not been determined; or
- 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.

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

GROUP
An employer or other legal entity with which TUFTS HEALTH PLAN has an agreement to provide GROUP coverage. An employer GROUP subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. If you are covered under a GROUP CONTRACT, the GROUP is your agent and is not TUFTS HEALTH PLAN's agent.

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

- TUFTS HEALTH PLAN agrees to provide GROUP coverage; and
- the GROUP agrees to pay a PREMIUM to TUFTS HEALTH PLAN on your behalf.

The GROUP CONTRACT includes this CERTIFICATE and any amendments.

INDIVIDUAL CONTRACT
The agreement between TUFTS HEALTH PLAN and the SUBSCRIBER under which:

- TUFTS HEALTH PLAN agrees to provide INDIVIDUAL COVERAGE; and
- the SUBSCRIBER agrees to pay a PREMIUM to TUFTS HEALTH PLAN.

The INDIVIDUAL 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 is classified as an INPATIENT for all or a part of the day.

INPATIENT NOTIFICATION (formerly known as "Preregistration")

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

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

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

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

In determining coverage for MEDICALLY NECESSARY Services, we use Clinical Coverage Guidelines which are:

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

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

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

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

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

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

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

NON-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.

NOTIFICATION PENALTY (formerly known as "Preregistration")

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

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

OPEN ENROLLMENT PERIOD
For a GROUP CONTRACT, the period each year when TUFTS HEALTH PLAN and the GROUP allow eligible persons to apply for GROUP coverage in accordance with the GROUP CONTRACT. This is also the period each year when TUFTS HEALTH PLAN allows eligible individuals to apply for coverage in accordance with an Individual Contract.

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

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

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

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

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

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

PREMIUM
Under a GROUP CONTRACT, the total monthly cost of Individual or FAMILY COVERAGE which the GROUP pays to TUFTS HEALTH PLAN. Under an INDIVIDUAL CONTRACT, the total monthly cost of INDIVIDUAL or FAMILY COVERAGE which the SUBSCRIBER pays to TUFTS HEALTH PLAN.

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

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

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

PROVIDER
A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, LIMITED SERVICE MEDICAL CLINICs (if available), URGENT CARE CENTERs (if available), physicians, doctors of osteopathy, certified nurse midwives, certified registered nurse anesthetists, physician assistants, 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, licensed alcohol and drug counselor I; licensed marriage and family therapists, licensed speech-language pathologists, and licensed audiologists.

TUFTS HEALTH PLAN will only cover services of a PROVIDER, if those services are listed as COVERED SERVICES and within the scope of the PROVIDER's license.

Notes:

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

REASONABLE CHARGE
The lesser of:

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

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

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

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

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

SUBSCRIBER
The person:

- for a GROUP CONTRACT, is an employee of the GROUP;
- for an INDIVIDUAL CONTRACT, is a Massachusetts resident;
- who 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 either a GROUP CONTRACT or an INDIVIDUAL CONTRACT (whichever applies).

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

Both TIC and TBA do business under the name TUFTS HEALTH PLAN. TUFTS HEALTH PLAN is also referred to as "TUFTS HP".

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

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

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

Appendix B - ERISA Information and other State and Federal Notices

ERISA RIGHTS

Note: Applies to Group Contracts only.

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

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

Receiving Information About Your Plan and Benefits
ERISA provides that all plan participants shall be entitled to:

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

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, youmay file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PROCESSING OF CLAIMS FOR PLAN BENEFITS

Note: Applies to Group Contracts only.

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

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

How do I designate an Authorized Claimant?
An authorized claimant can be designated at any point in the claims process - at the pre-service, post service or appeal level. Please contact a Tufts Health Plan Member Specialist at 1-800-423-8080 for the specifics on how to appoint an authorized claimant.

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

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

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

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

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

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

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

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

Note: Applies to Group Contracts only.

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

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

In addition, a plan or issuer may not, under federal law, require that a provider or other health care provider obtain authorization for prescribing a length of stay or up to 48 hours (or 96 hours). However, to use certain providers or facilities, you may be required to 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/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 Plan is committed to safeguarding the privacy of our members' protected health information ("PHI"). PHI is information which:

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

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use, and disclose your PHI, and your rights concerning your PHI. This Notice applies to all members of Tufts Health Plan's 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.

