Rhode Island Small Group

Health Maintenance Organization

ADVANTAGE HMO 2500 Gold

CERTIFICATE OF COVERAGE

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

Tufts Health Plan Address And Telephone Directory

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

Member Services Hours:
Monday – Thursday 8:00 a.m. - 7:00 p.m.,
Friday 8:00 a.m. - 5:00 p.m. (E.T.)

IMPORTANT PHONE NUMBERS:

***Emergency* Care**
For routine care, always call your *Primary Care Provider (PCP)*. Do this before seeking care. If you have an urgent medical need and cannot reach your *PCP* or your *PCP's Covering Provider*, seek care at the nearest *Emergency* room.

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

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

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

Member Services Department
Call our Member Services Department at 1-800-682-8059 for: general questions; help choosing a *Primary Care Provider (PCP);* benefit questions; and information about eligibility, enrollment and billing.

Behavioral Health Services
Call our Behavioral Health department at 1-800-208-9565 for (1) information about *Covered Services*; and/or (2) help finding a behavioral health or substance use *Provider.*

Services for Hearing Impaired Members
You may be hearing impaired. If so, these services are provided:

Telecommunications Device for the Deaf (TDD)
If you have access to a TDD phone, call 711 or 1-800-868-5850. You will reach our Member Services Department.

Rhode Island Relay
711 or 1-800-745-5555

Tufts Health Plan Address and Telephone Directory, continued

IMPORTANT ADDRESSES:

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

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

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

Web site
You may want more information about *Tufts Health Plan* or to learn about the self-service options available to you. If so, see the *Tufts Health Plan* Web site at www.tuftshealthplan.com.

Fraud, Waste and Abuse
You may have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud and abuse, or if you have questions, please call us at 1-800-682-8059, or email fraudandabuse@tufts-health.com. You can also call our confidential hotline anytime at 877-824-7123 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
705 Mount Auburn Street
Watertown, MA 02472

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.

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

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

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

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

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

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

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

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

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

1-800-682-8059

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

Overview

Welcome to *Tufts Health Plan*. We are pleased you have chosen us. We look forward to working with you to help you meet your health care needs. We are a health maintenance organization. We arrange for your health care through a network of health care professionals and hospitals. When you join *Tufts Health Plan,* you will need to choose a *Primary Care Provider (PCP)*. Your *PCP* will manage your care. Your *PCP* is a physician, physician assistant, or nurse practitioner in private practice. He or she personally cares for your health needs. If the need arises, your *PCP* will refer you to a specialist in our network. For *Children*, you may designate a pediatrician as the *Primary Care Provider.*

Important Note:

See the Benefit Overview and Chapter 3: *Covered Services* for more information about benefits, coverage and *Cost Sharing* under this plan.

- For *Outpatient* care: You may receive services from your *PCP*, a behavioral health/substance use *Provider*, or an obstetrician/gynecologist ("OB/GYN"). *Cost Sharing Amounts* may be lower than for services received from other *Providers*.
- For *Inpatient* care or *Day Surgery*: Your *Cost Sharing Amount at a Community Hospital* may be lower than at a *Tertiary Hospital.* See Appendix A for definitions of these facilities.

This book will help you find answers to your questions about *Tufts Health Plan* benefits. Italicized words are defined in the Glossary in Appendix A.

Your satisfaction with *Tufts Health Plan* is important to us. If you have any questions, call a Member Services. We will be happy to help you.

Tufts Associated Health Maintenance Organization, Inc. is licensed as a health maintenance organization in Massachusetts and Rhode Island. This company does business under the name *Tufts Health Plan*.

Eligibility for Benefits

When you join *Tufts Health Plan*, you agree to receive your care from *Tufts Health Plan Providers*. We cover only the services and supplies described as *Covered Services* in Chapter 3. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits on 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

Important Note For *Members* In *Group Contracts* Only:

If you live outside of Rhode Island, your benefits under this plan may also include benefits required by the laws of your state. For more information, call Member Services.

Calls to Member Services

Our Member Services Department is committed to excellent service. All calls are recorded and may be reviewed for quality and/or training purposes.

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Chapter 3 -- *Covered Services,* continued

Chapter 4 -- When Coverage Ends

Chapter 5 -- Continuation of *Group Contract* Coverage and Conversion Privilege

Chapter 6 -- *Member* Satisfaction

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BENEFIT OVERVIEW

This section describes your Cost Sharing Amounts, Deductible and Out-of-Pocket Maximum under this plan.

- Important Terms and Definitions
- Cost Sharing Highlights
  - Important information about your Cost Sharing Amounts
- Your Deductible
  - Important Information about your Deductible
- Out-of-Pocket Maximum
  - Important Information about your Out-of-Pocket Maximum
- Table of benefits, cost sharing, and certain benefit limits

See Chapter 3, Covered Services for details about benefits under this plan.

IMPORTANT TERMS AND DEFINITIONS

All defined terms are italicized and listed in Appendix A.

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

Contract Year is the 12-month period determined by the Group. Under this plan, benefit limits, Deductibles, Out-of-Pocket Maximums, and Coinsurance are calculated for a Contract Year. A Contract Year can be either a calendar year (January 1st through December 31st) or a plan year (a 12 consecutive month period). For example, a plan year might run from July 1st in one calendar year through June 30th in the following calendar year. For the Contract Year dates that apply to your plan, call Member Services or contact your Group.

Coinsurance is a percentage of costs you pay for certain Covered Services. See definition in Appendix A for details.

Copayment is a fee you pay for certain Covered Services. Copayments are paid to the Provider when you receive care unless the Provider arranges otherwise.

Cost Sharing Amount is the cost you must pay for certain Covered Services. This amount may consist of Deductibles, Copayments, and/or Coinsurance.

Deductible is the amount you and the enrolled Members of your family (if applicable) must pay each Contract Year for certain Covered Services before payments are made under this Evidence of Coverage. See definition in Appendix A for details.

Out-of-Pocket Maximum is the maximum amount a Member pays during a Contract Year for certain Covered Services. The Out-of-Pocket Maximum consists of Cost Sharing Amounts. It does not include: (1) premium you pay for this plan; (2) costs above the Reasonable Charge; or (3) costs for services that are not Covered Services under the Group Contract. If you meet your Out-of-Pocket Maximum in a Contract Year, then you no longer pay Cost Sharing Amounts in that Contract Year under to the terms of this Evidence of Coverage.

Network Provider (or In-Network) is a Provider or hospital that has an agreement with Tufts Health Plan (either directly or with a provider network with whom we have a contract) to provide Covered Services to Members.

Non-Network Provider (or Out-of-Network) is a Provider or hospital that does not have an agreement with Tufts Health Plan (either directly or with a provider network with whom we have a contract) to participate as a Network Provider.

Primary Care Provider (PCP): is a Network Provider who is a physician, physician assistant, or nurse practitioner you have chosen from the Directory of Health Care Providers. This PCP has an agreement with us to provide primary care and to coordinate, arrange, and authorize the provision of Covered Services.

If you have questions, please visit our Website at www.tuftshealthplan.com.
Or call our Member Services Department at 800-682-8059

COST SHARING OVERVIEW

Not all Cost Sharing Amounts under this plan are listed below.
See the table of cost sharing later in this Benefit Overview .

Network Level of Benefits – Covered Services received from Network Providers	
Emergency room	*Deductible* then covered in full.
Urgent Care visit	Cost sharing varies based on type of Provider and place of service. See "Important Information About Your Cost Sharing Amounts" below.
Office visit – Primary Care Provider Office visit - Any other Network Provider	PCP: $35 Copayment per visit Provider: $65 Copayment per visit
Hospital Inpatient admission	Deductible then $300 Copayment per admission
Day Surgery admission Free standing or other non-hospital setting Hospital Outpatient setting	 Deductible then $200 Copayment per admission Deductible then $200 Copayment per admission
Physician surgical and medical services	Tier 1 *Deductible* then covered in full Tier 2 *Deductible* then covered in full

IMPORTANT INFORMATION ABOUT YOUR COST SHARING AMOUNTS

In accordance with the Affordable Care Act (ACA), preventive care services are covered in full. Services include but are not limited to: (i) women's preventive health care services; (ii) certain prescription medications, and, (iii) certain over-the-counter medications when prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription.. Go to our website for a list of services that are preventive and covered in full:

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

Please call Member Services with any questions about whether specific services are considered preventive under the ACA.

Diagnostic Outpatient services provided in conjunction with a routine physical examination (i.e., a preventive care visit) may be subject to Cost Sharing Amounts. For example, diagnostic testing and diagnostic laboratory tests provided during a preventive care visit are covered as described under "Diagnostic testing" and "Laboratory tests" later in this Benefit Overview. You may be charged an office visit Cost Sharing Amount for certain diagnostic Outpatient services provided in conjunction with a preventive care visit.

Urgent Care service Cost Sharing Amounts vary depending upon (i) type of Provider (PCP vs. Specialist); (ii) where services are provided; And (iii) any additional diagnostic Outpatient services provided during the visit; such services, including but not limited to laboratory tests, x-rays, or Durable Medical Equipment, may be subject to separate Cost Sharing Amounts. See specific benefits later in this Benefit Overview for cost sharing. For more information, call Member Services.

For certain Outpatient services, you may be billed both a facility fee and a separate physician fee for a single episode of care if the services are provided in a hospital setting or a free-standing facility. If the Cost Sharing Amount for the Outpatient service includes a Deductible or Coinsurance charge, that charge will apply to both fees. If the Cost Sharing Amount is a Copayment charge, a single Copayment will apply unless otherwise stated in the "Benefit Overview."

A telemedicine services visit with a Tufts Health Plan Provider will apply the same Cost Sharing Amount that applies to an in-person office visit with that Provider.

YOUR DEDUCTIBLE

Individual Deductible ..... $2,500 each Contract Year
Family Deductible ..... $2,500 per Member; $5,000 per family each Contract Year

IMPORTANT INFORMATION ABOUT YOUR DEDUCTIBLE(s)
Your Deductible applies to all Covered Services except as listed in the table of benefits and cost sharing later in this Benefit Overview. This plan has a separate Prescription Drug Deductible (see below). Any amount paid toward the Prescription Drug Deductible will not count toward the Individual or Family Deductible listed above The Family Deductible is satisfied with any combination of Deductible payments for Covered Services for any enrolled Members. If any enrolled Member in a family meets the Individual Deductible before the Family Deductible is met; then coverage will begin for that Member; (1) subject to any other Cost Sharing Amounts that may apply, and (2) any such cost sharing will not count toward the Family Deductible. **The following amounts do not count toward any Deductibles under this plan:** • Any amount paid for services, supplies or medications that are not Covered Services • Costs in exceeds of the Reasonable Charge • The premium you pay for this plan Any Deductible amount paid by the Member for a Covered Service rendered during the last three (3) months of a Contract Year shall be carried forward to the next Contract Year's Deductible(s). Any amount carried forward will not apply toward the next Contract Year's Out-of-Pocket Maximum.

Prescription Drug Benefit Deductible

The following prescription drug Deductible is the amount you must pay first for covered prescription drugs before we will pay for any covered prescription drugs:

Individual Deductible: $250
Family Deductible (two or more Members): $500

This Prescription Drug Benefit Deductible does not apply to covered generic drugs, regardless of tier.

YOUR OUT-OF-POCKET MAXIMUM

Individual Out-of-Pocket Maximum.....$8,550 each Contract Year
Family Out-of-Pocket Maximum……..$8,550 per Member; $17,100 per family each Contract Year

IMPORTANT INFORMATION ABOUT YOUR OUT-OF-POCKET MAXIMUM
Any Deductible, Copayment or Coinsurance amount you pay for Covered Services under this plan counts toward your Out-of-Pocket Maximum. Once you satisfy your Out-of-Pocket Maximum, you no longer pay Deductibles, Copayments or Coinsurance. Any combination of enrolled Members in a family can pay toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met during a Contract Year, we begin to pay for Covered Services for all enrolled Members in a family under the terms of this Evidence of Coverage If any enrolled Member in a family meets the Individual Out-of-Pocket Maximum before the Family Out-of-Pocket Maximum is met; then (1) that Member has met his/her Out-of-Pocket Maximum requirement; and (2) we will begin to pay for his/her Covered Services subject to the terms of this Evidence of Coverage. Note: Out-of-Pocket Maximum limits are set every year by the federal government. This plan's In-Network Out-of-Pocket Maximum amount(s) comply with federal limits. **The following amounts do not count towards your Out of Pocket Maximum**: • Any amount paid for services, supplies or medications that are not Covered Services • Costs in excess of the Reasonable Charge • The premium you pay for this plan Note: Any Deductible amount carried forward to the next Contract Year will not count toward the next Contract Year's Out-of-Pocket Maximum. See **Important Information about Your Deductible**

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for detailed explanations of Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Emergency room	Deductible then covered in full
Observation services will take an Emergency room Cost Sharing Amount **We recommend that you call Tufts Health Plan within 48 hours after Emergency Care is received.** **If you are admitted as an Inpatient, we recommend that you or someone acting for you (such as a family member or the attending Provider) call your PCP or Tufts Health Plan within 48 hours.** **Coverage is the same for Emergency Covered Services whether provided by a Network Provider or a Non-Network Provider.**	
Acupuncture	$35 Copayment per visit
Allergy injections	$5 Copayment
Allergy testing	Deductible then covered in full
Ambulance services **(PA)**	
Ground ambulance services	Deductible then $50 Copaymant per trip
All other covered ambulance services	Deductible then $50 Copaymant per trip
Prior Authorization is required for <u>any</u> non-Emergency ambulance service.	
Autism spectrum disorders – diagnosis and treatment	
Applied behavioral analysis (ABA) services **(PA)**	
When provided by a Paraprofessional	Covered in full
When provided by a Board Certified Behavior Analyst (BCBA)	$35 Copayment per visit
Speech, physical, and occupational therapy services provided by licensed **(PA)**	$35 Copayment per visit
Prescription medications: See "Prescription Drug Benefit" later in this section and in Chapter 3. **Psychological and psychiatric care: See "Behavioral Health and Substance Use Disorders services" later in this section and in Chapter 3.** **Speech, physical and occupational therapy services provided to treat conditions other than autism: See "Speech, physical and occupational therapy services" later in this section.**	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Behavioral Health And Substance Use Disorder services **To contact the Tufts Health Plan Behavioral Health Department, call 1-800-208-9565.**	
Behavioral health services	
Outpatient individual and group therapy services	$35 Copayment per visit
Intermediate care services **(PA)**	Covered in full
Inpatient services, including Medically Necessary services in a residential treatment facility **(PA)**	
Facility services	Deductible then $300 Copayment per visit
Professional services	Deductible then covered in full
Substance use disorder services	
Outpatient individual and group therapy services	$35 Copayment per visit
Intermediate care services **(PA)**	Covered in full
Inpatient services, including Medically Necessary services in a residential treatment facility **(PA)**	
Facility services	Deductible then $300 Copayment per visit
Professional service	Deductible then covered in full
Community Residence **(PA)**	Deductible then $300 Copayment per visit
Medication-assisted treatment, including methadone maintenance, when provided in a medication-assisted treatment clinic	Covered in full

We recommend that you call Tufts Health Plan within 48 hours after Emergency Care is received.

If you are admitted as an Inpatient, we recommend that you or someone acting for you such as a family member or the attending Provider, call your PCP or Tufts Health Plan within 48 hours.

Coverage is the same for Emergency Covered Services whether provided by a Network Provider or a Non-Network Provider.

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Cardiac rehabilitation	Deductible then covered in full
Cardiac rehabilitation services are provided for up to 36 visits per Contract Year.	
Chemotherapy administration	Deductible then covered in full
For the costs of medications used in chemotherapy see "Injectable, infused, or inhaled medications" later in this Benefit Overview.	
Chiropractic medicine	$35 Copayment per visit
Clinical trials – Patient care services provided on an Inpatient or Outpatient basis as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions	See applicable Covered Services
Colonoscopies	See "Diagnostic or preventive screening procedures"
Day Surgery **(PA)**	Day Surgery admission*
Diabetes self-management education services and supplies	Office visit – PCP* Office visit – Provider*
Diabetic test strips: Covered under "Prescription Drug Benefit" later in this Benefit Overview. **Diabetes supplies covered as Durable Medical Equipment: See DME later in this Benefit Overview.**	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Diagnostic imaging**(PA)**	
General imaging (such as x-rays and ultrasounds)	
In a non-hospital setting, including a Free-standing imaging center	Deductible then $75 Copayment
In a hospital setting on an Outpatient basis	Deductible then $75 Copayment
MRI/MRA, CT/CTA, PET and nuclear cardiology:	
In a non-hospital setting, including a Free-standing imaging center	Deductible then $150 Copayment
In a hospital setting on an Outpatient basis	Deductible then $150 Copayment
Certain diagnostic imaging may be covered in full (after Deductible as applicable) when required as part of an active treatment plan for a cancer diagnosis. Please call Member Services for details.	
Diagnostic procedure or preventive screenings (for example, colonoscopy, sigmoid-oscopy and procto-sigmoidoscopy) **(PA)**	
Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention	Covered in full
Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms	
In a non-hospital setting, including a Free-standing ambulatory surgery center	Deductible then covered in full
In a hospital setting on an Outpatient basis	Deductible then covered in full
Diagnostic colon or colorectal procedure **accompanied by treatment/surgery** (for example, polyp removal):	See Day Surgery admission*

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Diagnostic testing **(PA)**	
In a non-hospital setting	Deductible then $75 Copayment
In a hospital setting on an Outpatient basis	Deductible then $75 Copayment
Durable Medical Equipment **(PA)**	Deductible then we pay 70% and you pay 30% Coinsurance
Early intervention services for a Dependent Child	Covered in full
Extended care **(PA)**	Deductible then covered in full
The maximum benefit payable in each Contract Year for Extended care Covered Services is 100 days.	
Family planning (procedures, services, and contraceptives)	
Day Surgery	Day Surgery admission*
Office visit	Office visit – PCP* Office visit – Provider*
Women's preventive health services are covered in full in accordance with the ACA including contraceptives and female sterilization procedures.	
Hearing Aids **(PA)**	Deductible then we pay 70% and you pay 30% Coinsurance
Coverage is limited to one hearing aid per ear every three (3) years for any Member	
Hemodialysis	Deductible then covered in full
Home health care **(PA)**	Deductible then covered in full
Hospice care **(PA)**	Deductible then covered in full

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Hospital Inpatient services (acute care) **(PA)**	Hospital Inpatient admission*
House calls to diagnose and treat illness or injury	Deductible then covered in full
Human leukocyte antigen (HLA) testing or histo-compatibility testing **(PA)**	Deductible then covered in full
Coverage is limited to one HLA test per lifetime.	
Immunizations, including those for travel, that are recommended by the Center for Disease Control (CDC)	Covered in full
Preventive immunizations, including those for travel, that are recommended by the Center for Disease Control (CDC) are listed on their website at: https://www.cdc.gov/vaccines/schedules/	
Infertility services **(PA)**	We pay 80% and you pay 20% Coinsurance
Injectable, infused or inhaled medications **(PA)**	Deductible then $50 Copayment for a 1-30 day supply
Laboratory tests **(PA)** In a non-hospital setting In a hospital setting on an Outpatient basis	 Deductible then $50 Copayment Deductible then $50 Copayment
Laboratory tests performed as part of routine preventive care are covered in full, in accordance with the ACA.	
Lead screenings	Covered in full
Lyme disease - Medically Necessary diagnosis and treatment of chronic Lyme disease	Office visit – PCP* Office visit – Provider*

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Mammograms	
Routine mammograms	Covered in full
Diagnostic mammogram	
In a non-hospital setting	Covered in full
In a hospital setting on an Outpatient basis	Covered in full
Mastectomy care	
Inpatient services	Covered in full
Outpatient services	Covered in full
In accordance with Rhode Island law, mastectomy care Covered Services are provided for mastectomy surgery (Prior Authorization is required); and breast reconstruction surgery, breast prostheses and treatment of physical complications for all stages of mastectomy.	
Maternity care	
Inpatient services	Hospital Inpatient admission*
Outpatient services	
Routine Maternity care	Covered in full
Non-routine maternity care:	
PCP or OB/GYN	Office visit – PCP*
Any other Network Provider	Office visit – Provider*
All other services	See applicable Covered Services
Routine laboratory tests associated with maternity care are covered in full, in accordance with the ACA	
Nutritional counseling	
Preventive services	Covered in full
All other nutritional counseling services	Office visit – Provider*
Certain nutritional counseling services are covered in full in accordance with ACA preventive services requirements, including obesity counseling and healthy diet counseling for adults with hyperlipidemia and other risk factors for cardio-vascular disease and diet-related chronic disease	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOU COST Network Providers
Office visits to diagnose and treat illness or injury	Office visit – PCP* Office visit – Provider*
A telemedicine services visit with a Tufts Health Plan Provider will apply the same Cost Sharing Amount that applies to an in-person office visit with that Provider.	
Oral Health Services **(PA)**	
Emergency services:	Emergency room*
Inpatient services:	Hospital Inpatient admission*
Day Surgery	Day Surgery admission*
Services in a Provider's office	See "Surgery in a Provider's office"
Breast prostheses following mastectomy are covered in full.	
Pap test (cervical cancer screening)	
Routine screening	Covered in full
Diagnostic cytology testing	
In a non-hospital setting	Deductible then $50 Copayment
In a hospital setting on an Outpatient basis	Deductible then $50 Copayment
Preventive health care – in accordance with the ACA and Rhode Island law (including hearing screenings for Members through age 19)	Covered in full
Any follow-up care determined to be Medically Necessary as a result of a routine physical exam or a routine annual gynecological exam is subject to a Cost Sharing Amount.	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Pediatric Dental Care Schedule

Benefit Overview, continued

This section provides basic information about your benefits and *Cost Sharing Amounts* under this plan. Chapter 3 provides additional detail about *Covered Services*.

