Rhode Island Small Group

Preferred Provider Organization

Advantage PPO 1000

EVIDENCE OF COVERAGE

Underwritten by Tufts Insurance Company.

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

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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 approval, or *Inpatient Notification* are applied in comparable ways to both mental/behavioral health and substance use disorder services and medical/surgical services.

Address and Telephone Directory

TUFTS HEALTH PLAN
1 Wellness Way
Canton, MA 02021

Member Services Hours:
Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.T.
Friday 8:00 a.m. to 5:00 p.m. E.T.

IMPORTANT PHONE NUMBERS:

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

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

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

For questions related to subrogation, call a Member Representative at 800-463-8080. If you are uncertain which department can best address your questions, call Member Services.

Member Services Department
Call *Our* Member Services Department at 800-463-8080 for general questions; benefit questions; and information regarding eligibility for enrollment and billing. For help finding a *Network Provider,* call Member Services and follow the appropriate prompts. *Our* Member Services team can help you find a *Provider* who is appropriate for your age, condition and type of treatment.

Behavioral Health and Substance Use Disorder Services
If you need assistance locating a *Provider* or in finding information about your behavioral health/substance use disorder benefits, please contact the Behavioral Health Department at 1-800-208-9565.

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

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

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

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

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

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

Tufts Health Plan
Attn: Appeals and Grievances Department
P.O. Box 9193
Watertown, MA 02472-9193

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

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Website
For more information about and to learn more about the self-service options that are available to you, please see the website.

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

Translating Services

Translating services for more than 200 languages

Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For no cost translation in English, call the number on your Member ID card.

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.

Telecommunications Device for the Deaf (TDD) - Call 711

EVIDENCE OF COVERAGE

This booklet is your *Evidence of Coverage* for health benefits underwritten by Tufts Insurance Company ("TIC"). TIC has entered into an agreement with Tufts Benefit Administrators ("TBA") for TBA to administer the health benefits. *TBA* also makes available a network of *Providers* described in this *Evidence of Coverage*. Both TIC and Tufts Benefit Administrators ("TBA") do business under the name of *Tufts Health Plan* ("Tufts HP").

This *Evidence of Coverage* describes the benefits, exclusions, conditions and limitations provided under the *Group Contract*. It applies to persons covered under the *Group Contract*. It replaces any *Evidence of Coverages* previously issued to you. Please read this *Evidence of Coverage* for a complete description of benefits and an understanding of how this plan works.

Introduction

Welcome to *Tufts Health Plan*. With *Tufts Health Plan PPO,* each time you need health care services, you may choose to obtain your health care from either a *Network Provider (In-Network Level of Benefits)* or any *Non-Network Provider (Out-of-Network Level of Benefits)*. Your choice will determine the level of benefits you receive for your health care services.

Providers are hospitals, community-based physicians and other community-based health care professionals working in their own offices throughout the *Network Contracting Area*. *Tufts Health Plan* does not provide health care services to *Members*. *Network Providers* provide health care services to *Members*. These *Providers* are independent contractors; and are not the employees or agents of *Tufts Health Plan* for any purposes.

In-Network Level of Benefits: If your care is provided by a *Network Provider*, you will be covered at the *In-Network Level of Benefits*.

Please Note: *In-Network Level of Benefits* refers to *Covered Services* that are provided by a *Network Primary Care Provider* or other *Network Provider*. According to Rhode Island law §27-20-65, you are required to designate a primary care *Provider* as your usual source of medical care; however, failure to designate a primary care provider will not result in cancellation of coverage.

Out-of-Network Level of Benefits: If your care is provided by a *Non-Network Provider*, you will be covered at the *Out-of-Network* Level of Benefits.

Covered Services Outside of the 50 United States: *Emergency* care services provided to you outside of the 50 United States qualify as *Covered Services*. In addition, *Urgent Care* services provided to you while traveling outside of the 50 United States qualify as *Covered Services*. However, any other service, supply, or medication provided to you outside of the 50 United States is not covered under this plan.

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

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

Your satisfaction with *Tufts Health Plan* is important to *Us*. If at any time you have questions, please call a Member Representative and *We* will be happy to help you.