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

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

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

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

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

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

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

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

Appendix C - Massachusetts Individual and Small Group 4-Tier Drug List

This list of covered drugs is effective January 1, 2016 and may change during the year. The drugs on this list may change 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.

IMPORTANT NOTE: Please see our Web site at **www.tuftshealthplan.com** for the most current list or call a Member Specialist.

Drug Category	Covered Drugs and their Tiers
ANTI-INFECTIVES AND INFECTIOUS DISEASE	
Antibiotics	Tier 1: amoxicillin, amox tr-potassium clavulanate, amoxicillin-clavulanate ER, ampicillin, azithromycin, cefaclor, cefadroxil, cefdinir, cefditoren pivoxil, cefepime, cefpodoxime proxetil, cefprozil, cefuroxime axetil, cephalexin, ciprofloxacin HCl, ciprofloxacin ER, clarithromycin, clarithromycin ER, clindamycin HCL, demeclocycline HCl, dicloxacillin sodium, doxycycline hyclate, doxycycline monohydrate, erythromycin, erythromycin base, erythromycin ethylsuccinate, erythromycin stearate, levofloxacin, linezolid, methenamine hippurate, metronidazole, minocycline HCl, neomycin sulfate, nitrofurantoin mono-macro, nitrofurantoin, ofloxacin, paromomycin sulfate, penicillin v potassium, sulfadiazine, sulfamethoxazole, trimethoprim, sulfamylon, tetracycline HCl, tobramycin nebulizer solution, trimethoprim, vancomycin HCl, voriconazole (QL) Tier 2: Cefaclor ER, Ketek Tier 3: Ceftin oral suspension, Dificid (PA), Eryped, E.E.S., Ery-tab, First Vancomycin, Flagyl ER, Monurol, Neo-fradin, Noroxin, PCE, Primsol, Suprax, Xifaxan (PA, QL), ZMAX, Zyvox oral suspension
Antifungals	Tier 1: clotrimazole, fluconazole, flucytosine, griseofulvin, itraconazole capsules (PA), ketoconazole, nystatin, terbinafine (QL), voriconazole (QL) Tier 2: Sporanox oral solution Tier 3: Cresemba, Lamisil oral packets (QL),Onmel (PA)
Antiparasitics	Tier 1: atovaquone suspension, chloroquine, hydroxychloroquine, lindane, malathion lotion, mefloquine, quinine sulfate Tier 2: atovaquone/proguanil, Coartem (QL), Daraprim, Primaquine Tier 3: Albenza, Alinia, Biltricide, Nebupent, Ulesfia (QL)
Anti-tuberculars	Tier 1: dapsone, ethambutol, isoniazid, isoniazid/rifampin, rifabutin, rifampin Tier 2: Priftin, Sirturo (PA) Tier 3: Paser, Rifater, Trecator
Antivirals	
Cytomegalovirus	Tier 1: valganciclovir tablet Tier 3: Valcyte oral solution

Hepatitis Agents	TiTier 1: ribavirin (SP) Tier 2:entecavir, Epivir HBV, Intron A (SP), Pegasys Proclick (SP, QL), Tyzeka Tier 3: Baraclude solution, PegIntron (SP, QL), Ribapak (SP), Sovaldi (SP, PA)
Herpes	Tier 1: acyclovir, famciclovir, valacyclovir Tier 3: Denavir, Zovirax cream (QL)
HIV/AIDS	Tier 1: abacavir, abacavir/lamivudine/zidovudine, didanosine, lamivudine, lamivudine/zidovudine, nevirapine, nevirapine extended release, stavudine, zidovudine Tier 2: Aptivus, Atripla, Complera, Crixivan, Edurant, Emtriva, Epzicom, Intelence, Isentress (QL), Invirase, Kaletra, Lexiva, Norvir, Prezista, Rescriptor, Reyataz, Selzentry, Stribild, Sustiva, Tivicay, Truvada, Viracept, Viread Tier 3: Videx oral solution, Viramune XR, Ziagen oral solution Tier 4: Fuzeon (SP)
Influenza	Tier 1: amantadine, rimantadine Tier 2: Tamiflu capsules (QL), Relenza (QL)
BLOOD THINNERS AND BLOOD MODIFYING AGENTS	
Antiplatelet Therapy	Tier 1: anagrelide, clopidogrel, dipyridamole, ticlopidine Tier 3: Brilinta, Effient
Blood Modifying Agents	Tier 2: Aranesp (SP, QL), Epogen (SP, QL), Granix (SP, QL), Leukine (SP, QL), Neulasta (SP, QL), Neupogen (SP, QL), Procrit (SP, QL)
Blood Thinners	Tier 1: enoxaparin (QL), fondaparinux (QL), heparin, warfarin Tier 2: Eliquis, Xarelto Tier 3: Fragmin (QL), Pradaxa, Savaysa
Miscellaneous	Tier 1: cilostazol, pentoxifylline, tranexamic acid (QL) Tier 2: Exjade, Ferriprox (PA, QL) Tier 4: Promacta (SP, PA, QL)
CANCER DRUGS	