COVERED SERVICES	**YOUR COST**
Pediatric dental care for *Members* under age 19	
Basic Coverage – such as cleanings, x-rays, and oral examinations	Covered in full
Intermediate Coverage – such as fillings, and root canal therapy	25% *Coinsurance*
Major Coverage – such as crowns, bridges, dentures and root planing and scaling	50% *Coinsurance*
Medically Necessary Orthodontia **(PA)**	50% *Coinsurance*

Note: See "Pediatric dental care for *Members* under age 19" in Chapter 3 for more description of covered dental services under each Service Type listed above.

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Private duty nursing in the Member's home **(PA)**	Deductible then covered in full
Prostate and colorectal exam	
Routine screening exams	Covered in full
Diagnostic prostate & colorectal exams	
In a non-hospital setting	Deductible then $75 Copayment
In a hospital setting on an Outpatient basis	Deductible then $75 Copayment
Radiation therapy	Deductible then covered in full
Respiratory therapy or pulmonary rehabilitation	Deductible then covered in full
Scalp hair prostheses or wigs for cancer or leukemia patients	Deductible then we pay 80% and you pay 20% Coinsurance
Smoking cessation counseling services	Covered in full
Special medical formulas	
Low protein foods	Covered in full
Nonprescription enteral formulas **(PA)**	Covered in full
Speech, physical and occupational therapy services (including rehabilitation and Habilitation services) **(PA)**	$35 Copayment per visit
Rehabilitative speech therapy services are covered up to 2 evaluations and 30 visits per Contract Year. **Rehabilitative physical therapy services are covered up to 2 evaluations and 30 visits per Contract Year.** **Rehabilitative occupational therapy services are covered up to 2 evaluations and 30 visits per Contract Year.** **Habilitative speech therapy services are covered up to 2 evaluations and 30 visits per Contract Year.** **Habilitative physical therapy services are covered up to 2 evaluations and 30 visits per Contract Year.** **Habilitative occupational therapy services are covered up to 2 evaluations and 30 visits per Contract Year.** **Visit limits do not apply (1) to the treatment of autism spectrum disorders or (2) to speech, physical or occupational therapy services provided as a part of the Home health care benefit.**	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

Benefit Overview, continued

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST
	Network Providers
Surgery – Hematopoietic stem cell transplants and human solid organ transplants **(PA)**	Hospital Inpatient admission*
Surgery – Surgery in a Provider's office	Deductible then covered in full
Surgery - Reconstructive surgical procedures, surgical treatment of functional deformity or impairment **(PA)**	Hospital Inpatient admission*
Surgery - Gender reassignment surgery **(PA)**	Hospital Inpatient admission*
Day Surgery: For surgery provided on an Outpatient basis, see Day Surgery admission*. **Prescription medications: Covered as described under "Prescription Drug Benefit"** **Notes related to gender reassignment surgery:** • **Outpatient care related to gender reassignment surgery (including pre-operative and post-operative Outpatient care) is covered as described under "Office visits to diagnose and treat illness or injury".** • **Behavioral health care services related to gender reassignment surgery (pre-operative and post-operative) is covered as described under "Behavioral health care".** **Gender reassignment surgery and related services only qualify as Covered Services when authorized in advance by an Authorized Reviewer; and obtained within the 50 United States from: (i) a Network Provider; or (ii) a -Non-Network Provider in the event services are not available in the Network Service Area or from any Network Provider.**	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Telemedicine services when obtained through Tufts Health Plan's designated telemedicine vendor (also called "telehealth")	
General Medicine Services and Behavioral Health Services	Covered in full
Dermatology services	Covered in full
See "Office visits to diagnose and treat illness or injury" for cost sharing that applies to telemedicine visits with Tuft Health Plan Network Providers.	
Urgent Care	
In your PCP's office	Office visit - PCP*
In a behavioral health/substance use disorder Provider's office	Office visit - PCP*
In a non-PCP / specialist Provider's office	Office visit - Provider*
In a Limited Services Medical Clinic	Office visit - PCP*
In a Free-standing Urgent Care Center	$50 Copaymemt per visit
In a hospital walk-in clinic	Office visit - PCP* Office visit - Provider*
See "Follow these guidelines for receiving Urgent Care" in Chapter 1 for information about when you need a referral. **Diagnostic Outpatient services provided during an Urgent Care visit may be subject to Cost Sharing Amounts. Such services may include but are not limited to laboratory tests, x-rays, or Durable Medical Equipment. See those benefits for cost sharing. For questions, call Member Services.**	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Important Note: The following table provides basic information about your benefits and Cost Sharing Amounts under this plan. Please see Chapter 3 for details about Covered Services.

COVERED SERVICES	YOUR COST Network Providers
Vision care services	
Routine eye exam (for Members age 19 and older)	$35 Copayment per visit
Other visions care services	
Care from an EyeMed optometrist	$35 Copayment per visit
Care from a Tufts Health Plan Network ophthalmologist	Office visit – Provider*
One pair of eyeglass lenses and standard frames are covered in full following cataract surgery or other surgery to replace the natural lens of the eye when the Member does not receive an intraocular implant	Covered in full
One routine eye exam per Contract Year for Members age 19 and over when provided by an EyeMed provider	

(PA) – Prior authorization is required for this service or certain services in this benefit category. Please see Chapter 1 for important information about Prior Authorization by an Authorized Reviewer.

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

Benefit Overview, continued

The following table explains your *Cost Sharing Amounts* and benefit limits for Pediatric Vision Care coverage. Please see Chapter 3, Covered Services for coverage details.

COVERED SERVICES	**YOUR COST**
Pediatric vision care for *Members* under age 19	
Routine	
Eye exam: One exam covered every *Contract Year.* Contact Lens: Fit and follow-up	Covered in full.
Diagnostic	
Eye Exams: Diagnostic eye exams when *Medically Necessary*	Covered in full.
Eyewear	
Lenses: One pair covered every *Contract Year*.	Covered in full.
Frames: One pair from a limited collection of frames covered every *Contract Year*.	Covered in full
Contact Lenses: Covered once every *Contract Year* in lieu of eyeglass lenses. Contact lens coverage includes material only.	Covered in full.
Other Vision Services	
See Chapter 3, Covered Services	Covered in full
Low Vision Services	
After prior authorization from EyeMed, covered low vision services will include: • One comprehensive low vision evaluation every five years; • Coverage for items such as high-power spectacles, magnifiers and telescopes; and • Follow-up care of up to four visits in any five-year period.	Covered in full

PRESCRIPTION DRUG COVERAGE TABLE

Please note: Your prescription drug coverage is subject to the Prescription Drug *Deductible* listed under **Your *Deductible*** at the beginning of this Benefit Overview, Please also refer to "Important Information about your *Deductible*" in that section for additional information**.**

DRUGS OBTAINED AT A RETAIL PHARMACY
Your *Cost Sharing* for covered prescription drugs, including both acute and maintenance drugs when obtained from a *Tufts Health Plan* designated retail pharmacy is listed below. **Also see Infertility Drugs and Oral Chemotherapy Drugs.**

Tier-1 drugs:	**Tier-2 drugs:**	**Tier-3 drugs:**	**Tier-4 drugs:**
$45 *Copayment* for a 1-30 day supply	$80 *Copayment* for a 1-30 day supply	$100 *Copayment* for a 1-30 day supply	75% Coinsurance for a 1-30 day supply
$90 *Copayment* for a 31-60 day supply	$160 *Copayment* for a 31-60 day supply	$200 *Copayment* for a 31-60 day supply	
$135 *Copayment* for a 61-90 day supply	$240 *Copayment* for a 61 90 day supply	$300 *Copayment* for a 61 90-day supply	

INFERTILITY DRUGS	20% *Coinsurance** for up to a 30-day supply
*Note: *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.	

ORAL CHEMOTHERAPY DRUGS	**Covered in full**

Notes:
- Certain drugs on our formulary are designated as part of our low cost drug program. Your retail pharmacy *Copayment* for these low cost drugs is $5 for up to a 30-day supply and $10 for a 31-90-day supply. Check the plan formulary on our Web site.
- You may fill your prescription in a state that allows you to request a brand drug even though your physician authorized a generic equivalent. In this case, you will also pay the applicable Tier *Cost Sharing Amount*. You will pay the difference in cost between the brand-name drug and the generic drug.
- If the cost of a drug is less than the minimum *Cost Sharing Amount*, you pay only for the cost of the drug.
- For the formulary exception process, please see Chapter 3, *Covered Services*, Prescription Drug Benefit.

See the formulary on our Web site at:

https://tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy/pharmacy-programs/ri-4-tier-pharmacy-copayment-program

Or you may call Member Services.

PRESCRIPTION DRUG COVERAGE TABLE
(Continued)

DRUGS OBTAINED THROUGH A MAIL SERVICE PHARMACY
Your *Cost Sharing* for most maintenance medications, when mailed to you through a *Tufts Health Plan* designated mail services pharmacy is listed below.

Tier-1 drugs: *Deductible* then	**Tier-2 drugs**: *Deductible* then	**Tier-3 drugs**: *Deductible* then
$90 *Copayment* for a 1-90 day supply	$240 *Copayment* for a 1-90 day supply	$300 *Copayment* for a 1-90 day supply

MENTAL HEALTH PARITY STATEMENT

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

For example:

- *Cost Sharing Amounts* such as *Deductibles*, *Copayments*, *Coinsurance*, or *Out-of-Pocket Maximums*, are not more restrictive for mental/behavioral health and substance use disorder services than they are for medical/surgical services.

- Limitations on the use of services, such as limits on the number of *Inpatient* days or *Outpatient* visits that are covered, are not more restrictive for mental/behavioral health and substance use disorder services than they are for medical/surgical services.

- Other kinds of treatment limitations, such as requirements for *Medical Necessity* determinations, *Prior Authorization*, or *Inpatient* Notification are applied in comparable ways to both mental/behavioral health and substance use disorder services and medical/surgical services.

Chapter 1
How Your HMO Plan Works

How the Plan Works

Primary Care Provider (PCP)

Each *Member* must choose a *Primary Care Provider* (*PCP*) who will provide or authorize care. If you do not choose a *PCP*, we will not pay for any services or supplies except for *Emergency* care.

Note**:** If you require non-*Emergency* health care services, you should always call your *PCP*. Your *PCP* will either provide or coordinate your care. Without approval from your *PCP*, services may not be covered. You should never wait until your condition becomes an *Emergency* to call.

Please see **About your *Primary Care Provider*** later in this chapter for more details.

Medically Necessary Services and Supplies

We will pay for *Covered Services* and supplies that are *Medically Necessary*. The term *Medically Necessary* is defined in Appendix A. See Chapter 3 for a description of the *Covered Services* available under this plan. You will pay a *Cost Sharing Amount* for most *Covered Services.* For more information about your *Cost Sharing*, see the Benefit Overview at the front of this *Evidence of Coverage*.

Service Area (see Appendix A)

In most cases, you must receive care in the *Tufts Health Plan Service Area*. (The *Service Area* is defined in Appendix A. . It includes both the Standard and Extended *Service Area*.) This does not apply to *Emergency* or *Urgent Care* while traveling outside of the *Service Area*. For information about where *Network Providers* are located, see our *Directory of Health Care Providers* at www.tuftshealthplan.com. Or call Member Services.

Please note: In the rare case that a service cannot be provided by a *Network Provider* in either the Standard or Extended *Service Area*, please call Member Services for assistance. Or visit our Web site at www.tuftshealthplan.com.

Provider Network

We offer *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*. We work to ensure the continued availability of our *Providers*. However, our network of *Providers* may change during the year.

This can happen for many reasons, for example: a *Provider* retires; moves out of the *Service Area*; or fails to continue to meet our credentialing standards. This may also occur if *Tufts Health Plan* and the *Provider* cannot reach agreement on a contract (*Providers* are independent contractors; they do not work for us.)

For questions about the availability of a *Provider*, call Member Services.

Referrals and *Prior Authorization*

A referral is an approval notice sent to another *Tufts Health Plan Provider* (and to us) by your *PCP*. This notice tells the other *Tufts Health Plan Provider* (and us) in advance how many visits and the type of specialty services you can receive. In most cases, you must have a referral to see any *Tufts Health Plan Provider* other than your *PCP*.

Please see "Referrals for specialty services" and "When referrals are not required" later in this chapter for more information.

Prior Authorization is an approval request usually sent to us by your *PCP* or another *Tufts Health Plan Provider*. It asks us to determine in advance if certain services are *Covered Services* under your benefit plan. We require *Prior Authorization* for services identified by **(PA)** in the "Benefit Overview" earlier in this document.

To request *Prior Authorization* or to confirm that your *Provider* obtained *Prior Authorization*, call Member Services at 1-800-682-8059. For behavioral health/substance use disorder services, call our Behavioral Health Department at 1-800-208-9565.

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

Please note: You do not need a referral or *Prior Authorization* in an *Emergency.*

Coverage

IF you…	AND you are…	THEN…
receive routine health care services, visit a specialist, or receive covered elective procedures	in the Standard or Extended *Service Area*	you are covered, if you receive care through your *PCP* or with a *PCP* referral.
	outside the Standard or Extended *Service Area*	you are not covered.
are ill or injured	in the Standard or Extended *Service Area*	you are covered. Please see the *Urgent Care* section later in this chapter for information about when referrals are required for services.
	outside the Standard or Extended *Service Area*	you are covered for *Urgent Care*.
have an *Emergency*	in the Standard or Extended *Service Area*	you are covered.
	outside the Standard or Extended *Service Area*	you are covered.

Care that could have been foreseen before leaving the Standard or Extended *Service Area* may not be covered.

This includes, but is not limited to:

- deliveries within one month of the due date. This includes postpartum care and care provided to the newborn *Child* and
- long-term conditions that need ongoing care

Emergency and *Urgent Care*

Emergency Care:

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

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

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

Follow these guidelines for receiving *Emergency* care

Call 911 for *Emergency* medical assistance.
If 911 services are not available in your area, call the local number for *Emergency* medical services.

Go to the nearest *Emergency* medical facility. You do not need approval from your *PCP.*

If you receive *Outpatient Emergency* care or are admitted as an *Inpatient*, we recommend that you or someone acting for you (such as a family member or the attending *Provider*) call your *PCP* or *Tufts Health Plan* within 48 hours. Your *PCP* will provide or arrange for any follow-up care that you may need.

If you receive *Emergency Covered Services* from a non-*Tufts Health Plan Provider:*
We will pay up to the *Reasonable Charge*. You pay the applicable *Cost Sharing Amount.*

Remember: You do not need approval from your *PCP* before receiving *Emergency* care.

Emergency and *Urgent Care*, continued

Urgent Care is defined as care provided when your health is not in serious danger, but you need immediate attention for a condition or unforeseen illness or injury, whether medical, physical, behavioral, related to a substance use disorder, or mental health. Examples in which *Urgent Care* might be needed are: a broken or dislocated toe; sudden extreme anxiety; a cut that needs stitches but is not actively bleeding; or symptoms of a urinary tract infection.

Note: Care provided after the urgent condition is treated and stabilized, and the *Member* is safe for transport, is not considered *Urgent Care*.

Follow these guidelines for receiving *Urgent Care*

Place of Service	*Network Provider*	*Non-Network Provider*/	
		Inside the Tufts HP *Service Area*	**Outside the Tufts HP *Service Area***
Your *Primary Care Provider (PCP)*	You are covered for *Urgent Care.* No referral is required.	Not Applicable	Not Applicable
• *Limited Service Medical Clinic,* • *Freestanding Urgent Care Center*	You are covered for *Urgent Care.* No referral is required.	You are covered for *Urgent Care* with a referral from your *Primary Care Provider.*	You are covered for *Urgent Care.* No referral is required.
• Behavioral health /substance use disorder *Provider*	You are covered for *Urgent Care.* No referral is required.	You are covered for *Urgent Care.* No referral is required.	You are covered for *Urgent Care.* No referral is required.
Emergency room	You are covered for *Urgent Care.* No referral is required.	You are covered for *Urgent Care.* No referral is required.	You are covered for *Urgent Care.* No referral is required.
• *Provider's* office (specialist / non-*PCP*) or • Hospital-based walk-in clinic	You are covered for *Urgent Care* with a referral from your *Primary Care Provider.*	You are covered for *Urgent Care* with a referral from your *Primary Care Provider.*	You are covered for *Urgent Care.* No referral is required.

If you are INSIDE the Standard or Extended *Service Area*:

You may seek *Urgent Care* at the following (**no** *PCP* referral required):

- your *PCP*'s office
- the office of a behavioral health or substance use disorder *Provider*
- a *Network Limited Service Medical Clinic* or *Free-standing Urgent Care Center*
- in an *Emergency* room

You may seek *Urgent Care* at the following, however, you must obtain a referral from your *PCP*:

- a *Network Provider* who is a specialist (non-*PCP*) or
- a *Network Hospital*-based walk-in clinic or
- any *Non-Network Provider, Limited Service Medical Clinic; Free-standing Urgent Care Center; or* hospital-based walk-in clinic

If you are OUTSIDE the Standard or Extended *Service Area*:

You may seek *Urgent Care* at the following (**no** *PCP* referral required):

- the office of a medical, behavioral health, or substance use disorder *Provider*
- a *Limited Service Medical Clinic*
- a *Free-standing Urgent Care Center* or
- a Hospital-based walk-in clinic
- an *Emergency* room

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

You do not need approval from your *PCP* before receiving *Emergency* care.

You can get *Emergency* and *Urgent Care Covered Services* whenever you need them, anywhere in the world.

- If you are admitted as an *Inpatient* after receiving *Emergency* or *Urgent Care Covered Services:* We recommend that you or someone acting for you (such as a family member or the attending *Provider)* call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care.
- If you receive *Urgent Care* outside of the *Service Area*: You or someone acting for you should contact your *PCP*. You may need to see your *PCP* for follow-up care.
- When your *Emergency* or *Urgent Care* condition is treated and stabilized:

  We may not cover continued services after your condition is treated and stabilized. This may happen if we determine the following with your *Providers*:

  (1) You are safe for transport back into the *Service Area* and:

  (2) Transport is appropriate and cost-effective
- Paying for care outside the Standard or Extended *Service Area:* An *Emergency* or *Urgent Care Provider* may:

  (1) bill *Tufts Health Plan* directly or

  (2) require you to pay at the time of service. We will reimburse you up to the *Reasonable Charge* for this care. You must pay the applicable *Cost Sharing Amount.* See "Bills from *Providers*/Member Reimbursement Process" in Chapter 6 for more information about how to get reimbursed for this care.