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

Please read this *Evidence of Coverage* carefully

Table of Contents

MENTAL HEALTH PARITY STATEMENT
Address and Telephone Directory
Translating Services
Introduction
BENEFIT OVERVIEW
Chapter 1 -- How Your PPO Plan Works

In-Network Level of Benefits
Out-of-Network Level of Benefits
Continuity of Care
Prior Approval by an *Authorized Reviewer* and *Inpatient Notification*
Emergency Care and *Urgent Care*
Inpatient Behavioral Health and Substance Use Disorder Services
Utilization Management
Extension of Hospitalization
Care Management
Financial Arrangements between *Tufts Health Plan Provider* and *Network Provider*
Member Identification Card

Chapter 2 -- Eligibility, Enrollment and Continuing Eligibility

Eligibility
Enrollment
Adding *Dependents* Under *Family Coverage*
Newborn *Children* and *Adoptive Children*
Continuing Eligibility for *Dependents*
Keeping *Tufts Health Plan's* records current

Chapter 3 -- *Covered Services*

When health care services are *Covered Services*
Acupuncture services
Allergy testing and treatment
Ambulance services
Autism spectrum disorders services, including applied behavior analysis (ABA) services
Behavioral Health and Substance Use Disorder Services (*Outpatient, Inpatient*, and Intermediate)
Cardiac rehabilitation services
Chemotherapy administration
Chiropractic medicine
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
Day Surgery
Diabetes services and supplies
Diagnostic imaging
Diagnostic or preventive screening procedures
Diagnostic testing
Durable Medical Equipment
Early intervention services
Emergency care
Extended care services
Family planning
Hearing Aids
Hemodialysis
Home health care

Hospice care services
Hospital *Inpatient* care (acute care)
Human leukocyte antigen testing or histocompatibility locus antigen testing
Immunizations and vaccinations
Infertility services
Injectable, infused, or inhaled medications
Laboratory tests
Lead screening
Lyme Disease
Mammograms
Mastectomy care
Maternity care
Medical supplies
Nutritional counseling
Office visits to diagnose and treat illness or injury
Oral health services
Orthoses and prosthetic devices
Pap tests (cervical cancer screening)
Preventive health care
Private duty nursing services in the *Member's* home
Radiation therapy
Respiratory therapy/pulmonary rehabilitation services
Scalp hair prostheses or wigs
Smoking cessation counseling services
Special medical formulas
Speech, physical and occupational therapy services (includes rehabilitative and *Habilitative* services)
Surgery -- Hematopoietic stem cell transplants, and human solid organ transplants
Surgery -- in a *Provider's* office
Surgery -- Gender reassignment surgery and related services*
Surgery -- Reconstructive surgery and procedures, and surgery to treat functional deformity or impairment*
Telemedicine services
Urgent Care
Vision care services
Pediatric vision care for *Members* under age 19
Pediatric dental care for *Members* up to age 19

Prescription Drug Benefit

Exclusions from Benefits

Chapter 4 -- When Coverage Ends

Reasons coverage ends
When a *Member* is No Longer Eligible
Membership Termination for Acts of Physical or Verbal Abuse
Membership Termination or Rescission for Misrepresentation or Fraud
Termination of a *Group Contract*
Extension of Benefits
Transfer to Other Employer Group Health Plans

Chapter 5 -- Continuation of *Group Contract* Coverage

Federal Continuation Coverage (COBRA)
Rhode Island Continuation Coverage
Coverage under an *Individual Contract*
The Uniformed Services Employment and Reemployment Rights Act

Chapter 6 -- How to File a Claim and *Member* Satisfaction

How to File a Claim
Member Satisfaction Process
Bills from *Providers* / *Member* Reimbursement Process
Limitation on Actions

Chapter 7 -- Other Plan Provisions

Subrogation
Coordination of This *Group Contract's* Benefits with Other Benefits Applicability
Medicare Eligibility
Use and Disclosure of Medical Information
Relationships between *Tufts Health Plan* and *Providers*
Circumstances beyond *Tufts Health Plan's* Reasonable Control
Group Contract

Appendix A -- Glossary of Terms And Definitions

Appendix B -- ERISA Information

ERISA RIGHTS
PROCESSING OF CLAIMS FOR PLAN BENEFITS
STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT
FAMILY AND MEDICAL LEAVE ACT OF 1993
PATIENT PROTECTION DISCLOSURE
NOTICE OF PRIVACY PRACTICES

BENEFIT OVERVIEW

This Benefit Overview describes your coverage and *Cost Sharing Amounts*, including *Deductible* and *Out-of-Pocket Maximum*, under this plan. Please see Chapter 3 for *Covered Services* and benefit exclusions details.

TERMS & DEFINITIONS

All defined terms are italicized and listed in Appendix A.

Here are a few terms to keep in mind as you read through this Benefit Overview.

Coinsurance is the percentage of costs you pay for certain *Covered Services*.