Antineoplastics	Tier 1: anastrozole, bicalutamide (SP), cetoposide (SP), exemestane, flutamide, hydroxyurea, leuprolide, letrozole, leucovorin, lomustine, megestrol acetate, mercaptopurine, tamoxifen Tier 2: Alkeran, Caprelsa (PA, QL), Ceenu (SP), Cometriq (PA), cyclophosphamide capsules (SP), Droxia, Fareston, Hexalen, Iclusig (PA, QL), Imbruvica (PA), Lynparza (PA), Lysodren, Matulane, Nilandron, Revlimid (SP, PA), Sprycel (SP, PA, QL), Sutent (SP, PA), Tabloid (SP), Tarceva (SP, QL), Trexall, Zydelig (PA) Tier 3: Panretin, Purixan, Tier 4: Afinitor (SP, PA, QL), bexarotene (SP), Bosulif (SP, PA, QL), capecitabine (SP, QL), Emcyt (SP), Erivedge (SP, PA), Farydak (SP, PA), Gilotrif (SP, PA), Gleevec (SP), Hycamtin (SP, PA, QL), Ibrance (SP, PA), Inlyta (SP, PA), Jakafi (SP, PA), Lenvima (SP, PA), Leukeran (SP), Mekinist (SP, PA), Myleran (SP), Nexavar (SP, PA, QL), Pomalyst (SP, PA), Revlimid (SP, PA), Sprycel (SP, PA, QL), Stivarga (SP, PA, QL), Sutent (SP, PA), Sylatron (SP, PA, QL), Tabloid (SP), Tafinlar (SP, PA), Tarceva (SP, QL), Targretin (SP), Tasigna (SP, PA), Temodar (SP), temozolomide (SP), Thalomid (SP), tretinoin capsules (SP), Tykerb (SP, PA, QL), Votrient (SP, PA, QL), Xalkori (SP, PA), Xeloda (SP, QL), Xtandi (SP, PA, QL), Zelboraf (SP, PA), Zolinza (SP, PA), Zykadia (SP, PA), Zytiga (SP, PA, QL)
CARDIOVASCULAR DRUGS	
ACE Inhibitors	Tier 1: benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolapril
Alpha-1 Blockers / Centrally Acting Agents	Tier 1: clonidine, doxazosin, guanabenz, guanfacine, prazosin, terazosin
Aldosterone Receptor Blockers	Tier 1: eplerenone (STPA), spironolactone
Angina	Tier 1: isosorbide dinitrate, isosorbide mononitrate, nitroglycerin Tier 2: Nitrostat, Ranexa Tier 3: Nitro-BID
Angiotensin II Receptor Blockers (ARBs)	Tier 1: eprosartan, irbesartan, losartan, valsartan Tier 2: candesartan, Benicar
Antiarrhythmics	Tier 1: amiodarone, disopyramide, flecainide, mexiletine, pacerone, propafenone, quinidine sulfate, quinidine gluconate Tier 2: Tikosyn Tier 3: Multaq
Beta Blockers	Tier 1: acebutolol, atenolol, betaxolol, bisoprolol, carvedilol, labetalol, metoprolol succinate, metoprolol tartrate, nadolol, pindolol, propranolol, propranolol ER, sotalol AF, sotalol, timolol Tier 3: Bystolic, Innopran XL, Levatol
Calcium Channel Blockers	Tier 1: amlodipine, diltiazem, diltiazem extended-release, felodipine, isradipine, nicardipine, nifedipine, nifedipine extended release, nimodipine, nisoldipine, verapamil, verapamil extended release
Carbonic Anhydrous Inhibitors	Tier 1: acetazolamide
Digitalis Glycosides	Tier 1: digoxin
Direct Renin Inhibitors	Tier 3: Tekturna