Inpatient Hospital Services

You may need *Inpatient* services. In most cases you will be admitted to your *PCP's Tufts Health Plan Hospital*. Your *PCP* or other *Tufts Health Plan Provider* is responsible for: (1) notifying *us* on your behalf; and (2) obtaining any required approval by an *Authorized Reviewer*.

- **Our *Inpatient* Notification process keeps us informed of all *Inpatient* admissions and transfers to another hospital**. We evaluate the anticipated hospital stay. We may also review proposed medical care and/or verify *Medical Necessity.* We may assess the need for a care management program after discharge or recommend an alternative treatment setting.
- ***Inpatient Notification* to *Tufts Health Plan* does not guarantee payment to the *Provider***. We are not obligated to pay claims: (1) for persons who are not eligible for coverage; (2) for persons who receive care that is determined not to be *Medically Necessary*; or (3) if a claim is for a service that is not a *Covered Service*.
- **Charges after the discharge hour.** You may choose to stay as an *Inpatient* after a *Tufts Health Plan Provider* has: (1) scheduled your discharge; or (2) determined that further *Inpatient* services are no longer *Medically Necessary*. If this happens, we may not pay for any costs incurred after that time.
- **You may be admitted to a facility that is not the *Tufts Health Plan Hospital* in your *PCP's Provider Organization***. If your *PCP* determines that transfer is appropriate, you will be transferred to:
  - the *Tufts Health Plan Hospital* in your *PCP's Provider Organization* or
  - another *Tufts Health Plan Hospital*

Important note: We may not pay for *Inpatient* care provided in the facility to which you were first admitted after:
(1) your *PCP* decides a transfer is appropriate and
(2) transfer arrangements are made

Behavioral Health and Substance Use Disorder Services

If you need *Outpatien*t behavioral health and substance use disorder therapy services:

- You do not need a referral or *Prior Authorization.*
- Your *Tufts Health Plan* behavioral health and/or substance use disorder *Provider* will obtain necessary authorization.
- Our *Outpatient* Behavioral Health/Substance Use Disorder Program can be reached at 1-800-208-9565.
- You or your *PCP* may also call us for authorization.

If you need *Inpatient* or intermediate behavioral health and/or substance use disorder services:

- There is no need to contact us first.
- Simply call or go directly to any *Tufts Health Plan Provider.* Identify yourself as a *Tufts Health Plan Member*.
- The *Tufts Health Plan Provider* is responsible for notifying us of your admission.

Please also see ***Emergency Care and Urgent Care*** earlier in this chapter.

If you have questions:

- Contact Member Services at 1-800-682-8059.
- Call 1-800-208-9565 for our Behavioral Health Department..

About Your *Primary Care Provider*

Importance of choosing a *PCP*: Each *Member* must choose a *PCP* when he or she enrolls.

Until you choose a *PCP*, only *Emergency* care is covered. Once you choose a *PCP*, you are eligible for all *Covered Services*.

The *PCP* you choose will be associated with a specific *Tufts Health Plan Provider Organization*. You will usually receive *Covered Services* from health care professionals and facilities associated with that *Tufts Health Plan Provider Organization*.

How to choose a *PCP.* Go to www.tuftshealthplan.com. Click on "Find a Doctor, Hospital…" to search our *Directory of Health Care Providers*. Or call Member Services. a representative will help you find *PCPs* to choose from in your area. Or maybe you already have a *Provider* who is a *Tufts Health Plan PCP*. In most cases you may choose him or her as your *PCP*. Be sure we know who you choose as your *PCP*. We will update your *Member* record; and then you will be eligible for all *Covered Services*.

Contact your new *PCP.* If you choose a new *Provider* as your *PCP*, please contact him or her as soon as possible. Identify yourself as a new *Tufts Health Plan Member*. Ask your previous *Provider* to transfer your medical records to your new *PCP*. And make an appointment for a check-up or to meet your *PCP*.

What your *PCP* does: Your *PCP* (1) provides routine health care, including routine physical examinations; (2) arranges for your care with other *Tufts Health Plan Providers*; and for other health care services you may need; and (3) provides referrals when required for other health care services you may need. You are responsible for getting a referral before you see a specialist.

> Note: You do not need a referral to receive *Outpatient* behavioral health and substance use disorder services from a *Tufts Health Plan Provider.* See Behavioral Health and Substance Use Disorder Services earlier in this chapter for more information. .

Your *PCP*, or a *Covering Provider*, is available 24 hours a day, 7 days a week. You may need medical services after hours. Contact your *PCP*. For *Inpatient* behavioral health or substance use disorder services after hours, call 1-800-208-9565.

- **If you can't reach your *PCP* by phone right away.** Your *PCP* may not be able to take your call right away. Always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return you call.
- **If you experience a medical *Emergency***. You do not have to contact your *PCP.* Go to the nearest *Emergency* medical facility for treatment (see "*Emergency* and *Urgent Care*" above for more information).

To change your *PCP.* First, see "To choose a *PCP*" above. Once you choose a new *Tufts Health Plan PCP*, let us know. Your choice is not final until we approve the change and update your medical record. Note that if you are an *Inpatient* or in a partial hospitalization program, you may not change your *PCP*, except in very limited situations

Canceling appointments. If you need to cancel an appointment be sure to give at least 24 hours' notice. If you do not, and your *PCP* or *Provider's* office bills you, you will have to pay the charges. We will not pay for missed appointments that you did not cancel in advance.

About Your *Primary Care Provider,* continued

Referrals for specialty services

Every *PCP* is associated with a specific *Provider Organization*. If you need to see a specialist, (including a pediatric specialist) your *PCP* will select the specialist and make the referral.

Usually, your *PCP* will select and refer you to another *Provider* in the same *Provider Organization* (as defined in Appendix A). The working relationship between your *PCP* and these *Providers* helps to provide quality and continuity of care.

You may need specialty care not available within your *PCP's Provider Organization.*
This is a rare event. If this happens, your *PCP* will choose a specialist in another *Provider Organization* and make the referral. When selecting a specialist for you, your *PCP* will consider: (1) any long-standing relationships that you have with any *Tufts Health Plan Provider*; and (2) your clinical needs. (A long-standing relationship means that you have recently been seen or been treated repeatedly by that *Tufts HP* specialist.)

You may require specialty care not available through any *Tufts Health Plan Provider.* This is a rare event. With the prior approval of *Tufts Health Plan or its designee*, your *PCP* may refer you, to a **non**-*Tufts Health Plan Provider.* .

Important Notes about Referrals

- You need a referral from your *PCP* to see a specialist.
- You need the referral before receiving any *Covered Services* from that specialist. If you do not get a referral, you will pay for those services.
- *Covered Services* provided by non-*Tufts Health Plan Providers* are not paid for unless:
  (1) approved in advance by your *PCP,* and
  (2) by *Tufts Health Plan* or its designee*.*
- If a specialist refers you to a non-*Tufts Health Plan Provider*, the referral must be approved by your *PCP* and *Tufts Health Plan* (or its designee).
- Referrals are not required for *Outpatient* behavioral health and substance abuse visits with a *Tufts Health Plan Provider*. Our *Providers* are responsible for verifying that services are *Covered Services*.

Referral forms for specialty services

Except as provided below, your *PCP* must complete a referral to refer you to a specialist. Your *PCP* may ask you to give a referral form to the specialist at your appointment. Your *PCP* may refer you for one or more visits and for different types of services. Your *PCP* must approve referrals a specialist makes to other *Providers*. Make sure that your *PCP* makes a referral before you go to any other *Provider*. A *PCP* may approve a standing referral. This referral would be for specialty health care provided by a *Tufts Health Plan Provider*.

When referrals are not required

- *Emergency* care and *Urgent Care* (also see that "*Emergency* and *Urgent Care*" earlier in this chapter)
  - *Emergency* Care in an *Emergency* room or *Provider's* office.
  - *Urgent Care s*ervices received outside the *Service Area* do not require a *PCP* referral. Referrals are required to seek *Urgent Care* services from certain *Providers* inside the *Service Area*. See "*Urgent Care"* under "*Emergency* and *Urgent Care*" earlier in this chapter.
- When provided by a *Tufts Health Plan Provider*
  - Acupuncture services
  - Behavioral health/substance use disorder services: See "Behavioral Health/Substance Use Disorders Services" section earlier in this chapter.
  - Chiropractic medicine
  - Mammograms, in accordance with American Cancer Society guidelines and Affordable Care Act
  - Oral surgery. (However, *Prior Authorization* is required.)
  - Pregnancy terminations
  - Prostate and colorectal exams
  - Routine eye exams
  - Telemedicine services when received from the *Tufts Health Plan* designated telemedicine vendor
  - Vision care services from an optometrist, including medical treatment
- Specialty care provided by a *Tufts Health Plan Provider* who is an obstetrician, gynecologist, certified nurse midwife or family practitioner for (1) maternity care; (2) *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions; or (3) routine annual gynecological exam. This includes any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam. Note: Services and items ordered by an OB/GYN shall be treated the same as if ordered by a *PCP*.

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

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

The *Tufts Health Plan Directory of Health Care Providers* indicates the method of payment for each *Provider* with whom we contract. Regardless of the method of payment, we expect all participating *Providers* to use sound medical judgment when providing care and when determining whether a referral for specialty care is appropriate. This approach encourages the provision of *Medically Necessary* care and reduces the number of unnecessary medical tests and procedures that can be both harmful and costly to *Members*.

We review the quality of care provided to our *Members* through our Quality of Health Care Program. Feel free to discuss specific questions with your *Provider* about how he or she is paid.

Member Identification Card

Introduction
Tufts Health Plan gives each *Member* a *Member Identification Card* (*Member ID*).

Reporting errors
When you receive your *Member ID Card*, check it carefully. If any information is wrong, call Member Services.

Identifying yourself as a *Tufts Health Plan Member*
Your *Member ID Card* 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, tell the office staff that you are a *Tufts Health Plan Member*.

Important Note: Please identify yourself as a *Tufts Health Plan Member*. If you do not, 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, call a Member Services.

Utilization Management

Tufts Health Plan's utilization management program evaluates whether health care services provided to *Members* are: (1) *Medically Necessary;* and (2) provided in the most appropriate and efficient manner.

Medical Necessity Guidelines are used to determine *Medical Necessity* for services or items which are covered when found to be *Medically Necessary*. These Guidelines are developed for specific services or items found to be safe and proven effective in a limited, defined population of patients or clinical circumstances.

Medical Necessity Guidelines are:

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

Tufts Health Plan considers these guidelines and the *Member's* individual health care needs to evaluate if a service or supply is *Medically Necessary*.

This program sometimes includes prospective, concurrent, and retrospective review of health care services for *Medical Necessity;* collectively, this is called *Authorized Review* and is performed by an *Authorized Reviewer*.

Prospective review is used in advance to determine if certain proposed treatments are *Medically Necessary*. Prospective review is also referred to as "Pre-Service Review".

Concurrent review is used to:

- monitor the course of treatment as it occurs and
- determine when that treatment is no longer *Medically Necessary*

Retrospective review is used to evaluate the *Medical Necessity* of care after it is provided. Sometimes, retrospective review is used to more accurately decide if a *Member's* health care services are appropriate. Retrospective review is also called "Post-Service Review".

TIMEFRAMES FOR TUFTS HEALTH PLAN TO REVIEW YOUR COVERAGE REQUEST:

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

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

Utilization review helps *Members* in the following ways:

- Prospective and concurrent reviews let *Members* know if proposed health care services are *Medically Necessary* and covered under their plan. This allows *Members* to make informed decisions about their care.
- Quality of care and convenience for a *Member* can be enhanced by evaluating *Medical Necessity* and appropriateness of a *Member's* treatment.
- By evaluating treatment cost effectiveness, *Member Cost Sharing Amounts* may be reduced.
- Helping to control overall plan costs plays an important part in making sure health care plans remain affordable.

Utilization Management, continued

If your request for coverage is denied, you have the right to file an appeal. See Chapter 6, Member Satisfaction for information on how to file an appeal. Note: Utilization review affects only coverage determinations under this plan You and your *Provider* make all treatment decisions.

Members can call *Tufts Health Plan* to find out the status or outcome of utilization review decisions:

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

Care Management. Some *Members* with Severe Illnesses or Injuries may need care management. The care management program: (1) encourages use of the most appropriate and cost effective treatment; and (2) supports the *Member*'s treatment and progress.

A *Member* may be identified as an appropriate candidate for care management. The *Member* and his or her *Tufts Health Plan Provider* will be contacted to discuss a treatment plan and establish goals. Alternative services or supplies available to the *Member* may also be suggested.

The *Member's* treatment plan may be reviewed periodically. Alternatives to the *Member's* current treatment plan may be identified that: (1) qualify as *Covered Services*; (2) are cost effective; and (3) are appropriate for the *Member*. In this case, the *Member* and his/her *Tufts Health Plan Provider* will be contacted to discuss alternatives.

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

- serious heart or lung disease
- certain neurological diseases
- severe traumatic injury
- major depressive disorder
- schizophrenia
- high-risk pregnancy and newborn *Children*
- AIDS or other immune system diseases
- cancer
- bipolar disorder
- substance use disorders

Individual care management (ICM). In certain circumstances, *Tufts Health Plan* may approve an individual care management ("ICM") plan for a *Member* with a Severe Illness or Injury. A *Member* must already be a participant 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, a *Member* may be approved for coverage for certain alternative services and supplies that do not otherwise qualify as *Covered Services* for that *Member*. This will occur only if we determine that all of the following conditions are met:

- 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.
  - are services and supplies a *Member* might otherwise 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*.

These alternative services and supplies will be monitored over time. We may decide at any time that these services and supplies no longer satisfy the conditions described above. At that time, coverage of services or supplies provided under the ICM plan may be modified or terminated. Please note that ICM plans are not used to authorize services and supplies that:

- are specifically excluded under the *Member's* plan
- fall within the parameters of the Utilization Review program or
- do not meet the relevant *Medical Necessity* criteria for *authorization*

Chapter 2

Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule

Subscriber

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 *Service Area*

Dependent

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

- qualifies as a *Dependent*, as defined in this *Evidence of Coverage* and
- meets *Group's* and *Tufts Health Plan's* eligibility rule.
- lives, works or resides in the *Service Area*

If you do not live, work or reside in the *Service Area*:

You can be covered ONLY IF:

- You are a *Spouse* or *Dependent* of a *Subscriber* or
- You are a *Child* or
- You are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO) or
- You are a divorced *Spouse* that *Tufts Health Plan* must cover.

Note: Care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only. Please see the following Chapter 1 sections for more information:

- "How the Plan Works: Coverage"
- "*Emergency* and *Urgent Care*"

Proof of eligibility

We may ask you for proof of your and your *Dependents'* eligibility or continuing eligibility. You must give us proof when asked. This may include proof of residence, marital status, birth or adoption of a *Child*, and legal responsibility for health care coverage.

Eligibility Requirements under Rhode Island and Federal Law

- An eligible *Child* is defined based on his or her relationship with the participant.
- Limiting eligibility is prohibited based on: financial dependency on the *Subscriber*; residency; student status; employment; eligibility for other insurance; or marital status.
- The terms of coverage for a *Child* under this *Group* does not vary based on the age of that *Child*.

Enrollment

When to enroll
You may enroll yourself and your eligible *Dependents*, if any, for this coverage only:

- During the annual *Open Enrollment Period* OR
- Within 30 days of the date you or your *Dependent* is first eligible for this coverage

You and your Dependents may fail to enroll when first eligible. You may be eligible to enroll yourself and your eligible *Dependents* at a later date IF.

- You failed to enroll because you or your eligible *Dependent* were covered under another *Group* health plan or other health care coverage at that time OR

You acquired a *Dependent* through marriage, birth, adoption, or placement for adoption. In these cases, you or your eligible *Dependent* may enroll within 30 days after any of the following events:

- Your coverage under the other health coverage ends involuntarily
- Your marriage OR
- Birth, adoption, or placement for adoption of your *Dependent Child*

In addition, you or your eligible *Dependent* may enroll within 60 days after either of the following events:

- You or your *Dependent* are eligible under a state Medicaid plan or state *Children's* health insurance program (CHIP) and the Medicaid or CHIP coverage is terminated OR
- You or your *Dependent* becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP

Effective Date of coverage
Once we accept your application and receive the needed *Premium*, your coverage starts on the date your *Group* chooses. Coverage for enrolled *Dependents* starts when coverage for the *Subscriber* starts. Coverage may start at a later date if the *Dependent* becomes eligible after the *Subscriber. Dependent* coverage cannot start before the *Subscriber* coverage starts.

You or your enrolled *Dependent* may be an *Inpatient* on your *Effective Date*. If this happens, 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 as follows to add any *Dependents* not currently enrolled in *Tufts Health Plan* only:

- During your *Open Enrollment Period,* or
- Within 30 days after any of the following events:
  - A change in your marital status
  - The birth of a *Child*
  - The adoption of a *Child* as of the earlier of: (1) the date the *Child* is placed with you for the purpose of adoption; or, (2) the date you file a petition to adopt the *Child*
  - A court orders you to cover a *Child* through a qualified medical *Child* support order
  - A *Dependent* loses other health care coverage involuntarily
  - A *Dependent* moves into the *Service Area* OR
  - Any other qualifying event IF your plan under the *Group* has an IRS qualified cafeteria plan

How to add *Dependents*

You may have *Family Coverage*. If so, fill out a membership application form listing the *Dependents*. Give the form to your *Group* during your *Open Enrollment Period*. Or, give your *Group* the form within 30 days after the date of an event listed above, under "When *Dependents* may be added." You may not have *Family Coverage*. In this case, ask your *Group* to change your *Individual Coverage* to *Family Coverage*. Then, follow the procedure above.

Effective Date of *Dependents'* coverage

We may accept your application to add *Dependents*. If this happens, 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
- The date of the qualifying event, in the case of marriage or loss of prior coverage

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* 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*:

Newborn *Child:* You must notify *Tufts Health Plan* of the birth of a newborn *Child* and pay the required *Premium* within 31 days after the date of birth. Otherwise, that *Child* will not be covered beyond such 31-day period. No coverage is provided for a newborn *Child* who remains hospitalized beyond that 31-day period and has not been enrolled in this plan. Choose a *PCP* for the newborn *Child* before or within 48 hours after the newborn *Child's* birth. That way, the *PCP* can manage your *Child's* care from birth.

Adoptive Child: You must enroll your *Adoptive Child* within 31 days after the *Child* has been adopted or placed for adoption with you. This is required 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*.

Steps to follow to choose a *PCP* for newborn *Children* and *Adoptive Children*

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

Continuing Eligibility for *Dependents*

When coverage ends

Dependent coverage for a *Child* ends on the last day of the month in which the *Child's* 26th birthday occurs. Note that this age limit does not apply to a *Child* who qualifies as a *Disabled Dependent* at any age.

Coverage after termination

When a *Child* loses coverage under this *Evidence of Coverage,* he or she may be eligible for federal or state continuation. He or she may also be able to enroll in *Individual Coverage*. See Chapter 5 for more information.

Disabled Dependents

When coverage ends. Coverage for a *Disabled Dependent* ends when:

- The *Dependent* no longer meets the definition of *Disabled Dependent* or
- The *Subscriber* fails to give us proof of the *Dependent's* disability

Coverage after termination. The former *Disabled Dependent* may be eligible to enroll in coverage under an *Individual Contract*. See Chapter 5 for more information.

Former *Spouses*

Rule for former *Spouses* for *Group Contract* (Also see Chapter 5)

If you and your *Spouse* divorce, your former *Spouse* may continue coverage as a *Dependent* under your *Family Coverage* in accordance with Rhode Island law if the order for continued coverage is included in the judgment when entered.