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

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

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

Covered Services are the services and supplies for which we will pay. They must be described in Chapter 3 (subject to the "Exclusions from Benefits" section) and *Medically Necessary*.

Deductible is the amount you pay during the *Contract Year* before we begin to pay for certain *Covered Services*. The amount credited towards the *Member*'s *Deductible* is based on the *Network Provider*'s 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. Certain amounts you pay do not count toward your *Deductible*:
(i) any amount paid for services, supplies or medications that are not *Covered Services*; (ii) costs in excess of the *Reasonable Charge*; or (iii) the premium you pay for this plan.

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: (i) premiums you pay for this plan; (ii) costs above the *Reasonable Charge;* or (iii) costs for services that are not *Covered Services* under the *Group Contract*. If you meet the *Out-of-Pocket Maximum* in a *Contract Year*, then you no longer pay *Cost Sharing Amounts* in that *Contract Year* under the terms of this *Evidence of Coverage*.

Primary Care Provider (PCP) is a *Provider* who is a physician, physician assistant, or nurse practitioner you choose for primary care *Covered Services*.

In-Network Level of Benefits is the level of benefits that a *Member* receives when *Covered Services* are provided by a *Network Provider*.

Out-of-Network Level of Benefits is the level of benefits that a *Member* receives when *Covered Services* are provided by a *Non-Network Provider*.

Network Provider is a *PCP, Provider* or hospital that has an agreement with *Us* (either directly or with a provider network with whom *We* have a contract) to provide *Covered Services* to *Members.*

Non-Network Provider refers to any *Provider* or hospital that does not have an agreement with *Us* (either directly or with a provider network with whom *We* have a contract) to provide *Covered Services* to *Members.*

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

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. See *Our* website for a list of services that are preventive and covered in full: **https://tuftshealthplan.com/documents/providers/payment-policies/preventive-services**.

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

Diagnostic *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" below.

For certain diagnostic *Outpatient* services provided in conjunction with a preventive care visit, you may be charged an office visit *Cost Sharing Amount*.

When certain *Outpatient* services are provided in a hospital setting or free-standing facility, you may be billed separately for facility services and physician services for a single episode of care. If the *Cost Sharing Amount* for such services includes a *Deductible* or *Coinsurance* charge, that charge will apply to both facility and physician services. If the *Cost Sharing Amount* is a *Copayment* charge, only a single *Copayment* will apply, unless otherwise specified in the Benefit Overview.

Cost Sharing Amounts for *Urgent Care* services vary depending upon:

- location in which the services are provided (for example, *Provider*'s office, *Limited Service Medical Clinic, Free-standing Urgent Care Center*, or emergency room); and
- which additional Diagnostic *Outpatient* services, if any, are provided during the visit. Diagnostic *Outpatient* services provided in conjunction with an *Urgent Care* visit (for example, laboratory tests, *Durable Medical Equipment*, etc.) may be subject to separate *Cost Sharing Amounts* specified in the Benefit Overview. For more information, please call Member Services.

A telemedicine visit with a *Network Provider* will apply the same *Cost Sharing Amount* that applies to an in-person office visit with that *Provider*. A telemedicine visit with a *Non-Network Provider* will apply the same *Cost Sharing Amount* that applies to an in-person office visit with that *Provider*.

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Your *Deductible* and *Out-of-Pocket Maximum*		
Deductible	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
- Per *Contract Year* - Medical Only (your prescription drug benefit has a separate *Deductible* listed later in this Benefit Overview) -Some services are not subject to the *Deductible*, as indicated below.	<u>*Individual Plan*</u>: $1,000/Individual <u>*Family Plan*</u>: $1,000/*Member* $2,000/Family	<u>*Individual Plan*</u>: $2,000/Individual <u>*Family Plan*</u>: $2,000/*Member* $4,000/Family

Your *Deductible* applies to all *Covered Services* except as listed in the Benefit Overview below.

The Family *Deductible* is satisfied with any combination of *Deductible* payments for *Covered Services* for any *Member* in a *Family Plan*. If any *Member* in a *Family Plan* satisfies the per *Member Deductible* before the Family *Deductible* amount is satisfied; coverage will begin for that *Member*: (i) subject to any other *Cost Sharing Amounts* that may apply; and (ii) any such *Cost Sharing Amounts* will not apply toward the Family *Deductible*.

<u>Note</u>: No *Member* of a *Family Plan* will pay more in a *Contract Year* towards the Family *Deductible* than the yearly amount set by the federal government as the *Out-of-Pocket Maximum* amount for one person.