Diuretics	Tier 1: amiloride, bumetanide, chlorothiazide, furosemide, hydrochlorothiazide, indapamide, methylclothiazide, metolazone, torsemide Tier 3: Edecrin
Endothelin receptor blockers	Tier 4: Letairis (SP, PA), Opsumit (SP, PA), Tracleer (SP, PA)
Miscellaneous	Tier 1: hydralazine, methyldopa, midodrine, minoxidil, phenoxybenzamine Tier 3: Corlanor (PA), Entresto (PA) Tier 4: Adempas (SP, PA)
Prostacyclin Analogue	Tier 4: Orenitram (SP, PA)
Selective Phosphodiesterase Inhibitors	Tier 4: Adcirca (SP, PA), sildenafil (SP, PA)
LIPID/CHOLESTEROL LOWERING AGENTS	
HMG-CoA Reductase Inhibitors	Tier 1: atorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin Tier 3: Crestor (PA)
Other	Tier 1: cholestyramine, colestipol, fenofibrate, gemfibrozil Tier 2: fenofibrate 48 mg, 145 mg, niacin ER, omega-3 ethyl esters Tier 3: Welchol, Zetia Tier 4: Kynamro (SP, PA, QL)
CONTRACEPTIVES **Note: In accordance with the ACA, contraceptives are covered in full.**	
Biphasic	Necon 10/11
Emergency Contraception	Ella
Extended cycle	Amethia Lo, Jolessa, Quasense
Four Phasic	Natazia
Injectable	medroxyprogesterone acetate 150 mg/ml
Monophasic	Amethyst, April, Aviane, Beyaz, Generess, Gianvi, Junel, Junel Fe, Kariva, Levora, Loestren 24 Fe, Lo Loestrin FE, Low-Ogestrel, Lutera, Microgestin, Microgestin Fe, Mononessa, Necon 0.5/35, Necon 1/35, Necon 1/50, Nortrel, Ocella, Ogestrel, Ovcon 50, Portia, Reclipsen, Safyral, Sprintec, Zovia 1/35, Zovia 1/50
Other	Ortho Evra
Progestin only	Camila, Errin
Triphasic	Aranella, Enpresse, Necon 7/7/7, Nortrel 7/7/7, Ortho Tri-Cyclen Lo, Tilia Fe, Trinesssa, Tri-Sprintec, Trivora, Velivet
Vaginal	Nuvaring
DIABETES MELLITUS	
Glucose Elevating Agent	Tier 2: Glucagon
Insulins	Tier 2: Cartridges, pens, and vials of the following insulins: Humalog, Humulin, Lantus, Lantus Solostar, Toujeo
Non-insulin Injectables	Tier 2: Trulicity, Victoza Tier 3: Symlin Pen, Tanzeum

Oral Agents	Tier 1: acarbose, chlorpropamide, glimepiride, glipizide, glyburide, metformin, nateglinide, pioglitazone, repaglinide, tolazamide, tolbutamide Tier 2: Januvia, Invokana Tier 3: Glyset, Jardiance, Proglycem, Riomet, Tradjenta
EAR	
Anti-infectives and Anti-infective/ anti-inflammatory Agents	Tier 1: acetic acid/aluminum, acetic acid/hydrocortisone, neomycin/ polymixin B/hydrocortisone, ofloxacin Tier 2: Ciprodex Tier 3: Cipro HC, Coly-Mycin S, Cortisporin TC
Other	Tier 1: fluocinolone acetonide oil
EYE	
Allergy	Tier 1: azelastine, cromolyn sodium, epinastine, naphazoline HCl Tier 3: Emadine, Alamast, Alocril, Alomide, Patanol
Antibiotics and antibiotic/ anti-inflammatory Agents	Tier 1: bacitracin, ciprofloxacin, erythromycin, gentamicin, levofloxacin, ofloxacin, tobramycin Tier 3: Azasite (QL), Besivance (QL), IQUIX, Moxeza (QL), Ocudox, Tobradex, Vigamox (QL), Zymar
Anti-inflammatories	Tier 1: bromfenac, dexamethasone, diclofenac, fluormethalone, flurbiprofen, ketorolac, prednisolone Tier 2: Alrex, Pred Mild, Vexol Tier 3: Bromday, Flarex, FML Forte, FML S.O.P., Lotemax, Maxidex, Nevanac
Antifungals	Tier 3: Natacyn
Antivirals	Tier 1: trifluridine Tier 3: Zirgan
Anesthetic	Tier 1: proparacaine
Dry Eye	Tier 3: Lacrisert, Restasis (PA)
Other	Tier 1: tropicamide
GLAUCOMA	
Oral Agents	Tier 1: methazolamide
Topical Agents	Tier 1: apraclonidine, betaxolol, brimonidine, caretolol, dorzolamide, dorzolamide/timolol, latanoprost, levobunolol, metipranolol, pilocarpine, timolol Tier 2: Azopt, Betimol, Pilopine HS Tier 3: Alphagan P, Betopic S, Combigan (QL), Cosopt PF, Istalol, Lumigan (STPA), Phopholine Iodide, Timoptic Ocudose, Travatan Z (STPA), Zioptan (STPA, QL)
GASTROINTESTINAL DRUGS	
Anti-diarrheals	Tier 1: atropine/diphenoxylate Tier 3: Motofen