Coverage for your divorced *Spouse* continues until:

- Either you or your divorced *Spouse* remarry
- As provided by the judgment for divorce; OR
- Your divorced *Spouse* becomes eligible for coverage in a comparable plan through his or her own employment

Follow these steps to continue coverage for a former *Spouse*

- Call Member Services within 30 days after the divorce decree is issued. Do this to tell us about your divorce.
- Send us proof of your divorce when asked.

Keeping our Records Current

You must notify us of any changes that affect you or your *Dependents'* eligibility. The following are examples of these changes:

- 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 *Service Area* or temporarily residing out of the *Service Area* for more than 90 consecutive days;
- Address changes and
- Changes in an enrolled *Dependent's* status as a *Child* or *Disabled Dependent*

We have forms for you to report these changes. The forms are available from your *Group* or from the Member Services Department.

Chapter 3
Covered Services

Chapter 3 describes plan benefits and services. See the "Preventive health care" section for information about coverage provided in accordance with the Affordable Care Act and state law.

See the **Benefit Overview** at the beginning of this document for *Cost Sharing Amounts* and any benefit limits that apply under this plan

When health care services are *Covered Services*.

Health care services and supplies are *Covered Services* only if they are:

- listed as *Covered Services* in this chapter
- determined to be *Medically Necessary* by us or our designee
- consistent with applicable state or federal law
- consistent with *Tufts Health Plan's Medical Necessity Guidelines* in effect at the time the services or supplies are provided: *Medical Necessity Guidelines* are available on our Web site.* Or you may call Member Services or our Behavioral Health department and speak with a representative.
- provided to treat an injury, illness or pregnancy, except for preventive care
- provided or approved in advance by your *PCP*, except in an *Emergency* or for *Urgent Care* (See Chapter 1, "How Your HMO Plan Works" for more information.)

* https://tuftshealthplan.com/member/employer-individual-or-family-plans/home."

- Click on "Tools + Resources"
- Scroll down and click on "*Tufts Health Plan Guidelines*"
- Click on the category you are looking for; they are listed alphabetically.

Important Note:

Please see Chapter 1 for important information, especially the following sections:

- **Referrals and *Prior Authorization***
- ***Inpatient* Hospital Services**
- **Behavioral Health and Substance Use Disorder Services**
- ***Emergency* and *Urgent Care***

Emergency care

Emergency room (no *PCP* referral required)

Notes**:**

- The *Emergency* Room *Cost Sharing Amount* is waived if the *Emergency* room visit results in immediate hospitalization or *Day Surgery*.
- You may receive *Emergency Covered Services* from a non-*Tufts Health Plan Provider*. In this case, we will pay up to the *Reasonable Charge*. You pay the applicable *Cost Sharing Amount*.

Acupuncture

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

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

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

2.2.1 Meet the requirements for licensure as a doctor of acupuncture set forth in the *Rules and Regulations for Licensing Doctors of Acupuncture and Acupuncture Assistants* promulgated by the Department of Health **or**

2.2.2 Successfully complete a course offered to physicians that meets the requirements set forth in these regulations and includes no less than the following:

a) a minimum of three hundred (300) hours of formal instruction
b) a supervised clinical practicum incorporated into the formal instruction required in subsection 2.2.2(a) (above)

When Acupuncture services are not covered:

- adjunctive therapies, such as but not limited to moxibustion, herbs, oriental massage, etc.
- acupuncture when used as an anesthetic during a surgical procedure
- precious metal needles (e.g., gold, silver, etc.)
- acupuncture in lieu of anesthesia
- any other service not specifically listed as a *Covered Service*

Allergy testing, treatment, and allergy injections

Coverage is provided for *Medically Necessary* allergy services, including antigens.

Ambulance services (PA)

- Ground, sea and air ambulance transportation for *Emergency* care.
  - Air ambulance services means transportation by helicopter or fixed wing plane (for example Medflight).
- Non-*Emergency*, *Medically Necessary* ambulance transportation between covered facilities.*
- Non-*Emergency* ambulance transportation for *Medically Necessary* care when a *Member's* medical condition prevents safe transportation by any other means.*

*Approval by an *Authorized Reviewer* may be required for these services

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

Autism spectrum disorders – diagnosis and treatment (PA)

Coverage is provided, in accordance with Rhode Island law, for the diagnosis and treatment of autism spectrum disorders for *Children*. 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
- pervasive *Developmental* disorders not otherwise specified

Tufts Health Plan provides coverage for the following *Covered Services*. Services with an asterisk (*) require *Prior Authorization.*

- Applied behavioral analysis services (ABA)*, supervised by a *Board-Certified Behavior Analyst (BCBA)* who is a licensed health care clinician. For the purposes of this benefit, ABA includes:
  - the design, implementation, and evaluation of environmental modification
  - using behavioral stimuli and consequences
  - to product socially significant improvement in human behavior
  - including the use of direct *Observation*, measurement, and functional analysis of the relationship between the environment and behavior

  For more information about these services, call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565.
- Prescription medications: See the prescription drug benefit for *Covered Services*
- Psychological and psychiatric care: See the behavioral health and substance use disorder benefit for *Covered Services*.
- Speech, physical and occupational therapy services* provided by licensed or certified therapists. There are no visit limits when services are provided under this autism spectrum disorders benefit.

  Note: For coverage that applies to conditions other than autism spectrum disorder, see "Speech, physical and occupational therapy services" later in this chapter.

Covered Services, continued

Behavioral health and substance use disorder services

*****Certain services in this benefit category may require approval by an *Authorized Reviewer*. See Behavioral Health and Substance Use Disorder Services in Chapter 1 for more information.

***Outpatient* behavioral health services**

Outpatient services to diagnose and treat *Mental Disorders*. This includes *Individual*, *Group*, and *Family* therapies. No *PCP* referral *or Prior Authorization* is required for *Outpatient* therapy.

Note: *Prior Authorization* **(PA)** is required for psychopharmacological services and neuropsychological assessment services. These services are covered as "Office visits to diagnose and treat illness or injury,"

***Inpatient* and intermediate behavioral health services ***

Inpatient services: *Medically Necessary* behavioral health services for *Mental Disorders* in a facility that is licensed as a general hospital, behavioral health hospital, substance use disorder facility, or behavioral health residential treatment facility.

Intermediate services: *Medically Necessary* behavioral health services that are more intensive than traditional *Outpatient* behavioral health services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate behavioral health services are:

- Level III community-based detoxification
- Crisis stabilization
- Intensive *Outpatient* programs
- Partial hospital programs and
- Adult intensive services (AIS)*

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

- ongoing *Emergency* or crisis evaluations available 24 hours a day, 7 days a week
- psychiatric assessment
- medication evaluation and management;
- care management
- psychiatric nursing services and
- *Individual*, *Group*, and *Family* therapy

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

***Outpatient* substance use disorder services**

Outpatient services to diagnose and treat substance use disorders, including methadone maintenance or methadone treatment related to chemical dependency disorders. (No *PCP* referral is required.)

Inpatient* and intermediate substance use disorder services

Inpatient substance use detoxification and treatment services in a general hospital, substance use disorder facility, or *Community Residence*

Intermediate substance use disorder services: These services are more intensive than traditional *Outpatient* substance use disorder services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate substance use disorder services are partial hospital programs and intensive *Outpatient* programs. Intermediate substance use disorder services also include adult intensive services (AIS). *Tufts Health Plan* covers adult intensive services approved by us and that meet our criteria for participation. AIS is a facility-based substance use disorder program. Adult intensive services are primarily in the home for qualifying adults with moderate to severe chemical dependency conditions. This program must consist of, but is not limited to, the following:

- ongoing *Emergency* or crisis evaluations available 24 hours a day, 7 days per week
- psychiatric and addiction assessment
- medication evaluation and management
- care management
- addiction nursing services
- *Individual*, *Group*, and *Family* therapy

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

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

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

Cardiac rehabilitation services

We cover the following *Outpatient* services for the treatment of documented cardiovascular disease:

- *Outpatient* convalescent rehabilitation services following hospital discharge and
- *Outpatient* services that address multiple risk reduction, adjustment to illness, and therapeutic exercise

Chemotherapy administration

Administration of chemotherapy. For more information about coverage of medications used in chemotherapy, see "Injectable, infused or inhaled medications" listed 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. During each visit, *Members* are covered for spinal manipulation and up to two chiropractic modalities (therapeutic exercise, and/or attended electrical stimulation (EMS)).

Clinical trials - Patient care services provided on an *Inpatient or Outpatient* basis as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions

This *Evidence of Coverage* provides coverage for certain experimental/investigational services as required by:

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

In accordance with Rhode Island General Law §27-20-60, coverage is provided for *Members* participating in approved clinical trials.

You are qualified to participate in a clinical trial if:

- You are eligible according to the trial protocol and
- A *Network Provider* has concluded that your participation would be appropriate or
- You provide medical and scientific information establishing that your participation in such trial would be appropriate

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

To qualify as a clinical trial, it must be:

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

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

Coverage includes routine patient costs for C*overed Services* furnished in connection with participation in the trial. These include C*overed Services* that are typically covered for a patient who is not enrolled in in a clinical trial.

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

- For information about office visits, see "Office visits to diagnose and treat illness or injury"
- For surgical procedures see "Hospital *Inpatient* services (acute care)"
- For lab, radiology, and machine tests see "Laboratory tests", "Diagnostic imaging", and Diagnostic testing"
- For prescription drugs, see "Prescription Drug Benefit"

In a clinical trial, this *Evidence of Coverage* does not cover:

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

Day Surgery (PA)

Also called ambulatory surgery or surgical day care.

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

Diabetes services and supplies

Covered Services are provided for the treatment of insulin treated diabetes, non-insulin treated diabetes, or gestational diabetes. In accordance with Rhode Island General Law § 27-41-44, the following coverage is provided when *Medically Necessary* and prescribed by a *Provider*:

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

Upon the approval of the United States Food and Drug Administration, new or improved diabetes equipment and supplies will be covered when *Medically Necessary* and prescribed by a *Provider*.

Diagnostic imaging (PA)

This includes:

- General imaging, for example, x-rays and ultrasounds and
- MRI/MRA, CT/CTA and PET tests and nuclear cardiology

Important Note: *Prior Authorization* by an *Authorized Reviewer* is required for MRI/MRA, CT/CTA, and PET tests and nuclear cardiology.

Diagnostic or preventive screening procedures

Coverage for preventive screenings (no *PCP* referrals required):

See "Preventive health care" benefit for more information. Routine screenings and exams including the following, are covered in full.

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

Coverage for diagnostic procedures & exams **(PA)**

Diagnostic procedures and exams are subject to *Member Cost Sharing Amounts*. See the Benefit Overview at the beginning of this document.

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

Diagnostic testing (PA)

Examples include, but are not limited to, ambulatory EKG testing, sleep studies (performed in the home or a sleep study facility), and diagnostic audiological testing. *Prior Authorization* is required for certain tests. Please call Member Services about specific tests.

Durable Medical Equipment

Equipment must meet the following definition*: Durable Medical Equipment* is a device or instrument of a durable nature that:

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

To be eligible for coverage, the equipment must also be the most appropriate amount, supply or level of service available for the *Member* in question considering potential benefits and harms to that individual. *Tufts Health Plan* determines this. *Tufts Health Plan* may decide that equipment is: (1) non-medical in nature; and (2) used primarily for non-medical purposes. (This may occur even though that equipment has some limited medical use.) In this case, the equipment will not be considered *Durable Medical Equipment* and. It will not be covered under this benefit.

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

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

- purchase of a manual or electric (non-hospital grade) breast pump or the rental of a hospital grade electric breast pump for pregnant or post-partum *Members*: The items must be prescribed by a physician.
- gradient stockings (Up to three pairs are covered per calendar year)
- insulin pumps
- oral appliances for the treatment of sleep apnea
- oxygen concentrators (stationary and portable)
- *Durable Medical Equipment* devices covered under this plan and are *Medically Necessary* for a *Member's Habilitation*
- prosthetic devices, except for arms, legs, or breasts Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Orthoses and prosthetic devices" benefit.
- scalp hair prostheses or wigs worn for hair loss suffered as a result of treatment of any form of cancer or leukemia (Also see "Scalp hair prostheses or wigs for cancer or leukemia patients)
- power/motorized wheelchairs
- therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease

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

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

- air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers
- articles of special clothing, mattress and pillow covers, including hypo-allergenic versions
- bath and toilet aids, including but not limited to, tub seats/benches/stools, raised toilet seats, commodes, and rails
- bed-related items, including bed trays, bed cradles; bed pans, bed rails over-the-bed tables, and bed wedges
- car seats; car/van modifications
- certain wearable devices (e.g. smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g. Fitbit, Biostamp, Embrace smartwatch, Smartmonitor smartwatch, Garmin Vivofit 4, Garmin Vivosmart 3, Samsung Galaxy Fit)
- comfort or convenience devices
- dentures; ear plugs
- fixtures to real property. Examples are ceiling lifts, elevators, ramps, stair lifts, or stair climbers
- *Emergency* response systems (e.g., LifeAlert)
- exercise equipment and saunas
- heat and cold therapy devices, including but not limited to, hot packs, cold packs, and water pumps with or without compression wrap
- heating pads, hot water bottles, paraffin bath units, and cooling devices
- home blood pressure monitors and cuffs
- hot tubs, jacuzzis, swimming pools, or whirlpools
- mattresses except for mattresses used in conjunction with a hospital bed and ordered by a *Provider:* Commercially available standard mattresses (for example, Tempur-Pedic® and Posturepedic® mattresses) are not covered. This is the case even if used in conjunction with a hospital bed.
- 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
- wheelchair trays; and scooters

Note: For coverage of orthoses and prosthetic devices, including breast prostheses, prosthetic arms and legs (in whole or in part), see "Orthoses and prosthetic devices" later in this chapter.

Early intervention services for a *Dependent Child*

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

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

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

Extended care*

In an extended care facility (including Medicare-certified *Skilled Nursing Facilities*, rehabilitation hospitals, and chronic hospitals) for:

- *Skilled Nursing* services
- rehabilitative services or
- chronic disease services

Notes: *Custodial Care* is not covered.

Family planning

Coverage is provided for *Outpatient* contraceptive services. This includes consultations, examinations, procedures, and medical services. These services must be related to the use of all contraceptive methods approved by the United State Food and Drug Administration (FDA).

Procedures:

- sterilization and
- pregnancy terminations

Services:

- medical examinations
- consultations
- birth control counseling
- genetic counseling

Contraceptives:

- medical exams
- cervical caps
- implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants)
- Intrauterine devices (IUDs)
- Depo-Provera or its generic equivalent and
- any other *Medically Necessary* contraceptive device approved by the United States Food and Drug Administration*

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

Hearing Aids

Coverage is provided for:

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

Hemodialysis

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

Home health care

This is a *Medically Necessary* program to: (1) reduce the length of a hospital stay or; (2) delay or eliminate an otherwise *Medically Necessary* hospital admission. Coverage includes:

- home visits by a *Tufts Health Plan Provider*
- *Skilled Nursing* care and physical therapy
- *Medically Necessary* private duty nursing care: A certified home health care agency needs to provide this care.
- speech therapy
- occupational therapy
- medical/psychiatric social work
- nutritional consultation
- prescription drugs and medication
- medical and surgical supplies (Examples include dressings, bandages and casts.)
- laboratory tests
- x-rays, and E.K.G. and E.E.G. evaluations
- use of *Durable Medical Equipment* and
- services of a part-time home health aide

Notes

- Home health care services for speech, physical and occupational therapies may follow an injury or illness. If this occurs, services provided for rehabilitation are only covered to restore function lost or impaired (as described under "Speech, physical and occupational therapy services.") Home health care services are not subject to the rehabilitation visit limits listed under "Speech, physical and occupational therapy services."
- Sleep studies performed in the home are not covered under this Home health care benefit; these sleep studies are covered as described under Diagnostic testing earlier in this chapter.

Hospice care services

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

- *Provider* services
- nursing care provided by or supervised by a registered professional nurse
- social work services
- volunteer services and
- counseling services (This includes bereavement counseling services for the *Member's* family. This applies for up to one year after the *Member's* death.)

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

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

Hospital *Inpatient* services (acute care)

- Anesthesia
- Diagnostic tests and lab services
- Dialysis
- Drugs
- Intensive care/coronary care
- Physical, occupational, speech, and respiratory therapies
- Nursing care
- *Provider* services while hospitalized
- Radiation therapy
- Surgery
- Semi-private room (private room when *Medically Necessary*)

Note: Also see "Surgery" later in this chapter.

House calls to diagnose and treat illness or injury or provide follow up care as appropriate and in accordance with federal and state law.

A licensed physician or licensed behavioral health *Provider* must provide this care.

Human leukocyte antigen testing

Coverage is provided for human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. Coverage includes costs of testing for A, B or DR antigens.

Immunizations

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

Infertility services (PA)

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

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

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

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

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

The following procedures are *Covered Services* when approved in advance by an *Authorized Reviewer* for *Members* with a diagnosis of infertility who also:

- meet our eligibility requirements, which are based on the Member's medical history and
- meet the eligibility requirements of our contracting Infertility Services Providers

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

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

- In-vitro fertilization (IVF) and/or embryo transfer (ET)
- Frozen embryo transfer (FET
- Gamete Intra-fallopian transfer (GIFT)
- Donor oocyte (DO/IVF)
- Donor embryo/frozen embryo transfer (DE/FET)
- Intracytoplasmic sperm injection (ICSI)
- Assisted hatching (AH)
- Cryopreservation of embryos/blasts
- Cryopreservation of sperm
- Cryopreservation of oocytes (eggs)*

**Members* who meet the criteria for infertility services and who also (1) have a documented contraindication to pregnancy; (2) are using their own eggs; and, (3) are self-paying for a gestational carrier or surrogate; may be authorized for ovarian stimulation, egg retrieval, and fertilization. *Prior Authorization* is required. For more details on services that are available to a *Member* who meets the definition of infertility, call Member Services and see the *Medical Necessity Guidelines* for infertility services available at https://tuftshealthplan.com/documents/providers/guidelines/medical-necessity-guidelines/infertility-svcs-ri

Infertility services (PA), continued

B. Other related ART treatments, including:
- artificial insemination (intrauterine or intracervical)
- gonadotropin medication (FSH)
- artificial insemination (intrauterine or intracervical) used in conjunction with Gonadotropin medication
- cryopreservation of eggs (less than 90 days) and
- procurement and processing of eggs or inseminated eggs or storage of inseminated eggs when associated with active infertility treatment

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

For more information, call Member Services and see our *Medical Necessity Guidelines* for infertility services at the web address listed above.

(III.) Preimplantation Genetic Diagnosis (PGD) testing with IVF:
PGD testing is covered when either of the partners is a known carrier for certain genetic disorders. In addition to the Infertility Services provided in connection with Rhode Island law (as described above), PGD testing with IVF may be covered for *Members* who do not have a diagnosis of infertility in certain circumstances when the fetus would be at risk for an inherited genetic disorder associated with severe disability and/or premature death. Prior approval by an *Authorized Reviewer* is required. For more information, please call Member Services and see the *Medical Necessity Guideline* for "Preimplantation Genetic Diagnosis" on our Web site.

Oral and injectable drug therapies may be used to treat infertility. These therapies are considered *Covered Services* for *Members* with prescription drug coverage. . See "Prescription Drug Benefit" later in this chapter for information about drug therapy benefit levels.

Injectable, infused or inhaled medications

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

Notes:
- Quantity limitations may apply for certain medications.
- There are designated home infusion *Providers* for a select number of specialized pharmacy products and drug administration services. These *Providers* offer clinical management of drug therapies, nursing support, and care coordination to *Members* with acute and chronic conditions. Medications offered by these *Providers* include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. Call Member Services or see our Web site for more information on these medications and *Providers.*
- Coverage includes the components required to administer these medications. This includes, but is not limited to, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.
- Medications listed on our web site as covered under a *Tufts Health Plan* pharmacy benefit are not covered under this "Injectable, infused or inhaled medications" benefit. For more information, call Member Services. Also, see our Web site at www.tuftshealthplan.com.

Laboratory tests (PA)

Covered tests include, but are not limited to: blood tests; urinalysis; throat cultures; glycosylated hemoglobin (A1c) tests; genetic testing; and urinary protein/microalbumin and lipid profiles.