Anti-nausea	Tier 1: chlorpromazine, dronabinol, granisetron (QL), meclizine, metoclopramide, ondansetron (QL), perphenazine, prochlorperazine, trimethobenzamide Tier 2: Anzemet (QL) Tier 3: Cesamet (QL), Emend (QL), Granisol (QL), Sancuso (QL), Transderm Scop
Gallstones/liver disease	Tier 1: ursodiol
Hemorrhoids	Tier 1: hydrocortisone cream
Inflammatory Bowel Disease	Tier 1: alosetron, balsalazide, budesonide EC, dexamethasone, dicyclomine, hydrocortisone enema, mesalamine rectal suspension, methylprednisolone, prednisolone sodium phosphate, prednisone, sulfasalazine Tier 2: Apriso, Asacol HD, Canasa, Dipentum, Pentasa, Relistor, Sfrowasa Tier 3: Amitiza, Linzess (QL)
Laxatives	Tier 1: lactulose Tier 3: Kristalose, Moviprep, Suprep
Pancreatic Enzymes	Tier 2: Creon Tier 3: Pancreaze, Pertzye, Zenpep
Peptic Ulcer/Reflux (GERD)	Tier 1: famotidine tablets, glycopyrrolate, methscopolamine, misoprostol, ranitidine, sucralfate Tier 2: cimetidine, nizatidine, omeprazole, pantoprazole Tier 3: Cantil, esomeprazole, famotidine oral suspension, lansoprazole, omeprazole/sodium bicarbonate
Short Bowel Syndrome	Tier 4: Gattex (SP, PA, QL)
GENITO-URINARY TRACT	
Symptomatic BPH (enlarged prostate)	Tier 1: alfuzosin, doxazosin, finasteride, tamsulosin, terazosin Tier 2: Avodart
Miscellaneous	Tier 1: bethanecol
Urological Disorders	Tier 1: desmopressin, flavoxate, oxybutynin, oxybutynin ER, tolterodine Tier 2: Gelnique, tolterodine extended release, Vesicare Tier 3: Elmiron, Enablex, Myrbetriq (STPA), Sanctura XR
Other	Tier 1: calcium acetate
HORMONES	
Corticosteroid hormones	Tier 1: cortisone acetate, dexamethasone, fludrocortisone, hydrocortisone, methylprednisolone, prednisolone sodium phosphate, prednisone Tier 3: Prednisone Intensol
Endometriosis	Tier 1: danazol Tier 2: Synarel
Cushing's Disease	Tier 4: Signifor (SP, PA, QL)

Female Hormone Replacement Therapy	Tier 1: estradiol, estropipate Tier 2: Estrace cream, estradiol transdermal patch, Estring, Femring, Vagifem Tier 3: Alora, Cenestin, Divigel, Elestrin, Enjuvia, Estrogel, Evamist (QL), Femtrace, Menostar, Menest, Premarin
Human Growth Hormone	Tier 4: Increlex (SP, PA), Norditropin Nordiflex (SP, PA), Norditropin Flexpro (SP, PA), Serostim (SP, PA), Zorbtive (SP, PA)
Infertility	Tier 1: chorionic gonadotropin (SP), Novarel (SP, PA), Pregnyl (SP, PA) Tier 4: Bravelle (SP, PA), Follistim AQ (SP, PA), Gonal-F (SP, PA), Gonal-F RFF (SP, PA), Menopur (SP, PA), Repronex (SP, PA)
Progestins	Tier 1: medroxyprogesterone, norethindrone acetate, progesterone micronized Tier 3: Crinone, Endometrin
Male Hormone Replacement	Tier 1: Android, oxandrolone, testosterone cypionate, testosterone enanthate Tier 2: testosoterone transdermal Tier 3: Androgel, Androxy, Methitest, Striant, Testim, Vogelxo
Miscellaneous	Tier 1: cabergoline Tier 3: Duavee, Somavert (PA) Tier 4: Egrifta (SP, PA)
Thyroid/Anti-thyroid Agents	Tier 1: levothyroxine, Levothroid, Levoxyl, liothyronine, methimazole, propylthiouracil, Unithroid Tier 3: Synthroid, Thyrolar
IMMUNOLOGICAL/IMMUNOSUPPRESSANT DRUGS	
Disease Modifying Antirheumatic Drugs (DMARDs)	Tier 1: hydroxychloroquine, leflunomide, methotrexate Tier 2: Cuprimine, Ridaura, Tier 4: Zeljanz (SP, PA, QL)
Immunosuppressants	Tier 1: azathioprine, cyclosporine, mycophenolate mofetil, mycophenolate sodium, sirolimus, tacrolimus Tier 2: Zortress (QL)
IMMUNOMODULATORS	
Interferons	Tier 2: Actimmune, Tier 4: Intron A (SP), Pegasys Proclick (SP, QL), PegIntron (SP, QL)
Miscellaneous	Tier 4: Actemra prefilled syringe (SP, PA, QL), Arcalyst (SP, PA, QL), Cimzia (SP, PA, QL), Enbrel (SP, PA, QL), Humira (SP, PA, QL), Kineret (SP, PA, QL), Orencia (SP, PA, QL), Otezla (SP, PA, QL), Simponi (SP, PA, QL), Stelara (SP, PA, QL)
MISCELLANEOUS DRUGS	
Cystic Fibrosis	Tier 1: tobramycin nebulizer solution Tier 2: Cayston, Kalydeco (PA, QL)
Cystinosis	Tier 3: Cystagon
Gaucher's Disease	Tier 4: Zavesca (SP, PA)
Hereditary Tyrosinemia Type I	Tier 4: Orfadin (SP, PA)
Huntington's Disease	Tier 4: Xenazine (SP, PA, QL)

Hypercalcemia	Tier 2: Sensipar
Hypoammonemia	Tier 2: Carbaglu (PA)
Hyperparathyroidism	Tier 1: doxercalciferol, paricalcitol
Lipodystrophy	Tier 3: Myalept (PA, QL)
Myasthenia Gravis	Tier 1: pyridostigmine
Phenylketonuria	Tier 4: Kuvan (SP, PA)
Phosphate Binding Agents	Tier 2: Fosrenol, Phoslyra, Renagel, Renvela Tier 3: Velphoro
Smoking Cessation Note: These medications are covered in full.	budeprion, bupropion (Zyban) Chantix, Nicotrol NS
MOUTH/THROAT/DENTAL AGENTS	
Miscellaneous	Tier 1: cevemeline, chlorhexidine, doxycycline hyclate, lidocaine viscous, pilocarpine, triamcinolone paste Tier 3: Aphthasol
NEUROLOGICAL DRUGS	
Alzheimer's Disease	Tier 1: donepezil, ergoloid mesylate, galantamine, rivastigmine Tier 2: memantine tablet Tier 3: Exelon solution
Amyotrophic Lateral Sclerosis	Tier 1: riluzole
Fibromyalgia	Tier 2: Savella (STPA, QL) Tier 3: Lyrica (STPA)
Migraine Headaches	Tier 1: amlotriptan (QL), dihydroergotamine, naratriptan (QL), rizatriptan (QL), sumatriptan (QL) Tier 2: zolmitriptan (QL) Tier 3: Alsuma (STPA, QL), Ergomar, Frova (STPA, QL), Migranal (QL), Relpax (STPA, QL)
Migraine Prevention	Tier 1: atenolol, divalproex sodium, topiramate
Muscle Spasm	Tier 1: baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, dantrolene, metaxolone, methocarbamol, orphenadrine, tizanidine
Multiple Sclerosis	Tier 4: Ampyra (SP, PA, QL), Aubagio (SP, QL), Avonex (SP, QL), Betaseron (SP, QL), Copaxone (SP, QL), Extavia (SP, QL), Gilenya (SP, QL), Glatopa (SP, PA), Rebif (SP, QL), Tecfidera (SP, QL)
Parkinson's Disease	Tier 1: amantadine, benztropine, bromocriptine, carbidopa, carbidopa/levodopa, entacapone, pramipexole, ropinirole, ropinirole extended-release (QL), selegiline, tolcapone, trihexyphenidyl Tier 2: Apokyn, Azilect
Anticonvulsants	Tier 1: carbamazepine, diazepam rectal (QL), divalproex sodium, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, primidone, topiramate, valproic acid, zonisamide Tier 2: Banzel (QL), lamotrigine extended-release (QL), Sabril, topiramate extended release, Vimpat (PA, QL) Tier 3: Aptiom (PA), Celontin, Equetro, Fycompa (PA), Lyrica (STPA), Potiga (PA), Stavzor
NUTRITIONAL/SUPPLEMENTS	