Notes:
- *Prior Authorization* is required for certain laboratory tests. An example is genetic testing.
- Laboratory tests must be (i) ordered by a physician, physician assistant, or nurse practitioner, and (ii) performed at a licensed laboratory.
- Certain laboratory tests associated with routine preventive care are covered in full when billed in accordance with our Preventive Services Payment Policy. An example of this is the colorectal cancer screening test Cologuard. If a laboratory test is not billed according to this policy, it will be subject to the *Member Cost Sharing Amount* for "Laboratory tests" specified in the "Benefit Overview." For additional information on this policy, please see our website at https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services

Lead screenings

In accordance with Rhode Island law, coverage is provided for (1) lead screening related services; and (2) diagnostic evaluations for lead poisoning.

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

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

Mastectomy care

The following services in connection with mastectomy in accordance with Rhode Island law:

- Surgical procedures known as a mastectomy
- Axillary node dissection
- Reconstruction of the breast affected by the mastectomy
- Surgery and reconstruction of the other breast to produce a symmetrical appearance and
- Prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema)

* Breast prostheses are covered as described under "Orthoses and prosthetic devices" later in this chapter.

Inpatient care in hospital for mastectomies is covered for (1) a minimum of 48 hours following a surgical procedure known as a mastectomy; and (2) a minimum of 24 hours following an axillary node dissection. Any decision to shorten this minimum coverage shall be made by the attending *Provider* in consultation with and upon agreement by the *Member.* Coverage shall also include a minimum of one (1) home visit conducted by a *Provider* or registered nurse.

Removal of a breast implant is covered when:

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

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

Note: Cosmetic surgery is not covered.

Covered Services, continued

Maternity care (no *PCP* referral required)

Outpatient coverage for routine and non-routine care, including:

- Prenatal care, exams and tests
- Postpartum care provided in a *Provider's* office

Note: *Member Cost Sharing* will apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of routine maternity care. See "Diagnostic testing" and "Laboratory tests"

Inpatient coverage includes:

- Hospital and delivery services and
- Well newborn *Child* care in hospital
- *Inpatient c*are in the hospital is covered for mother and newborn *Child* for at least:
  - 48 hours following a vaginal delivery and
  - 96 hours following a caesarean delivery

No *Prior Authorization* is required for the minimum hospital stay. There is no requirement that the mother give birth in a hospital to qualify for this minimum hospital stay. Hospital length of stay begins at the time of delivery if delivery occurs in a hospital; it begins at time of admission in connection with childbirth if delivery occurs outside the hospital. Any decision to shorten these minimum coverages shall be made by the attending health care *Provider* in consultation with the mother. The attending *Provider* may be an obstetrician, pediatrician, family practitioner, general practitioner, or certified nurse midwife.

Coverage of the newly-born *Child* will continue for 31 days after birth. For coverage to continue beyond this 31-day period, you must enroll the *Child* as described under "Newborn *Children* and *Adoptive Children*".

Notes: *Covered Services* will include one (1) home visit by a registered nurse, *Provider*, or certified nurse midwife. It includes 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.

In accordance with federal law (42 U.S.C. § 300gg-25), *Tufts Health Plan* shall not:

(1) deny to the mother or her newborn *Child* eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, solely for the purpose of avoiding the requirements of this section
(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section
(3) penalize or otherwise reduce or limit the reimbursement of an attending *Provider* because such *Provider* provided care to an individual participant or beneficiary in accordance with this section
(4) provide incentives (monetary or otherwise) to an attending *Provider* to induce such *Provider* to provide care to an individual participant or beneficiary in a manner inconsistent with this section or
(5) restrict benefits for any portion of a period within a hospital length of stay required in a manner which is less favorable than the benefits provided for any preceding portion of such stay

Medical supplies (PA)

Tufts Health Plan covers the cost of certain types of medical supplies. The supplies must come from an authorized vendor. These supplies include: ostomy, tracheostomy and catheter supplies, and insulin pumps.

Note: Medical supplies must be obtained from a vendor that has an agreement with us to provide such supplies. Contact Member Services with coverage questions.

Nutritional counseling

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

- When *Medically Necessary* for the purpose of treating an illness: Please see the Benefit Overview for applicable *Cost Sharing Amount*.
- As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, behavior change and counseling; in accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full

Note: Weight loss programs and clinics are not covered

Office visits to diagnose and treat illness or injury

Coverage includes, but is not limited to, office visits for evaluations and consultations; *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions (no *PCP* referral required); and visits to a *Limited Service Medical Clinic*. See "Diagnostic imaging", "Diagnostic tests", and "Laboratory tests"" for coverage of services associated with these office visits.

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 are *Covered Services* when provided 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

  See "Pediatric dental care for *Members* under age 19" for coverage under that benefit.

  If you wish to make sure that a planned service is a *Covered Service,* call Member Services.

  The following services are covered in an *Inpatient* or *Day Surgery* setting. *Prior Authorization* is required. Hospital / facility, *Provider,* and surgical charges are included:
  - Extraction of seven or more permanent teeth during one visit
  - Surgical treatment of skeletal jaw deformities
  - Surgical repair related to Temporomandibular Joint Disorder (TMJ)
  - Surgical removal of impacted or un-erupted teeth when embedded in bone

  In addition, surgical removal of impacted or un-erupted teeth when embedded in bone is covered in an office setting without *Prior Authorization.*

Notes:

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

Orthoses and prosthetic devices

We cover the cost of orthoses and prosthetic devices (including repairs), as required by Rhode Island law. This includes coverage of breast prostheses as required by federal law. Coverage is provided for the most appropriate model that adequately meets the *Member's* needs. His or her treating *Provider* decides this. *Prior Authorization* is required for these services. *

*Important Note: Breast prostheses require *Prior Authorization* EXCEPT when provided in connection with a mastectomy.

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

Covered Services, continued

Pediatric dental care for *Members* under age 19

Note**:** For these pediatric services, "under age 19" means the last day of the month in which a *Member* turns 19 years old.

This pediatric dental benefit is administered by DentaQuest USA Insurance Company, Inc. To find a dentist for your *Dependent Child*, call DentaQuest 844-241-5612 toll free. Or visit their website at http://www.dentaquest.com/members/

If you have any questions about what your pediatric dental benefit covers or how a claim was paid, call DentaQuest Customer Service Department toll free at 844-241-5612. DentaQuest's automated information line is available 24 hour a day, seven days a week. Customer service representatives are available Monday - Friday from 8:00 am – 5:00 pm.

Dental claims and written correspondence should be sent to:

DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906

The following are examples of *Covered Services* under the dental categories covered under this plan:

<table>
<tr><th colspan="2">BASIC SERVICES</th></tr>
<tr><td>Preventive Services:
Prophylaxis (cleanings): Twice per calendar year
Topical application of fluoride Twice per calendar year
Sealants for unrestored permanent molars: Once every 36 months.*
Space maintainers: Once every 60 months for lost deciduous (baby) teeth</td><td>Diagnostic and Treatment:
Periodic oral evaluations: Twice per calendar year
Bitewing X-rays for Children: Two sets per calendar year
X-ray series and panoramic film: Once every 60 months*
Single tooth x-rays. As required</td></tr>
<tr><th colspan="2">INTERMEDIATE SERVICES</th></tr>
<tr><td>Minor Restorative Services:
Amalgam (silver) fillings on any teeth
Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for amalgam filling
Repairs to existing partial or complete dentures: Once per calendar year
Re-cementing Crowns or Bridges: Once every 60 months*
Rebasing or relining partial or complete dentures: Once every 36 months*</td><td>Endodontic Services:
Root canal therapy
Oral Surgery:
Extractions and other routine oral surgery covered when not covered by medical plan
IV/sedation/general anesthesia for certain complex surgical procedures
Palliative Treatment
Minor procedures necessary to relieve acute pain</td></tr>
<tr><th colspan="2">MAJOR SERVICES</th></tr>
<tr><td colspan="2">Services listed in this section are subject to dental review and alternate benefit. Pre-treatment estimate is recommended.</td></tr>
<tr><td>Major Restorative Services:
Crowns, build-up, posts/core: Covered over natural teeth when teeth cannot be restored with regular fillings. Replacement limited to once every 60 months*
Periodontic Services:
Periodontal maintenance following active therapy: Twice per calendar year
Root planing and scaling: Once per quadrant every 24 months*
Osseous (bone) surgery (bone grafts are not covered): Once per quadrant every 36 months*
Gingivectomies Once per site every 24 months*</td><td>Prosthodontic Services:
Bridges and Crowns over Implants. Replacement is limited to once every 60 months*
Partial and Complete dentures Replacement is limited to once every 60 months*
Surgical Placement of Endosteal Implants and Abutment Once per tooth per lifetime</td></tr>
</table>

Pediatric dental care for *Members* under age 19, continued

ORTHODONTIA SERVICES
• *Medically Necessary* orthodontia is covered for *Members* under age 19. • Patient must have severe and handicapping malocclusion as defined by HLD index score of at least 22 and/or one or more auto qualifiers, such as cleft palate or other specified craniofacial anomaly. • *Prior Authorization* is required. • Offered to *Dependent Children* only. *Dependent Children* are covered for orthodontic services until their 19th birthday. Orthodontic benefits end at cancellation of coverage.

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

Preventive health care

Important Information about Preventive Services:

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

Note: Also see Diagnostic or preventive screening procedures" earlier in this chapter.

- Preventive screenings are covered in full (1) In accordance with the Affordable Care Act and current recommendations of the U.S. Preventive Services Task Force (USPSTF) and (2) when received from a *Network Provider.*

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

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

  or

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

  If you have any questions about whether specific services are considered preventive under the ACA, please call Member Services.

- Diagnostic services are subject to *Member Cost Sharing Amounts*.
  For these *Cost Sharing Amounts*, see the Benefit Overview at the beginning of this document.

Preventive health care for *Members* through age 19

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

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

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an office visit *Cost Sharing Amount.*

Preventive health care for *Members* age 20 and older

- Routine physical examinations. These include appropriate immunizations and lab tests as recommended by a *Tufts Health Plan Provider*
- Routine annual gynecological exam. This includes any follow-up obstetric or gynecological care we decide is *Medically Necessary* based on that exam (no *PCP* referral required) and
- Hearing examinations and screenings

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to an office visit *Cost Sharing Amount.*

Private duty nursing services in the *Member's* home

Coverage is provided for private duty nursing services that are:

- M*edically Necessary*
- ordered by a physician
- received in the *Member's* home for a *Member* who is homebound* and
- performed by a certified home health care agency by a licensed nurse (RN or LPN)

*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.

Private duty nursing services are only covered when the patient requires continuous *Skilled Nursing* observation and intervention. *Prior Authorization* is required for these services.

Important Notes: The following services do not qualify as *Covered Services* under this benefit:

- Services of a private duty nurse:
  - when the primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as companion or sitter,
  - who is a member of your household or the cost of any care provided a *Member's* relatives (by blood, marriage or adoption),
  - after the caregiver or patient has demonstrated the ability to carry out the plan of care
  - provided outside the home (for example, school, nursing facility or assisted living facility)
  - that duplicate or overlap services (for example, when a person is receiving hospice care services or for the same hours of a *Skilled Nursing* home care visit) or
  - that are for observation only or
- Services of a nurse's aide or
- Care for a person without an available caregiver in the home (twenty-four hour private duty nursing is not covered) or
- Maintenance care when the condition has stabilized (including routine ostomy care or tube feeding administration) or if the anticipated need is indefinite or
- Respite care (for example, care during a caregiver's vacation) or private duty nursing so that the caregiver may attend work or school

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

Radiation therapy

Respiratory therapy or pulmonary rehabilitation services

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. (See "*Durable Medical Equipment*" in this chapter.)

Smoking cessation counseling sessions

Coverage includes *Individual*, *Group*, and telephonic smoking cessation counseling services that: (1) are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and, (2) meet the requirements of the Rhode Island Office of the Health Insurance Commissioner Regulation 14.

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

Special medical formulas

Includes nonprescription enteral formulas and low protein foods as follows:

Low protein foods: When prescribed by a *Provider*, to treat inherited diseases of amino acids and organic acids.

Nonprescription enteral formulas: When prescribed by a *Provider*, for home use to treat malabsorption caused by the following: Crohn's disease; ulcerative colitis; gastro-esophageal reflux; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids.

Speech, physical and occupational therapy services (including rehabilitative services and *Habilitative* services) (PA)

Coverage is provided for *Habilitative* services that are *Medically Necessary* as required by state and federal law. Coverage is provided for rehabilitative services when provided to restore function lost or impaired as the result of an accidental injury or sickness, and includes cognitive rehabilitation and retraining.

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

- provided by a licensed physical therapist and
- in compliance with *Tufts Health Plan's Medical Necessity Guidelines*: See information at the beginning of this chapter for how to locate guidelines on the *Tufts Health Plan* Web site. Or call Member Services.

Note: Separate speech, physical and occupational therapy visit limits for *Habilitative* services and rehabilitative services are provided under this benefit..

Surgery – *Prior Authorization* **(PA)** is required. (Also see "Hospital *Inpatient* services (acute care)" and "*Day Surgery*")

Hematopoietic stem cell transplants and human solid organ transplants

Hematopoietic stem cell transplants and human solid organ transplants provided to *Members*:

- These services must be provided at a *Tufts Health Plan* designated transplant facility.
- We pay for charges incurred by the donor in donating stem cells or solid organ to the *Member*. However, we will do this 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 related directly to donating the stem cells or solid organ to the *Member*

Notes:

- We do not cover donor charges of *Members* who donate stem cells or solid organs to non-*Members*.
- We cover a *Member's* donor search expenses for donors related by blood.
- We cover the *Member's* donor search expenses for donors not related by blood when *Medically Necessary*. These services are only covered to the extent such services are not covered by any other plan of health benefits or health care coverage.
- We cover a *Member's* human leukocyte antigen (HLA) testing. See Human Leukocyte Antigen (HLA) testing benefit earlier in this chapter.

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

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

Surgery in a *Provider*'s office

Gender reassignment surgery and related services

Coverage is provided for gender reassignment surgery, pre-operative and post-operative services related to the surgery, and prescription drugs and behavioral health care services for *Members* undergoing the gender reassignment process. *Covered Services* include:

- *Inpatient* services, including female to male or male to female gender reassignment surgery and related surgical procedures
- *Day Surgery* for surgical procedures related to the female to male or male to female gender reassignment surgery: These services are covered as described under "*Day Surgery"* earlier in this chapter.
- *Outpatient* medical care (pre-operative or post-operative) related to gender reassignment surgery: These services are covered as described under "Office visits to diagnose and treat illness or injury", earlier in this chapter.
- Behavioral health care services (pre-operative or post-operative) related to gender reassignment surgery or the gender reassignment process: These services are covered as described under the behavioral health and substance use disorder services section later in this chapter.
- Prescription medications required as part of the gender reassignment process: These medications are covered as described under the "Prescription Drug Benefit", later in this chapter.

Services must be authorized in advance by an *Authorized Reviewer. Members* must meet specific *Medical Necessity Guidelines* in order for these services to be covered. Gender reassignment surgery and related services only qualify as *Covered Services* when they are obtained within the 50 United States. For more information, please contact Member Services.

Telemedicine services

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

Telemedicine services may be obtained from a *Tufts Health Plan Network Provider* with real-time interactive capabilities and or through *Tufts Health Plan's* designated telemedicine vendor (services from our vendor may be referred to as "telehealth services".) Please visit www.teledoc.com/tuftshealthplan or contact Member Services for information about our telemedicine vendor and how to access services

When you seek telemedicine services through the *Tufts Health Plan* telemedicine vendor, you will pay the *Cost Sharing Amount* for telemedicine services listed in the Benefit Overview. No *PCP* referral is required.

When you seek telemedicine services from a *Tufts Health Plan Network Provider*, you will pay the same *Cost Sharing Amount,* and follow the same referral rules, that apply to an in-person office visit with that *Provider*.

Additionally, at your choice, audio only consultation services may be available to you when obtained through the *Tufts Health Plan* telemedicine vendor. If you access such audio only consultation services, the same C*ost Sharing Amount* as indicated for Telemedicine services in the Benefit Overview will apply.

Urgent Care*, including services in a *Free-standing Urgent Care Center

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

Vision care services

Routine eye examination for *Members* age 19 and older: Coverage is provided for one routine eye examination every *Contract Year*.

Note: You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network. Otherwise, these services are not covered. A *PCP* referral is not required. Go to www.tuftshealthplan.com. Or, contact Member Services for more information.

Other vision care services: **(PA)**
Coverage is provided for eye examinations and necessary treatment of a medical condition *Prior Authorization* may be required for certain services.

Notes:

- A *PCP* referral is not required to receive medical treatment from an EyeMed Vision Care optometrist practicing within the scope of his/her license,
- You must obtain a *PCP* referral to receive services from a *Tufts Health Plan Provider* (eye specialist/ ophthalmologist). Otherwise, services will not be covered.
- 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.
  .

Covered Services, continued

Pediatric vision care for *Members* under age 19

Note: See the following table for a description of the Pediatric vision benefit. For these pediatric services, "under age 19" means the last day of the month in which a *Member* turns 19 years old.

Diagnostic Benefits
Eye exam: • New patient exam • Established patient exam • Routine ophthalmologic exam with refraction for new or established patient **Contact Lens Fit and Follow-Up:** • Standard Contact Lens Fit and Follow-U; • Premium Contact Lens Fit and Follow-Up
Eyewear Benefits
Lenses • Single vision lenses • Conventional (lined) bifocal lenses • Conventional (lined) trifocal lenses and • Lenticular lenses Notes: • Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), solid and gradient tinting • Polycarbonate lenses are covered in full (*In-Network*) for *Children* • All lenses include scratch resistant coating with no additional charge **Frames** (from a limited collection of frames) **Contact Lenses** (coverage includes material only) • Extended wear disposables • Daily wear disposables • *Medically Necessary*/Conventional

IMPORTANT NOTE: Contact lenses may be determined to be *Medically Necessary* in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism. *Medically Necessary* contact lenses are dispensed in lieu of other eyewear.

Other Vision Services	
Optional lenses and treatments:	
• Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch and Coating • Standard Polycarbonate – *Children* under 19 • Standard Anti-Reflective Coating	• UV Treatment • Polarized • Photocromatic/Transitions Plastic • Oversized

Low Vision Services
Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for *Members* with low vision. Note: See "Benefits Overview" for additional information.

Prescription Drug Benefit

Introduction

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

- How Prescription Drugs Are Covered
- What is Covered
- What is Not Covered
- *Tufts Health Plan* Pharmacy Management Programs
- Filling Your Prescription
- Filling Prescriptions for Maintenance Medications

How Prescription Drugs Are Covered

Prescription drugs may be considered *Covered Services* only if they comply with the "*Tufts Health Plan* Pharmacy Management Programs" section below and are:

- listed below under "What is Covered"
- approved by the United States Food and Drug Administration (FDA)
- provided to treat an injury, illness, or pregnancy
- *Medically Necessary* and
- written by a *Tufts Health Plan* participating *Provider*: This is not required in cases of *authorized* referral or in *Emergencies*.

We have a current list of covered drugs. See our Web site at www.tuftshealthplan.com. You can also call our Member Services Department.

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 a middle level *Cost Sharing Amount*.
- Tier-3 drugs have a higher level *Cost Sharing Amount*.
- Tier 4 drugs have the highest level *Cost Sharing Amount*.

Note: Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered. See the Benefits Overview for applicable *Cost Sharing Amounts.*

Prescription Drug Benefit – continued

What is Covered

We cover the following under this Prescription Drug Benefit:

- Prescribed drugs that by law require a prescription and are not listed under "What is Not Covered": (See "Important Notes" below.)
- Test strips for glucose monitors and/or visual aid reading; insulin, syringes, injection aids, cartridges for the legally blind; and oral agents for controlling blood sugar levels
- Generic and brand name contraceptives, including oral contraceptives, diaphragms, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives (e.g., female condoms or contraceptive spermicides) when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription, are covered as follows*. Certain brand name contraceptives may be subject to *Prior Authorization*.
  - Generic contraceptives are covered in full.
  - Brand name contraceptives without a generic equivalent are covered in full
  - Brand name contraceptives with a generic equivalent are subject to the applicable *Tier Copayment.* The only exception to this is when the generic equivalent is deemed by your physician to be medically inappropriate for you. In this case, the brand name contraceptive will be covered in full. The prescriber's statement of *Medical Necessity* is required.

  *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 for 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 covered contraceptive drugs and devices.
- Fluoride for *Children*
- Injectables and biological serum included in the list of covered drugs on our Web site. For more information, call Member Services. Also see our Web site at www.tuftshealthplan.com.
- Prefilled sodium chloride for inhalation (This is covered both by prescription and over-the-counter.)
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or disabling or life-threatening chronic diseases which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, in the medical literature, 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 specific medication or kit is covered, 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. Also, see our Web site at www.tuftshealthplan.com.
- Prescription and over-the-counter smoking cessation agents: These must be recommended and prescribed by a *Tufts Health Plan Provider*.

Note: Certain prescription drug products may be subject to a "*Tufts Health Plan* Pharmacy Management Program" described below.

Prescription Drug Benefit – continued

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)
- Drugs not listed on the "*Tufts Health Plan* Prescription Drug List". See the list at www.tuftshealthplan.com. Also, you can call Member Services for more information.
- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for *Children*
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent (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" above.
- Prescriptions written by *Providers* who do not participate in *Tufts Health Plan*. These drugs are excluded except in cases of authorized referral or *Emergency* care.
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care
- Drugs for asymptomatic onychomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status
- Acne medications, unless *Medically Necessary*
- Compounded medications, if no active ingredients require a prescription by law
- 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. Also, the entire class of prescription medications may also not be covered. For more information, call Member Services. You can also check our Web site at www.tuftshealthplan.com. Note: This restriction on prescription drugs does not apply to prescription and over-the-counter smoking cessation agents.
- Prescription medications when packaged with non-prescription products
- Oral non-sedating antihistamines
- Compounding kits that are not FDA-approved and include ingredients that are readily available may not be covered. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

Prescription Drug Benefit – continued

***Tufts Health Plan* Pharmacy Management Programs**

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

Quantity Limitations Program

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

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*.

Medication Synchronization (Med sync)

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

- dispensed by a *Tufts Health Plan Network* pharmacy
- in a quantity less than a thirty (30) days' supply
- used for the management or treatment of a chronic, long-term condition

Limitation: Medication synchronization is limited to one per *Contract Year* per maintenance prescription drug.

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

Prior Authorization Program

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

Step Therapy PA Program

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

Non-Covered Drugs:

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

New-To-Market Drug Evaluation Process:

New-to-market drug products are reviewed for safety, clinical effectiveness and cost by the *Tufts Health Plan's* Pharmacy and Therapeutics Committee. We then make a coverage determination based on the Committee's recommendation.

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

The formulary exception process is described in the next section.

Prescription Drug Benefit – continued

Formulary Exceptions

Your *Provider* may feel it is *Medically Necessary* for you to take medications that:
(1) are not on the formulary or
(2) are restricted under any of the "*Tufts Health Plan* Pharmacy Management Programs"

- An exception request may be submitted for any of our pharmacy management programs.
- Prescribers may submit a formulary exception request to *Tufts Health Plan* using our *Massachusetts Standard Form for Medication Prior Authorization Requests*. This form may be submitted to us in one of the following ways:

  By fax, submit the form to 617-673-0988
  By phone, contact us at 617-972-1071
  By mail, submit the form to:
  Tufts Health Plan
  Pharmacy Utilization Management Department
  705 Mt Auburn St
  Watertown, MA 02472

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

  Please call Member Services if you have questions about which tier your medication is on.
- If your request is denied, you and your *Provider* have the right to appeal.

  Your appeal can be submitted in one of the following ways:

  By phone, call Member Services at 1-800-682-8059
  By mail, submit your appeal in writing to:

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

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

  Please see Chapter 6, "Member Satisfaction," for information about *Member* appeals, including expedited appeals.

Prescription Drug Benefit – continued

Formulary Exceptions, continued

Our formulary is effective January 1st of each year

The drugs on our formulary may change periodically as needed, for example:

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

***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 either:
  - moving the brand drug from Tier-2 to Tier-3 or
  - moving the brand drug to our non-covered drug list when a generic alternative becomes available
- *Members* who are affected by these changes will be notified at least 30 days in advance of such changes.
- Many generic drugs are available on Tier-1.

You may have questions about your prescription drug benefit.

You may want to know the tier of a particular drug. You might like to know if your medication is part of a Pharmacy Management Program. For these questions:

- Check our Web site at www.tuftshealthplan.com or
- Call Member Services at 1-800-682-8059.

Filling Your Prescription

Where to Fill Prescriptions:

Fill your prescriptions at a *Tufts Health Plan* designated pharmacy. *Tufts Health Plan* designated pharmacies include many of the pharmacies in Massachusetts and Rhode Island; and additional pharmacies nationwide.

How to Fill Prescriptions:

- Make sure the prescription is written by a *Tufts Health Plan* participating *Provider*, except. This is not required, though, in cases of authorized referral or in *Emergencies*.
- When you fill a prescription, provide your *Member ID* to any *Tufts Health Plan* designated pharmacy and pay your *Cost Sharing Amount*.
- The cost of your prescription may be less than your *Copayment*. In this case, you only need to pay the actual cost of the prescription.
- If you have any problems using this benefit at a *Tufts Health Plan* designated pharmacy, call the Member Services Department.

Important: Your prescription drug benefit is honored only at *Tufts Health Plan* designated pharmacies. In cases of *Emergency*, call the Member Services .They can explain how to submit your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:

You may need to take a "maintenance" medication. If so, 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. This is done through a *Tufts Health Plan* designated mail services pharmacy.

*These drugs may not be available to you through a *Tufts Health Plan* designated mail services pharmacy:

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

Note: See the Benefits Overview earlier in this document for your prescription drug *Cost Sharing Amounts.*

Exclusions from Benefits

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

General Exclusions

The following are excluded from coverage under this *Evidence of Coverage*:'

1.

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

2. Any services that is provided to a non-*Member,* except as described in Chapter 3 for the following:
   - Bereavement counseling services under **Hospice care services**
   - Costs of procurement and processing of donor sperm, egg, or embryos, under **Infertility services** (coverage is only to the extent such costs are not covered by the donors health coverage, if any) and
   - Organ donor charges under **Transplants (human solid organ and hematopoietic stem cells)** in Chapter 3

3. Any services provided to you by your relative (by blood or marriage) unless the relative is a *Tufts Health Plan Provider* and the service is authorized by your *PCP*. Please note: if you are a *Tufts Health Plan Provider*, you cannot provide or authorize services for yourself or be your own *PCP* for yourself or a member of your immediate family (by blood or marriage).

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

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

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

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

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

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

Exclusions from Benefits, continued

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

Acupuncture

Dental care

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

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

*Please note that this bulleted exclusion does not apply for *Covered Services* described under the "Pediatric dental care for *Members* under age 19", described earlier in this chapter.

The following pediatric dental care services, treatments, and supplies are not covered under **Pediatric dental care for *Members* under age 19**:

- Adjustments of a denture or bridgework that is made within six months after installation by the same dentist who installed it
- Caries tests
- Consultations
- General anesthesia or IV sedation rendered by anyone other than a dentist, or for non-surgical procedures
- Gold foil restorations
- Orthodontia that is not *Medically Necessary*
- Plaque control programs, oral hygiene instructions; and dietary instructions
- Precision attachments, personalization, precious metal losses, and other specialized techniques
- Prescription drugs
- Restorations due to bruxism, erosion, attrition, or abrasion
- Sealants for teeth other than unrestored permanent molars
- Services and treatments not prescribed by or under the direct supervision of a dentist
- Services meant to improve appearance
- Services related to TMJ, including night guards and surgery
- Services or supplies that are not dentally necessary or which do not meet generally accepted standards of dental practice
- Services to increase height of teeth or restore occlusion
- Splinting and other services to stabilize teeth
- Temporary, interim, or provisional crowns, bridges or dentures
- Use of material or home health aides, such as toothpaste, fluoride gels, dental floss, and teeth whiteners, to prevent decay

Exclusions from Benefits, continued

Experimental or Investigative

A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative* is not covered. If a treatment is *Experimental or Investigative*, we will not pay for any related treatments provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment. In accordance with requirements of Rhode Island and federal law, this exclusion does not apply to the following.

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

Family planning or maternity care

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

Infertility services

- Infertility services for
  - *Members* who do not meet the definition of Infertility as described earlier in this chapter
  - experimental infertility procedures
  - reversal of voluntary sterilization
  - costs associated with donor recruitment and compensation
  - infertility services which are necessary for conception as a result of voluntary sterilization, or following an unsuccessful reversal of a voluntary sterilization and
  - donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner
- The costs of surrogacy, which means all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member.* These costs include, but are not limited to: (1) use of donor egg and gestational carrier; (2) costs for drugs necessary to achieve implantation in a surrogate, embryo transfer, and cryopreservation of embryos; and; and (3) costs for maternity care if the surrogate is not a *Member.*
  - A surrogate is a person who carries and delivers a *Child* for another either through artificial insemination or surgical implantation of an embryo.
  - A gestational carrier is a surrogate with no biological connection to the embryo/*Child*. Note:
- Long-term (longer than 90 days) cryopreservation (freezing, storage and thawing) sperm or embryo unless:
  - a *Member* is in active infertility treatment; or
  - a *Member* is not in active infertility treatment and a *Medically Necessary* medical treatment may directly or indirectly cause iatrogenic infertility (impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes).

  Note*: Prior Authorization* is required for these cryopreservation services.

Surgery

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

- Circumcisions performed in any setting other than a hospital, *Day Surgery,* or a *Provider's* office
- Cosmetic (to change or improve appearance) surgery
- Hair removal (for example, electrolysis, laser hair removal), except when *Medical Necessary* (1) to treat an underlying skin condition or (2) for skin preparation for genital surgery that has been approved by an *Authorized Reviewer* under "Gender reassignment surgery and procedures".
- Liposuction or brachioplasty
- Removal of tattoos
- Reversal of gender reassignment surgery
- Rhinoplasty, except as provided under "Reconstructive surgery and procedures" in Chapter 3
- Treatment of spider veins; removal or destruction of skin tags

Exclusions from Benefits, continued

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

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

- Biofeedback, except for the treatment of urinary incontinence
- Hypnotherapy
- Massage therapies, cognitive rehabilitation programs and cognitive retraining programs, except as described under **Physical, occupational and speech therapy services** in Chapter 3.
- Neuromuscular stimulation; neuromuscular stimulators and supplies
- Psychoanalysis

Transplants

Transplants are not covered except as described in Chapter 3.

Transportation

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

Vision care

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

The following pediatric vision care services, treatments, and supplies:

- Aniseikonic lenses
- Any eye or vision examination or corrective eyewear required by a *Member* as a condition of employment
- Contact lenses insurance
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when covered vision materials would next become available. See Pediatric vision care for *Members* under age 19 in Chapter 3.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing
- Plano (non-prescription) lenses and/or contact lenses
- Replacement of lost or stolen eyewear
- Safety eyewear
- Services and materials not meeting accepted standards of optometric practice
- Services rendered after the date a *Member* ceases to be covered under the plan, except when covered vision materials ordered before coverage ended are delivered; and the services rendered to the *Member* are within 31 days from the date of such order
- Special lens, designs, or coatings other than those described as *Covered Services*
- Two pairs of eyeglasses in lieu of bifocals

Exclusions from Benefits, continued

Other Exclusions under this plan

- Blood, blood donor fees, blood storage fees, or blood substitutes, blood banking, cord blood banking, and blood products are not covered.. The following are exceptions:
  - Blood processing
  - Blood administration
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (*Prior Authorization* is required for these services.)
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (*Prior Authorization* is required for these services.)

- *Custodial Care*

- Devices and procedures intended to reduce snoring. These include but are not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

- Facility charges or related services if the procedure being performed is not a *Covered Service*, except as provided under **Oral health services** in Chapter 3.

- Laboratory tests ordered by a *Member* (online or through the mail), even if they are performed at a licensed laboratory

- *Inpatient* and *Outpatient* weight-loss programs and clinics; relaxation therapies; services by a personal trainer; and exercise classes (diagnostic services related to any of these excluded programs or procedures are also excluded)

- Lodging related to receiving any medical service

- Multi-purpose general electric devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electric devices including USB devices and direct connect devices (for example, speakers, microphones, cables, cameras, batteries, etc.) Internet and modern connection or access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet and all related accessories.

- Nutritional counseling, except as described under **Nutritional counselin**g in Chapter 3

- Routine foot care. Examples includes: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace or other non-orthotic support devices for the feet. Note: This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.

- Service or therapy animals and related supplies

Chapter 4
When Coverage Ends

Reasons coverage ends

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

- You lose eligibility because you no longer meet your *Group's* or *Tufts Health Plan's* eligibility rules or
- You no longer live, work or reside in the *Service Area** or
    - You choose to drop coverage; or
- You commit an act of physical or verbal abuse unrelated to your physical or mental/behavioral condition which poses a threat to any *Provider*, any *Tufts Health Plan Member*, or *Tufts Health Plan* or any *Tufts Health Plan* employee or
- You commit an act of misrepresentation or fraud or
- Your *Group Contract* with us ends. For more information, see "Termination of a *Group Contract*" later in this chapter.

***Note:** Please see "**If you no longer live, work or reside in the *Service Area*"** below and in Chapter 2, Eligibility, Enrollment and Continued Eligibility. Care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only.

Benefits after termination

If you are totally disabled when your coverage ends, you may be able to continue your coverage as described in "Extension of Benefits" later in this chapter. Otherwise, we will not pay for services you receive after your coverage ends even if:

- you were receiving *Inpatient* or *Outpatient* care when your coverage ended or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends

Continuation and converted plans

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

When a *Member* is No Longer Eligible

Loss of eligibility
Your coverage ends on the date you no longer meet your *Group's* or *Tufts Health Plan's* eligibility rules.

> **Important Note:** Your coverage will terminate retroactively. This is done back to the date you are no longer eligible for coverage.

If you no longer live, work or reside in the *Service Area*

If you no longer live, work or reside in the *Service Area,* you can be covered **ONLY IF:**

- You are a *Child* or
- You are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO) or
- You are a divorced *Spouse* that *Tufts Health Plan* must cover

Note: Care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only. Please see "*Emergency* and *Urgent Care*" in Chapter 1 for more information.

Before you no longer live, work or reside in the *Service Area*, tell your *Group* or call a Member Specialist to notify us of the date you no longer live, work or reside there. For more information about coverage available to you when you no longer live, work or reside in the *Service Area*, contact a Member Specialist.

***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. See Chapter 2, "Continuing Eligibility for *Dependents*," for more information.

You choose to drop coverage
Coverage ends if you decide you no longer want coverage and you meet any qualifying event your *Group* requires. To end your coverage, notify your *Group*. You must do this at least 30 days before the date you want your coverage to end. You must pay *Premiums* up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

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

- are unrelated to your physical or mental/behavioral condition
- pose a threat to any *Provider,* any *Tufts Health Plan Member*, or *Tufts Health Plan* or any *Tufts Health Plan* employee

Membership Termination or Rescission for Misrepresentation or Fraud

Policy
We may terminate your coverage for misrepresentation or fraud under this plan. If your coverage is terminated for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an individual plan or another employer's plan) or type of coverage (for example, coverage as a *Dependent* or *Spouse*).

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

- false or misleading information on your application
- enrolling as a *Spouse* someone who is not your *Spouse*
- receiving benefits for which you are not eligible
- abuse of the benefits under this plan, including the resale or transfer of supplies, medication, or equipment provided to you as *Covered Services*
- keeping for yourself payments made by *Tufts Health Plan* that were intended to be used to pay *Provider*
- submission of any false paperwork, forms, or claims information or
- allowing someone else to use your *Member ID*

Membership Termination or Rescission for Misrepresentation or Fraud, continued

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

Payment of claims

We will pay for all *Covered Services* you received between:

- your *Effective Date* and
- your termination date, as chosen by us: In cases of rescission, we may retroactively terminate your coverage back to a date no earlier than your *Effective Date*.

We may use any *Premium* you paid for a period after your termination date to pay for any *Covered Services* you received after your termination date.

The *Premium* may not be enough to pay for that care. In this case, *Tufts Health Plan*, at its option, may:

- pay the *Provider* for those services and ask you to pay us back or
- not pay for those services: In this case, you will have to pay the *Provider* for the services.

The *Premium* is may be more than is needed to pay for *Covered Services* you received after your termination date. In this case, we will refund the excess to your *Group*.

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

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

Termination of a *Group Contract*

End of *Tufts Health Plan's* and *Group's* relationship

If you enrolled under a *Group Contract*, coverage will terminate if the relationship between your *Group* and *Tufts Health Plan* ends for any reason, including:

- your *Group's* contract with *Tufts Health Plan* terminates
- your *Group* fails to pay *Premiums* on time*
- *Tufts Health Plan* stops operating or
- your *Group* stops operating

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

Extension of Benefits

If you are totally disabled on the date the *Group Contract* ends, you will continue to receive *Covered Services* for 12 months.

The following conditions apply:

- the *Covered Services* must be:
  - *Medically Necessary*
  - provided while the total disability lasts and
  - directly related to the condition that caused the *Member* to be totally disabled on that date and
- all of the terms, conditions, and limitations of coverage under the *Group's* contract with *Tufts Health Plan* will apply during the extension of benefits

The extension of benefits will end on the earliest of:

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

Transfer to Other Employer Group Health Plans

Conditions for transfer

You may transfer from *Tufts Health Plan* to any other health plan offered by your *Group* only:

- during your *Group's Open Enrollment Period*
- within 30 days after moving out of the *Service Area* or
- as of the date your *Group* no longer offers *Tufts Health Plan*

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

Chapter 5
Continuation of *Group Contract* Coverage and Conversion Privilege

Federal Continuation Coverage (COBRA)

Rules for federal COBRA continuation

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible to continue coverage after *Group* coverage ends if you were enrolled in *Tufts Health Plan* through a *Group* which as 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 qualifying event is defined as:

- the *Subscriber's* death
- termination of the *Subscriber's* employment for any reason other than gross misconduct
- reduction in the *Subscriber's* work hours
- the *Subscriber's* divorce or legal separation
- the *Subscriber's* entitlement to Medicare or
- the *Subscriber's* or *Spouse's* enrolled *Dependent* ceases to be a *Dependent Child*

If a *Member* experiences a qualifying event, he or she may be eligible to continue *Group* coverage as a *Subscriber* or an enrolled *Dependent* under federal COBRA law as described below.

When federal COBRA coverage is effective

A *Member* who is eligible for federal COBRA continuation coverage (a "qualified beneficiary") 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.		

Federal Continuation Coverage (COBRA), continued

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

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

Rhode Island Continuation Coverage

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

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

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

Coverage under an *Individual Contract*

If *Group* coverage ends, the *Member* may be eligible to enroll in coverage under an *Individual Contract* offered through the Rhode Island Health Benefits Exchange called Health Source R.I. For more information, contact Health Source R.I. either by phone at 1-855-840-HSRI (4774) or on its Web site **(www.healthsourceri.com**)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military 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 service, 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 service 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 anyone 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.gove/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 of representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact your *Group* or the *Plan Administrator*.

Chapter 6
Member Satisfaction

Member Satisfaction Process

Tufts Health Plan has a multi-level *Member* Satisfaction Process including:

- Internal Inquiry
- *Member* Grievances Process; and
- Internal *Member* Appeals and
- External review by an independent review organization (IRO) designated by the Rhode Island Office of the Health Insurance Commissioner

Mail all grievances and appeals to us at:

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

You can also call us at **1-800-682-8059**. Or you may submit your appeal or grievance in-person at the above address.