Electrolytes	Tier 1: potassium chloride Tier 3: Klor-con, Samsca
OSTEOPOROSIS	
Bisphosphonates	Tier 1: alendronate, etidronate, ibandronate Tier 2: risedronate, Skelid
Bone Formation Agent	Tier 4: Forteo (SP, PA)
Calcitonins	Tier 1: calcitonin, calcitonin-salmon Tier 3: Fortical
Selective Estrogen Receptor Modulator	Tier 1: raloxifene Tier 3: Evista
PAIN AND INFLAMMATORY DISEASES	
Gout	Tier 1: allopurinol, cochicine (QL), probenecid, probenecid/colchicine Tier 3: Uloric (STPA)
NSAIDs (Non-steroidal anti-inflammatory drugs)	Tier 1: diclofenac, diflunisal, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, sulindac Tier 2: celecoxib (PA)
Narcotic Pain Medications	Tier 1: butorphanol (QL), codeine, codeine/acetaminophen, fentanyl (QL), hydrocodone/acetaminophen, hydromorphone, levorphanol, meperidine, methadone, morphine, morphine sulfate beads (QL), morphine sulfate ER, oxycodone, oxycodone/acetaminophen, oxycodone/aspirin, oxymorphone Tier 2: hydromorphone extended release (QL), Onsolis (QL), oxycodone extended-release (QL), OxyContin (QL) Tier 3: Subsys (QL), Talwin, Xartemis XR (QL)
Non-narcotic Pain Medications	Tier 1: tramadol
PSYCHIATRIC	
Anxiety	Tier 1: alprazolam, alprazolam extended-release, buspirone, chlordiazepoxide, clonazepam, clorazepate, diazepam, escitalopram, fluvoxamine, hydroxyzine, lorazepam, meprobamate, oxazepam, paroxetine, sertraline, venlafaxine, venlafaxine ER
Antidepressants	Tier 1: amitriptyline, bupropion, citalopram, clomipramine, desipramine, doxepin, escitalopram, fluoxetine, fluvoxamine, imipramine, maprotiline, mirtazapine, nefazodone, nortriptyline, protriptyline, sertraline, tranylcypromine, trazodone, trimipramine, venlafaxine, venlafaxine ER Tier 2: amoxapine, duloxetine (QL), Pristiq (STPA) Tier 3: Aplenzin (STPA), desvenlafaxine fumurate ER (STPA), Emsam (STPA), Marplan, Oleptro ER (STPA), Pexeva (STPA), Sarafem (STPA)
Attention Deficit Disorder (Prior authorization required for all ADHD stimulants for all Members 25 years and older)	Tier 1: amphetamine salt combinations, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate Tier 2: methylphenidate ER, Methylin Chewable Tablet, Strattera (QL) Tier 3: Daytrana (STPA), Focalin XR (STPA), Metadate CD (STPA), Ritalin LA (STPA), Vyvanse (STPA)