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

Member Grievance Process
A grievance is a formal complaint about actions taken by *Tufts Health Plan* or a *Tufts Health Plan Provider*. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact us as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. You may choose to file a grievance verbally. If you do this, please call a *Tufts Health Plan* Member Specialist. That person will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing. Then, send it to the address at the beginning of this section. Your explanation should include:

- your name and address
- your *Member ID* number
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and *Provider* names and
- any supporting documentation

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

Administrative Grievances
An administrative grievance is a complaint about a *Tufts Health Plan* employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline

- You may file your grievance verbally or in writing. If you do this, we will notify you by mail. We will do notify you, within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That notification will provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your grievance.
- We will review your grievance and will send you a letter regarding the outcome. As allowed by law, we will send that letter within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law. This would be done by mutual written agreement between you or your authorized representative and *Tufts Health Plan*.

Member Satisfaction Process, continued

Clinical Grievances

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

- You may file your grievance verbally or in writing. We will notify you, within five (5) business days after receiving your grievance, that your verbal grievance or grievance letter has been received. That notification will provide you with the name, address, and telephone number of the Quality Management Intake Coordinator who is coordinating the review of your grievance.
- We will review your grievance and will send you a letter regarding the outcome. As allowed by law, we will send that letter within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law. This would be done by mutual written agreement between you or your authorized representative and *Tufts Health Plan*.

Internal *Member* Appeals

An appeal is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by *Tufts Health Plan* based on:

- *Medical Necessity* (an adverse *Medical Necessity* determination) or
- a denial of coverage for a specifically excluded service or supply

The *Tufts Health Plan* Appeals and Grievances Department will coordinate a review of all of the information submitted upon appeal. That review will consider your benefits as detailed in this *Evidence of Coverage.*

It is important that you or your *Provider* contact us 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.

Appeals may be filed either verbally or in in writing. You may file a verbal appeal. To do this, call a Member Specialist. That person will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing. Then, send it to the address listed earlier in this section. Or you may submit your appeal or grievance in-person at the address at the beginning of this chapter.

Your explanation should include:

- your name and address
- your *Member ID* number
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and *Provider* names and
- any supporting documentation

Appeals Timeline

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

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

When Medical Records are Necessary

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

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

Member Satisfaction Process, continued

Who Reviews Appeals?
Appeals of a *Medical Necessity* determination will be reviewed by a licensed practitioner:

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

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 an adverse *Medical Necessity* appeal determination will include: the specific information upon which the adverse *Medical Necessity* appeal determination was based; our understanding of your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; the title and credentials of the individual who reviewed the case; notification of the steps to request external review by an independent review organization designated by the Rhode Island Office of the Health Insurance Commissioner; and the availability of translation services and consumer assistance programs.

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

Additionally, we will expedite your appeal if a medical professional determines it involves emergent health care services. (Defined as services provided in the event of the sudden onset of a medical, mental/behavioral health, or substance use disorder or other health care condition manifesting itself by acute symptoms of a severity (e.g., severe pain); where the absence of immediate medical attention could be reasonably expected to result in placing your health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part). If you feel your request meets the criteria cited above, you or your attending *Provider* should contact Member Services. Under these circumstances, you will be notified of our decision as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of your request..

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

External Review
Tufts Health Plan provides for independent external review of final adverse *Medical Necessity* determinations.

The Rhode Island Office of the Health Insurance Commissioner (OHIC) has designated independent review organizations (IROs)to perform independent external reviews. Assignment of IROs to perform these external reviews is on a rotational basis as directed by OHIC.

Please note that these IROs are not connected in any way with *Tufts Health Plan*. Also, appeals for coverage of services excluded from coverage under your plan are not eligible for external review.

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

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

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

Tufts Health Plan considers all medical exigencies when handling an external review and will process the request as expeditiously as possible. No later than six (6) business days for standard appeals and two (2) business days for expedited appeals of receipt of your written request, *Tufts Health Plan* will forward the complete review file, including the criteria utilized in rendering its decision, to the IRO.

Member Satisfaction Process, continued

External Review, continued

The IRO's external review shall be based on the following:

- the review criteria used by *Tufts Health Plan* to make the internal appeal determination
- the *Medical Necessity* for the care, treatment or service for which coverage was denied and
- the appropriateness of the service delivery for which coverage was denied

The IRO shall notify you and your *Provider* of record of the outcome of its external appeal decision to uphold or overturn the appeal:

- no more than10 calendar days from receipt of all the information necessary to complete the review for standard appeals, (within 72 hours from receipt of the request for expedited appeals) and
- Not greater than forty-five (45) calendar days after receipt of the request for external review

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

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

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

Bills from *Providers* / Member Reimbursement Process

Medical Expenses
Occasionally, you may receive a bill from a *Provider* for *Covered Services*. Before paying the bill, contact the Member Services Department.

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

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

Note: We will provide the *Member* making a claim, or to the *Group* for delivery to such person, the claim forms we furnish for filing proof of loss for *Covered Services*. If we do not provide such forms within 15 days after we received notice of any claim under the *Group Contract*, the *Member* making that claim will be deemed to have met the requirements under that *Group Contract* for proof of loss, upon submitting to us within the time fixed in the *Group Contract* for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

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

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

If you receive *Covered Services* from a non-*Tufts Health Plan Provider*, we will pay up to the *Reasonable Charge* for the services within 30 days of receiving: (1) a completed Member Reimbursement Medical Claim Form, and (2) all required supporting documents. Incomplete requests and requests for services received outside of the United States may take longer. Reimbursements will be sent to the *Subscriber* at the address *Tufts Health Plan* has on file.

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

IMPORTANT NOTE:
Certain services you receive from non-*Tufts Health Plan Providers at an In-Network setting are reimbursable.* Some examples of these types of non-*Tufts Health Plan Providers* include:

- Radiologists, pathologists, and anesthesiologists who work at *Tufts Health Plan Hospitals*; and
- *Emergency* room specialists

You may receive a bill from a *Provider* who is not a *Tufts Health Plan Provider*. If this happens, please follow the Member Reimbursement Process described above.

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

Limitation on Actions
You cannot bring an action at law or in equity to recover on this *Group Contract* prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this *Group Contract*. You cannot bring such action at all unless you bring it within three (3) years from the expiration of the time within which proof of loss is required by this *Group Contract.*

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, could be, or is claimed to be responsible for the costs of injuries or illness to you. This includes such costs to any *Dependent* covered under this plan.

Tufts HP 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 Med Pay benefits have been exhausted, we may recover the cost of those benefits as described above.

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

- payments made by a Third Party
- payments made by any insurance company on behalf of the Third Party
- any payments or awards under an uninsured or underinsured motorist coverage policy
- any disability award or settlement
- medical payments coverage under any automobile policy
- premises or homeowners medical payments coverage
- premises or homeowners insurance coverage and
- any other payments from a source intended to compensate you when a Third Party is responsible

We have the right to be reimbursed up to the amount of any payment received by you. This is regardless of whether:

- all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses or
- the payment is for an amount less than that necessary to compensate you fully for the illness or injury

Subrogation, continued

Member cooperation

You further agree:

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

Workers' compensation

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

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. We will not provide coverage for any injury or illness for which it determines that the *Member* is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability (2) or indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay the costs of health care services or medications for any work-related illness or injury. If we do this, we have the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider*. If your *Provider* bills services or medications to us for any work-related illness or injury, contact the Liability and Recovery Department at 1-888-880-8699, x. 1098.

Subrogation Agent

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

Constructive Trust

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

Coordination of This *Group Contract's* Benefits with Other Benefits

Applicability

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

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of "This Plan" are determined before or after those of another plan. The benefits of "This Plan":
   (1) shall not be reduced when, under the order of benefit determination rules, "This Plan" determines its benefits before another plan but
   (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first: The above reduction is described in the "Effect on the Benefits of "This Plan" " section below.
   (3) Medical benefits coverage under group or individual automobile contracts

Definitions

A. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
   (1) Group insurance or *group*-type coverage whether insured or uninsured. This includes prepayment, *Group* practice or *Individual* practice coverage. It also includes coverage other than school accident-type coverage.
   (2) Coverage under a governmental plan or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the *Group Contract* that provides benefits for health care expenses.

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

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

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

Order of Benefit Determination Rules

A. General. When there is a basis for a claim under "This Plan" and another plan, "This Plan" is a Secondary Plan which has its benefits determined after those of the other plan, unless:
   (1) The other plan has rules coordinating its benefits with those of "This Plan"; and
   (2) Both those rules and "This Plan's rules, in Subsection B below, require that "This Plan"'s benefits be determined before those of the other plan.

B. Rules. "This Plan" determines its order of benefits using the first of the following rules which applies:
   (1) Non-*Dependent/Dependent*
      (a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a *Dependent*, for example as an employee, *Member*, *Subscriber*, policyholder or retiree, is the primary plan and the plan that covers the person as a *Dependent* is the secondary plan.
      (b)(i) If the person is a Medicare beneficiary, and, as a result of the provisions on Title XV111 of the Social Security Act and implementing regulations, Medicare is:
         (I) Secondary to the plan covering the person as a *Dependent*; and
         (II) Primary to the plan covering the person as other than a *Dependent* (e.g., a retired employee),
      (b)(ii) Then the order of benefits is reversed so that the plan covering the person as an employee, *Member*, *Subscriber*, policyholder or retiree is the secondary plan and the other plan covering the person as a *Dependent* is the primary plan.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Order of Benefit Determination Rules, continued

(2) *Dependent Child*/Parents Not Separated or Divorced. Except as stated in Paragraph B(3) below, when "This Plan" and another plan cover the same *Child* as a *Dependent* of different person, called "parents:"
   (a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   (b) If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of the plan which covered the other parent for a shorter period of time.

(3) *Dependent Child*/Separated or Divorced. If two or more plans cover a person as a *Dependent Child* of divorced or separated parents, benefits for the *Child* are determined in this order:
   (a) First, the plan of the parent with custody of the *Child*;
   (b) Then, the plan of the *Spouse* of the parent with the custody of the *Child*; and
   (c) Then, the plan of the parent not having custody of the *Child*.
   (d) Finally, the plan of the non-custodial parent's *Spouse*

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the *Child*, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. If the parent with responsibility has no health care coverage for the *Dependent Child's* health care expenses, but that parent's *Spouse* does, that parent's *Spouse's* plan is the primary plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Responsibility. If a court decree states that both parents are responsible for the *Dependent Child's* health care expenses or health care coverage, the provisions of Paragraph B(2) of this section shall determine order of benefits.

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

(6) Parental and Spousal Coverage.
   (a) For a *Dependent Child* who has coverage under either or both parents' plans, rule in Paragraph B(9) applies.
   (b) In the event the *Dependent Child's* coverage under the *Spouse's* plan began on the same date as the *Dependent Child's* coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Paragraph B(2) to the *Dependent Child's* parent(s) and the *Dependent's spouse*.

(7) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's *Dependent*) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's *Dependent*). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (7) is ignored. This rule does not apply if the rule in Paragraph B(1) can determine the order of benefits.

(8) COBRA or State Continuation.
   (a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, *Member*, *Subscriber* or retiree or covering the person as a *Dependent* of an employee, *Member*, *Subscriber* or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
   (b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (8) is ignored.
   (c) This rule does not apply if the rule in Paragraph B(1) can determine the order of benefits.

(9) Longer/Shorter Length of Coverage.
   (a) If the preceding rules do not determine the order of benefits, the plan that covered the person longer is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
   (b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage from the first ended.
   (c) The start of a new plan does not include:
      (i) A change in the amount or scope of the plan's benefits;
      (ii) A change in the entity which pays, provides or administers the plan's benefits; or
      (iii) A change from one type of plan to another (such as, from a single employer to a multiple employer plan.
   (d) The person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If the date is not readily available, the date the person first became a *Member* of the *Group* shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Effect on the Benefits of "This Plan"

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

If the amount of the payments made by *Tufts Health Plan* is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid
B. Insurance companies or
C. Other organizations

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

For more information

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

Medicare Eligibility

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

Tufts Health Plan will pay benefits **before** Medicare:

- for you or your enrolled *Spouse*, if you or your *Spouse* is age 65 or older, if you are actively working and if your employer has 20 or more employees
- for you or your enrolled *Dependent,* for the first 30 months you or your *Dependent* is eligible for Medicare due to end stage renal disease or
- for you or your enrolled *Dependent,* if you are actively working, you or your *Dependent* is eligible for Medicare under age 65 due to disability, and your employer has 100 or more employees

Tufts Health Plan will pay benefits **after** Medicare:

- if you are age 65 or older and are not actively working
- if you are age 65 or older and your employer has fewer than 20 employees
- after the first 30 months you are eligible for Medicare due to end stage renal disease or
- if you are eligible for Medicare under age 65 due to disability, but are not actively working or are actively working for an employer with fewer than 100 employees

Note: In any circumstance described above, you will receive benefits for *Covered Services* that Medicare does not cover.

Use and Disclosure of Medical Information

Tufts Health Plan mails a separate "Notice of Privacy Practices" to all *Subscribers*. This notice explains how we use and disclose your medical information. If you have questions or would like another copy of our "Notice of Privacy Practices", please call Member Services. Information is also available on our Web site at www.tuftshealthplan.com.

Relationships between *Tufts Health Plan* and *Providers*

Tufts Health Plan and *Providers*

We arrange health care services. We do not provide health care services. We have agreements with *Providers* practicing in their private offices throughout the *Service Area*. These *Providers* are independent. They are not *Tufts Health Plan* employees, agents or representatives. *Providers* are not authorized to:

- change this *Evidence of Coverage* or
- assume or create any obligation for *Tufts Health Plan*

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

Circumstances beyond *Tufts Health Plan's* Reasonable Control

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

Group Contract

Acceptance of the terms of the *Group Contract*

By signing and returning the membership application form, you: (1) apply for *Group* coverage; and (2) agree, on behalf of yourself and your enrolled *Dependents*, to all the terms and conditions of the *Group Contract*, including this *Evidence of Coverage*.

Notes:

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

Payments for coverage

We will bill your *Group* and your *Group* will pay *Premiums* to us for you. We are not responsible if your *Group* fails to pay the *Premium*. This is true even if your *Group* has charged you (for example, by payroll deduction) for all or part of the *Premium*.

Note: Your *Group* may fail to pay the *Premium* on time. If this happens, we may cancel your coverage in accordance with the *Group Contract* and applicable state law. For more information on the notice to be provided, see "Termination of the *Group Contract*" in Chapter 4.

We may change the *Premium*. If the *Premium* is changed, the change will apply to all *Members* in your *Group*.

Changes to this *Evidence of Coverage*

We may change this *Evidence of Coverage*. Changes do not require your consent. Notice of changes in *Covered Services* will be sent to your *Group* at least 60days before the *Effective Date* of the modifications. That notice 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.

n amendment to this *Evidence of Coverage* describing the changes will include the *Effective Date* of the change. Changes will apply to all benefits for services received on or after the *Effective Date* with one exception.

Exception: A change will not apply to you if you are an *Inpatient* on the *Effective Date* of the change until the earlier of:

- your discharge date; or
- the date *Annual Coverage Limitations* are used up

Note: If changes are made, they will apply to all *Members* in your *Group*. They will not apply just to you.

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

Notice to *Tufts Health Plan*: *Members* should address all correspondence to:

Tufts Health Plan
705 Mount Auburn Street
P.O. Box 9173
Watertown, MA 02471-9173

Enforcement of terms
We may choose to waive certain terms of the *Group Contract* if applicable. This includes the *Evidence of Coverage*. This does not mean that we give up our rights to enforce those terms in the future.

When this *Evidence of Coverage* Is Issued and Effective
This *Evidence of Coverage* is issued and effective on your *Group Anniversary Date* on or after January 1, 2021. It supersedes all previous *Evidences of Coverage*. We will issue a copy of the *Evidence of Coverage* to the *Group* and to all *Subscribers* enrolled under this plan.

Appendix A
Glossary of Terms and Definitions

This section defines the terms used in this *Evidence of Coverage*.

Adverse Benefit Determination

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

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. The *Child* is no longer considered placed for adoption if the legal obligation ceases.

Note: A foster *Child* is considered an adoptive child as of the date of placement for adoption.

Anniversary Date

The date when the *Group Contract* first renews; then, each successive annual renewal date

Annual Coverage Limitations

Annual dollar or time limitations on *Covered Services*.

Authorized Reviewer

Authorized reviewers review and approve certain services and supplies to *Members*. They are our Chief Medical Officer (or equivalent) or someone he or she names.

Board-Certified Behavior Analyst (BCBA)

A Board-certified behavior analyst *(*BCBA*)* meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience and other requirements. BCBAs must also be individually licensed by the Rhode Island Department of Health as a healthcare *Provider*/clinician, and credentialed by *Tufts HP.* A BCBA professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for *Members* with diagnoses of autism spectrum disorders. BCBAs may supervise the work of Board-Certified Assistant Behavior Analysts and other *Paraprofessionals* who implement behavior analytic interventions.

Child

The following individuals until the last day of the month in which the *child's* 26th birthday occurs:

- The *Subscriber's* or *Spouse's* natural child, *Stepchild*, or *Adoptive Child* who qualifies as a *Dependent* for federal tax purposes or
- Any other child for whom the *Subscriber* has legal guardianship

Coinsurance

The percentage of costs you must pay for certain *Covered Services*.

- For services provided by a non-*Tufts Health Plan Provider*, your share is a percentage of the *Reasonable Charge* for those services. Please note that costs in excess of the *Reasonable Charge* are not subject to coinsurance*.* The *Member* is responsible for any charges in excess of the *Reasonable Charge.*
- For services provided by a *Tufts Health Plan Provider*, your share is a percentage of:
  - the applicable *Tufts Health Plan* fee schedule amount for those services or
  - the *Tufts Health Plan Provider's* actual charges for those services, whichever is less

Note: The *Member's* share (percentage) is based on the *Tufts Health Plan Provider* payment at the time a claim is paid. It does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.

Community Hospital
Any *Network Hospital* other than a *Tertiary Hospital*.

Community Residence
Any home or other living arrangement which is established, offered, maintained, conducted, managed, or operated by any person for a period of at least 24 hours, where, on a 24-hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, *Habilitation*, psychological support, and/or social guidance for three or more persons with substance use disorder or *Mental Disorders,* or persons with *Developmental* disabilities or cognitive disabilities such as brain injury. Examples include, but are not limited to, group homes, halfway homes, and fully-supervised apartment programs. Semi-independent living programs, foster care, and parent deinstitutionalization subsidy aid programs are not considered community residences under this *Evidence of Coverage.*

Contract Year
This is the 12-month period determined by the *Group* in which benefit limits, *Deductibles*, *Out-of-Pocket Maximum,* and *Coinsurance* are calculated under this plan. A contract year can be either a calendar year or a plan year.
- Calendar year: Coverage based on a calendar year runs from January 1st through December 31st within a year.
- Plan year: Coverage based on a plan year runs during a period of 12 consecutive months that are not a calendar year. As an example, a plan year can run from July 1st in one calendar year through June 30th in the following calendar year.

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

Copayment
Fees you pay for *Covered Services*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise.

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

Covered Services
The services and supplies for which we will pay; they must be:
- described in Chapter 3 (They are subject to the "Exclusions from Benefits" section in Chapter 3.)
- *Medically Necessary* and
- provided or authorized by your *PCP* and in some cases, approved by *Tufts Health Plan* or its designee

These services include *Medically Necessary* coverage of pediatric specialty care by *Providers* with recognized expertise in specialty pediatrics. (This includes mental/behavioral health care.).

Covering Provider
The *Provider* named by your *PCP* to provide or authorize services in your *PCP's* absence.

Custodial Care
- Care provided primarily to assist in the activities of daily living. Examples include bathing, dressing, eating, and maintaining personal hygiene and safety.
- Care, other than behavioral health care, provided primarily for maintaining the *Member's* or anyone else's safety, when no other aspects of treatment require an acute hospital level of care
- Services that could be provided by people without professional skills or training or
- Routine maintenance of colostomies, ileostomies, and urinary catheters or
- Adult and pediatric day care

Note: Custodial care is not covered by *Tufts Health Plan*.

Day Surgery
Any surgical procedure(s) provided to a *Member* at a facility licensed by the state to perform surgery. The *Member* must be expected to depart the same day or in some instances within twenty-four hours. This is also called "Ambulatory Surgery" or "Surgical Day Care".

Deductible
For each *Contract Year*, the amount paid by the *Member* for certain *Covered Services* before any payments are made under this *Evidence of Coverage*. (Any amount paid by the *Member* for a *Covered Service* rendered during the last 3 months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *deductible*. Any amount carried forward will not apply to the next *Contract Year's Out-of-Pocket Maximum*.)

See "Benefit Overview" at the front of this *Evidence of Coverage* for more information.

Please note that costs in excess of the *Reasonable Charge* do not apply to the *deductible*.

Note: The amount credited towards the *Member's deductible* is based on the *Tufts HP Provider* negotiated rate at the time the services are rendered. It does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.

Dependent
This is the *Subscriber's Spouse*, *Child*, or *Disabled Dependent*.

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

Directory of Health Care Providers
A searchable list of *Tufts Health Plan PCPs,* their affiliated *Tufts Health Plan Hospital,* and certain other *Tufts Health Plan Providers*.

Note: This list is updated from time to time. This is done to show changes in *Providers* affiliated with *Tufts Health Plan*. For information about the *Providers* listed in the *Directory of Health Care Providers*, you can call Member Services. Or, you can check our Web site at www.tuftshealthplan.com.

Disabled Dependent
The *Subscriber's* or *Spouse's* natural *Child*, *Stepchild*, or *Adoptive Child* of any age who:

- is medically determined to have a physical or mental health impairment which can be expected to result in death or can be expected to last for a period of not less than 12 months and
- who is financially dependent on the *Subscriber*

Durable Medical Equipment
Devices or instruments of a durable nature that:

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

Effective Date
This is the date, according to our records, when you become a *Member* and are first eligible for *Covered Services*.

Emergency

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

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

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

Evidence of Coverage

This document and any future amendments.

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered *experimental or investigative* and therefore not *Medically Necessary* if **any** of the following apply:

- the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished;
- the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval;
- reliable scientific evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or
- evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe;
- even if approved for lawful marketing by the U.S. Food and Drug Administration, reliable scientific evidence does not support that the treatment is effective in improving health outcomes or that appropriate patient selection has been determined;
- the peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled, or cohort studies; or there are few or no well-designed randomized, controlled trials; or
- there is no scientific or clinical evidence that the treatment is at least as beneficial as any established, evidence-based alternatives.

This definition is fully explained in the corresponding *Medical Necessity Guidelines.*

Family Coverage

Coverage for a *Subscriber* and his or her *Dependents*.

Free-standing ambulatory surgery center or imaging center

A free standing ambulatory surgery center or imaging center is a facility not affiliated with a hospital or a hospital system.

Free-standing Urgent Care Center

A medical facility that provides treatment for *Urgent Care* services (see definition of *Urgent Care*). A free-standing urgent care *center* primarily treats patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an *Emergency* room. A free-standing urgent care center offers an alternative to certain *Emergency* room visits for a *Member* who is not able to visit his or her *Primary Care Provider* or health care *Provider* in the time frame that is felt to be warranted by their condition or symptoms. A free-standing urgent care *Center* does not provide *Emergency* care, and is not appropriate for people who have life-threatening conditions. *Members* experiencing these conditions should go to an *Emergency* room. Free-standing urgent care centers are not part of a hospital or hospital system; and they are not *Limited Service Medical Clinics*. To find an *Urgent Care Center* in our *Network*, please visit our website at www.tuftshealthplan.com, and click on "Find a Doctor".

Terms and Definitions, continued

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. The group is your agent. It is not *Tufts Health Plan's* agent.

Group Contract
The agreement between *Tufts Health Plan* and the *Group* under which: (1) we agree to provide *Group* coverage; and (2) the *Group* agrees to pay a *Premium* to us on your behalf. The group contract includes this *Evidence of Coverage* and any amendments.

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

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

Inpatient
A patient who is: (1) admitted to a hospital or other facility licensed to provide continuous care; and (2) classified as an inpatient for all or a part of the day.

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

Medically Necessary
A service or supply that is:

- appropriate, in terms of type, amount, frequency, level, setting and duration to the *Member's* diagnosis or condition or
- informed by generally accepted medical or scientific evidence and consistent with general accepted practice parameters

In determining coverage for *medically necessary* services, *Tufts Health Plan* uses *Medical Necessity Guidelines* that are:

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

Our *Medical Necessity Guidelines* are available on our website at: https://tuftshealthplan.com/member/employer-individual-or-family-plans/home."

- Click on "Tools + Resources"
- Scroll down and click on "*Tufts Health Plan Guidelines*"
- Click on the category you are looking for; they are listed alphabetically.

Or call Member Services at 1-800-682-8059; or our Behavioral Health Department at 1-800-208-9565

Terms and Definitions, continued

Member

A person enrolled in *Tufts Health Plan* under the *Group Contract;* also referred to as "you."

Mental Disorders

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

Network Hospital (In-Network)

A hospital that has an agreement either with *Tufts Health Plan* directly or with a *Provider Network* with whom we have 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. Their staff are not *Tufts Health Plan's* employees. Network hospitals are subject to change.

Network Provider (In-Network)

A *Provider* or hospital that has an agreement either with *Tufts Health Plan* directly or with a *Provider Network* with whom *We* have a contract to provide *Covered Services* to *Members*. Network providers are located throughout the *Network Contracting Area*.

Non-Network Provider (Out-of-Network)

A *Provider* or *Hospital* that does not have an agreement either with *Tufts Health Plan* directly or with a *Provider Network* with whom *We* have a contract to participate as a *Network Provider*.

Non-Conventional Medicine

A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the *Tufts Health Plan* definition of *Medical Necessity* and are not covered. *Providers* of these *Non-Covered Services* may be contracting or non-contracting traditional medical *Providers*. These services may be offered in connection with a traditional office visit. *Providers* of non-conventional medicine services often request payment up front because health insurance typically does not cover these services.

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

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

Observation

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

This is 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.*

Outpatient

- This refers to 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*.

Terms and Definitions, continued

Out-of-Pocket Maximum

This is the maximum amount of money paid by a *Member* during a *Contract Year* for certain *Covered Services*. The out-of-pocket maximum consists of *Copayments*, *Deductibles* and *Coinsurance*:

- It does not include costs above the *Reasonable Charge or*
- costs for health care services that are not *Covered Services* under the *Group Contract*

Once you meet your out-of-pocket maximum in a *Contract Year,* you no longer pay any *Copayments*, *Deductibles* and/or *Coinsurance* in that *Contract Year*.

See "Benefit Overview" at the front of this *Evidence of Coverage* for more information.

Paraprofessional

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

Premium

This is the total monthly cost of *Individual* or *Family Coverage* which the *Group* pays to us.

Primary Care Provider (PCP)

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

Prior Authorization

This is an approval request usually sent to us by your *PCP* or another *Tufts Health Plan Provider*. It asks us to determine in advance if certain services are *Covered Services* under your benefit plan. We require prior authorization for services identified by **(PA)** in the "Benefit Overview" earlier in this document. Please also see Chapter 3, *Covered Services* for information.

If you wish to request prior authorization, or if you wish to confirm with us that prior authorization has been obtained by a *Provider*, please call our Member Services at 1-800-682-8059. For behavioral health services, you may call our Behavioral Health Department at 1-800-208-9565.

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

Provider

A health care professional or facility licensed in accordance with applicable law, including, but not limited to: hospitals; *Limited Service Medical Clinics* and *Urgent Care Centers*, if available; physicians; doctors of osteopathy; physician assistants; licensed nurse midwives; certified registered nurse anesthetists; certified registered nurse practitioners; optometrists; podiatrists; psychiatrists; psychologists; licensed alcohol and drug counselor I; licensed mental/behavioral health counselors; licensed independent clinical social workers; licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental/behavioral health nursing, ;tobacco treatment specialists licensed speech-language pathologists; licensed marriage and family therapists; and licensed audiologists.

We will only cover services of a *provider*, if those services are: listed as *Covered Services*; and within the scope of the provider's license.

Provider Organization

A provider organization is comprised of doctors and other health care *Providers* who practice together in the same community. They often admit patients to the same hospital. A provider organization does this to give their patients a full range of care. Also called a "*Provider Group*".

Terms and Definitions, continued

Reasonable Charge

The lesser of:

- the amount charged or
- the amount that we determine. We decide this amount based on nationally accepted means and amounts of claims payment. These means and amounts include, but are not limited to: Medicare fee schedules and allowed amounts; CMS medical coding policies; AMA CPT coding guidelines; nationally recognized academy and society coding; and clinical guidelines.

With respect to *Emergency* care, reasonable charge is the highest of: (1) the median amount negotiated with *In-Network Providers* for the *Emergency* service; or (2) the amount for the *Emergency* service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable (UCR) amount); or (3) the amount that would be paid under Medicare for the *Emergency* service (collectively, minimum payment standards).

Service Area

The service area is the geographical area within which we have developed a network of *Providers* to provide *Members* adequate access to *Covered Services*. The service area consists of the Standard Service Area and the Extended Services Area:

The Standard Service Area is comprised of:

- all of Massachusetts, New Hampshire and Rhode Island.
- in which *Tufts Health Plan PCPs* are located and
- which are a reasonable distance from *Tufts Health Plan* specialists who provide the most-often used services, such as behavioral health practitioners and physicians who are surgeons or OB/GYNs

The Extended Service Area includes certain towns in Connecticut,-Maine, New York, and Vermont which:

- surround the Standard Service Area and
- are within a reasonable distance from *Tufts Health Plan PCPs* and specialists who provide the most-often used services, such as behavioral health practitioners and physicians who are surgeons or OB/GYNs

Notes:

- There are generally no *Tufts Health Plan PCPs* located within the Extended Service Area.

For a list of cities and towns in the service area, call Member Services. Or check our Web site at www.tuftshealthplan.com.

Note: Certain services may be available when you are traveling outside the 50 united States through the *Tufts Health Plan* telemedicine vendor. For more information, visit www.teledoc.com/tuftshealthplan or call Member Services.

Skilled

This is a type of care that is *Medically Necessary*. This care must be provided by, or under the direct supervision of, licensed medical personnel. Skilled care is provided to achieve a medically desired and realistically achievable outcome.

Spouse

The *Subscriber's* legal spouse, according to the law of the state in which you reside.

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

Subscriber

The person who:

- is an employee of the *Group*
- enrolls in *Tufts Health Plan* and signs the membership application form on behalf of himself or herself and any *Dependents* and
- in whose name the *Premium* is paid in accordance with the *Group Contract*

Tufts Health Plan

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

Tufts Health Plan Hospital

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

Terms and Definitions, continued

Tufts Health Plan Provider

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

Urgent Care

Care provided when your health is not in serious danger, but you need immediate attention for a condition or unforeseen illness or injury, whether medical, physical, behavioral, related to a substance use disorder or mental health. Examples in which *urgent care* might be needed are: a broken or dislocated toe; sudden extreme anxiety; a cut that needs stitches but is not actively bleeding; or symptoms of a urinary tract infection.

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

Appendix B - ERISA Information

ERISA RIGHTS

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

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

Receiving Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

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

Continuing Group Health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

- Continue health care coverage for yourself, *Spouse* or *Dependents* if there is a loss of coverage under the plan as a result of a qualifying event. You or your *Dependents* may have to pay for such coverage.
- Review your summary plan description and the documents governing the plan on the rules governing your continuation coverage rights under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a *Group* health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your *Group* health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

  Note: This plan does not include a pre-existing condition exclusion.

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 a daily penalty until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical *Child* support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ERISA RIGHTS, continued

Assistance with Your Questions

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

PROCESSING OF CLAIMS FOR PLAN BENEFITS

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

Who can submit a claim?

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

How do I designate an Authorized Claimant?

An authorized claimant can be designated at any point in the claims process – at the pre-service, post service or appeal level. Please contact a *Tufts Health Plan* Member Representative at the number on your ID card for the specifics on how to appoint an authorized claimant.

Types of claims

There are several different types of claims that you may submit for review. *Tufts Health Plan's* procedures for reviewing claims depends upon the type of claim submitted (*Urgent Care* claims, pre-service claims, post-service claims, and concurrent care claims). Note: 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.

Urgent Care claims: 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 be adequately managed without the care or treatment being requested. For *Urgent Care* claims, we will respond to you within 72 hours after receipt of the claim. If we determine that additional information is needed to review your claim, we will notify you within 24 hours after the receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hours after that time to provide the requested information. We will evaluate your claim within 48 hours after the earlier of our receipt of the requested information, or the end of the extension period given to you to provide the requested information.

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

Pre-Service Claim: A "pre-service claim" is a claim that requires approval of the benefit in advance of obtaining the care. For pre-service claims, we will respond to you within 72 hours for an urgent request and within 15 days for a non-urgent request after receipt of the claim. If we determine that an extension is necessary for a non-urgent request due to matters beyond our control, we will notify you within 15 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a pre-service claim, but do not submit enough information for us to make a determination, we will notify you within 15 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

Post-service claim: A "post-service claim" is a claim for payment for a particular service after the service has been provided. For post-service claims, we will respond to you within 30 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care *Provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). For more information, please see Maternity Care in Chapter 3 or call Member Services.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Note: The Family and Medical Leave Act applies only 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. Effective October 28, 2009, deployment to a foreign country was added as a requirement for exigency leave.
- Military Caregiver Leave: An eligible employee who is the *Spouse*, son, daughter parent or next of kin of a covered member of the armed services 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 member of the armed services. The employee is entitled to a combined total of 26 weeks for all types of FMLA leave in the single 12-month period. Effective March 8, 2013, the definition of "covered service member" was expanded to include certain veterans.

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.

PATIENT PROTECTION DISCLOSURE

This plan generally requires the designation of a *Primary Care Provider*. You have the right to designate any *Primary Care Provider* who participates in our network and who is available to accept you or your family members. For information on how to select a *Primary Care Provider,* and for a list of the participating *Primary Care Providers,* contact Member Services or see our Web site at www.tuftshealthplan.com.

For *Children*, you may designate a pediatrician as the *Primary Care Provider.*

You do not need *Prior Authorization* from *Tufts Health Plan* or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining *Prior Authorization* for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or see our Web site at www.tuftshealthplan.com.

NOTICE OF PRIVACY PRACTICES

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

Tufts Health Plan is committed to safeguarding the privacy of our *Members'* protected health information ("PHI"). PHI is information which:

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

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

How We Obtain PHI

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

How We Use and Disclose Your PHI

We use and disclose PHI in a number of ways to carry out our responsibilities as a managed care plan. The following describes the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

- **Treatment:** We may use and disclose your PHI to health care *Providers* to help them treat you. For example, our care managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from a hospital.
- **Payment Purposes:** We use and disclose your PHI for payment purposes, such as paying doctors and hospitals for *Covered Services*. Payment purposes also include activities such as: determining eligibility for benefits; reviewing services for *Medical Necessity*; performing utilization review; obtaining *Premiums*; coordinating benefits; subrogation; and collection activities.
- **Health Care Operations:** We use and disclose your PHI for health care operations. For example, this includes coordinating/managing care; assessing and improving the quality of health care services; reviewing the qualifications and performance of *Providers*; reviewing health plan performance; conducting medical reviews; and resolving grievances. It also includes business activities such as: underwriting; rating; placing or replacing coverage; determining coverage policies; business planning; obtaining reinsurance; arranging for legal and auditing services (including fraud and abuse detection programs); and obtaining accreditations and licenses. We do not use or disclose PHI that is genetic information for underwriting purposes.
- **Health and Wellness Information:** We may use your PHI to contact you with information about: appointment reminders; treatment alternatives; therapies; health care *Providers*; settings of care; or other health-related benefits, services and products that may be of interest to you. For example, we might send you information about smoking cessation programs, or we might send a mailing to *Subscribers* approaching Medicare eligible age with materials describing our senior products and an application form.
- **Organizations That Assist Us:** In connection with treatment, payment and health care operations, we may share your PHI with our affiliates and third party "business associates" that perform activities for us or on our behalf, for example, our pharmacy benefit manager. We will obtain assurances from our business associates that they will appropriately safeguard your information.
- **Plan Sponsors:** If you are enrolled in *Tufts Health Plan* through your current or former place of work, you are enrolled in a *Group* health plan. We may disclose PHI to the *Group* health plan's sponsor – usually your employer – for plan administration purposes. A plan sponsor of an insured health benefit plan must certify that it will protect the PHI in accordance with law.
- **Public Health and Safety; Health Oversight:** We may disclose your PHI: to a public health authority for public health activities, such as responding to public health investigations; when authorized by law, to appropriate authorities, if we reasonably believe you are a victim of abuse, neglect or domestic violence; when we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to your or others' health or safety; or to health oversight agencies for certain activities such as: audits; disciplinary actions; and licensure activity.
- **Legal Process; Law Enforcement; Specialized Government Activities:** We may disclose your PHI in the course of legal proceedings; in certain cases, in response to a subpoena, discovery request or other lawful process; to law enforcement officials for such purposes as responding to a warrant or subpoena; or for specialized governmental activities such as national security.

How We Use and Disclose Your PHI – continued

- **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. Examples of personal representatives are an individual named in a durable power of attorney or a parent or a guardian of an unemancipated minor.
- **Communications:** We will communicate information containing your PHI to the address or telephone number we have on record for the *Subscriber* of your health benefits plan. Also, we may mail information containing your PHI to the *Subscriber*. For example, communication regarding *Member* requests for reimbursement may be addressed to the *Subscriber*. We will not make separate mailings for enrolled *Dependents* at different addresses, unless we are requested to do so and agree to the request. See below "Right to Receive Confidential Communications: for more information on how to make such a request.
- **Required by Law:** We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

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

How We Protect PHI Within Our Organization

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

Your Individual Rights

The following is a summary of your rights with respect to your PHI:

- **Right of Access to PHI:** You have the right to inspect and get a copy of most PHI *Tufts Health Plan* has about you, or a summary explanation of PHI if agreed to in advance by you. Requests must be made in writing and reasonably describe the information you would like to inspect or copy. If 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*.

Your Individual Rights, continued

- **Right to Receive Confidential Communications:** You have the right to ask us to send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the *Subscriber's* address. We will accommodate your request if: you state that disclosure of your PHI through our usual means could endanger you; your request is reasonable; it specifies the alternative means or location; and it contains information as to how payment, if any, will be handled. Requests may be made verbally or in writing to *Tufts Health Plan*.
- **Right to Amend PHI:** You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to *Tufts Health Plan* and must include a reason to support the requested amendment.
- **Right to Receive an Accounting of Disclosures:** You have the right to a written accounting of the disclosures of your PHI that we made in the last six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to: (i) disclosures we made for treatment, payment or health care operations; (ii) disclosures made to you or people you have designated; (iii) disclosures you or your personal representative have authorized; (iv) disclosures made before April 14, 2003; and (v) certain other disclosures, such as disclosures for national security purposes. IF you request an accounting more than once in a 12-month period, we may charge you a reasonable fee. All requests for an accounting of disclosures must be made in writing to *Tufts Health Plan*.
- **Right to authorize other use and disclosure:** You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- **Right to receive a privacy breach notice:** You have the right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.
- **Right to this notice:** You have a right to receive a paper copy of this Notice from us on request.
- **How to Exercise Your Rights:** To exercise any of the individual rights described above or for more information, please call a Member Services Coordinator at 1-800-462-0224 (TDD: 1-800-815-8580) or write to:

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

Effective Date of Notice

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

Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that we maintain – whether created or received before or after the effective date for the new Notice. Whenever we make an important change, we will publish the updated Notice on our Web site at www.tuftshealthplan.com**.** In addition, we will use one of our periodic mailings to inform *Subscribers* about the updated Notice.

NOTICE OF PRIVACY PRACTICES, continued

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.

Tufts Associated Health Maintenance Organization, Inc., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., and Tufts Insurance Company do business as *Tufts Health Plan*. *Tufts Health Plan* is a registered trademark of Tufts Associated Health Maintenance Organization, Inc.