Mood Stabilizers	Tier 1: carbamazepine, lamotrigine, lithium carbonate, valproic acid Tier 2: lithium citrate Tier 3: Equetro
Pseudobulbar Affect	Tier 2: Nuedexta (PA)
Psychoses	Tier 1: chlorpromazine, clozapine, fluphenazine, haloperidol, loxapine, olanzapine, perphenazine, quetiapine 25 mg and 50 mg (PA), quetiapine 100 mg, 200 mg, 300 mg & 400 mg, risperidone, thioridazine, thiothixene, trifluperazine Tier 2: aripiprazole (STPA), ziprasidone (STPA) Tier 3: Orap, Seroquel XR (STPA), Versacloz
Sleep Disorders	Tier 1: doxepin, zaleplon (QL), zolpidem (QL), zolpidem tartrate CR (STPA, QL) Tier 2: eszopiclone Tier 3: modafinil (STPA, QL), Nuvigil (STPA, QL), Rozerem (STPA, QL) Tier 4: Hetlioz (SP, PA, QL)
Substance Abuse	Tier 1: acamprosate, buprenorphine (PA, QL), buprenorphine/naloxone (PA), disulfiram, naltrexone Tier 3: Evzio (QL), Suboxone Film (PA)
RESPIRATORY DRUGS	
Anaphylaxis emergency treatment	Tier 1: epinephrine (QL) Tier 2: Epipen (QL) Tier 3: Auvi-Q (QL)
Allergy	Tier 1: azelastine (QL), azelastine nasal spray (QL), clemastine, cyproheptadine, flunisolide (QL), fluticasone nasal spray (QL), hydroxyzine, ipratropium (QL), levocetirizine Tier 2: budesonide nasal spray (QL), Nasonex (QL) Tier 3: Grastek (PA, QL), Oralair (PA, QL), Ragwitek (PA, QL)
ASTHMA/COPD/EMPHYSEMA	
Anticholinergics	Tier 1: ipratropium (QL) Tier 2: Atrovent HFA, Spiriva (QL)
Anticholinergics/Beta Agonists	Tier 3: Anoro Ellipta (QL)
Beta agonists	Tier 1: albuterol, albuterol sulfate solution (QL), levalbuterol solution (STPA, QL), metaproterenol, terbutaline Tier 2: Foradil (QL), Proair HFA (QL), Perforomist (QL), Serevent Diskus (QL) Tier 3: Brovana (QL), Maxair (QL), Proventil HFA (QL), Ventolin HFA (QL), Xopenex HFA (QL)
Leukotriene modifiers	Tier 1: montelukast, zafirlukast
Mast Cell Stabilizer	Tier 1: cromolyn sodium solution (QL)
Steroid	Tier 1: budesonide (QL) Tier 2: Flovent Diskus (QL), Flovent HFA (QL), QVAR (QL)
Steroid/Beta Agonists	Tier 2: Advair Diskus (QL), Advair HFA (QL) Tier 3: Breo Ellipta (QL)
Theophylline	Tier 1: theophylline, theophylline ext-rel Tier 2: Theo-24

SKIN	
Antibiotic	Tier 1: gentamicin, mupirocin, silver sulfadiazine
Acne	Tier 1: adapalene (PA), clindamycin phosphate, clindamycin/benzoyl peroxide, erythromycin, metronidazole, tretinoin (PA) Tier 2: Finacea Tier 3: Azelex, Differin lotion (PA), Tretin-X (PA)
Acne oral	Tier 1: Amnesteem, Claravis
Antifungal	Tier 1: ciclopirox, econazole, itraconazole, ketoconazole, naftifine, nystatin, terconazole Tier 2: Oxistat Tier 3: Exelderm, Ertaczo, Gynazole 1, Mentax
Antiviral	Tier 1: imiquimod
Local anesthetic	Tier 1: lidocaine jelly
Miscellaneous	Tier 1: methoxsalen Tier 2: tacrolimus ointment (STPA) Tier 3: Elidel (STPA), Picato (QL)
Psoriasis	Tier 1: acitretin, calcipotriene Tier 2: calcipotriene – betamethasone dipropionate, Tazorac (PA)
Scabies and Lice	Tier 1: permethrin, spinosad (QL) Tier 2: Eurax
Steroids	Tier 1: alclometasone, amcinonide, betamethasone, betamethasone/clotrimazole, clobetasol, clocortolone, desonide, desoximetasone, diflorasone, fluocinolone, fluocinonide, fluticasone, halobetasol, hydrocortisone, mometasone Tier 3: Apexicon, Cordran