Any amount paid by the *Member* for a *Covered Service* received during the last 3 months of a *Contract Year* will be carried forward to the next *Contract Year's Deductibles*. Any amount carried forward will not apply towards the next *Contract Year's Out-of-Pocket Maximum*.

The following amounts do not count towards the *Deductible*:

- Any amount you pay toward the Prescription Drug *Deductible*
- Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Costs in excess of the *Reasonable Charge*.
- The *Premium* you pay for this plan.

Out-of-Pocket Maximum	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
- Per *Contract Year*	<u>*Individual Plan*</u>: $7,750/Individual <u>*Family Plan*</u>: $7,750/*Member* $15,500/Family	<u>*Individual Plan*</u>: $23,250/Individual <u>*Family Plan*</u>: $23,250/*Member* $46,500/Family

Any *Deductible*, *Copayment* or *Coinsurance* amount you pay under this plan for *Covered Services* will count toward your *Out-of-Pocket Maximum*. Once you satisfy your *Out-of-Pocket Maximum*, you no longer pay these *Cost Sharing Amounts.*

Any combination of *Members* in a *Family Plan* can pay toward the Family *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* is satisfied, *We* begin to pay for *Covered Services* for all *Members* in a *Family Plan* under the terms of this *Evidence of Coverage*. If a *Member* in a *Family Plan* reaches the per *Member Out-of-Pocket Maximum* before the Family *Out-of-Pocket Maximum* is satisfied; then (i) that *Member* has met his/her *Out-of-Pocket Maximum* requirement; and (ii) *We* begin to pay for his/her *Covered Services* under the terms of this *Evidence of Coverage*.

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Out-of-Pocket Maximum	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***
Note: *Out-of-Pocket Maximums* are set every year by the federal government. This plan's *Out-of-Pocket Maximum* amounts do not exceed federal maximums. **Certain amounts do not count towards an *Out-of-Pocket Maximum*:** • Any amount you pay for services, supplies, or medications that are not *Covered Services.* • Costs in excess of the *Reasonable Charge*. • The *Premium* you pay for this plan.		

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
Emergency room		
	$350 *Copayment* per visit	Same as *In-Network Level of Benefits*
Notes: Contact *Us* within 48 hours of receiving *Emergency* care. If you are admitted as an *Inpatient*, you or someone acting for you should call *Us* within 48 hours. A family member or the attending physician can call for you. An *Inpatient* Hospital *Cost Sharing Amount* will apply. Call Member Services about waiving the *Emergency* room *Copayment* if you are admitted. Observation services will take an Emergency room *Cost Sharing Amount.* A *Day Surgery Cost Sharing Amount* may apply if *Day Surgery* services are provided.		
Acupuncture		
	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Allergy injections		
	$5 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Allergy testing and treatment		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Ambulance (AR)		
	In-Network Deductible then $50 *Copayment* per trip	Same as *In-Network Level of Benefits*
Notes: Ground, sea, and air ambulance transportation for *Emergency* care are *Covered Services*. Prior approval is not required. Non-*Emergency* ambulance transportation is covered only when an *Authorized Reviewer* determines in advance that such services are *Medical Necessary*.		
Autism spectrum disorders services, including applied behavior analysis (ABA) services (AR)		

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
	Paraprofessional: Covered in full **Board Certified Behavior Analyst (BCBA):** $35 *Copayment* per visit **Licensed physical, speech language or occupational therapist:** $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Prescription medications are covered under "Prescription Drug Benefit". Psychiatric and psychological care services are covered under "Behavioral health and substance use disorder services".		
Behavioral health and substance use disorder services		
Office visits	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Inpatient **(AR)**	**Hospital facility services:** *In-Network Deductible* then $150 *Copayment* per admission **Professional services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Medically Necessary treatment in a behavioral health residential treatment facility **(AR)**	*In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Intermediate care **(AR)**	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Community Residence **(AR)**	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Medication assisted treatment, including methadone maintenance when provided by a network medication assisted treatment clinic	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: To contact *Our* Behavioral Health Department, call 1-800-208-9565 Psychological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury." Prior approval is required by an *Authorized Reviewer* at the *In-Network* and *Out-of-Network Levels of Benefits*.		
Cardiac rehabilitation Services are limited to 36 visit(s) per *Contract Year*. Coverage is combined for *In-Network* and *Out-of-Network Levels of Benefits*.		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Chemotherapy administration		

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: For information about your coverage for the medications used in chemotherapy, see "Injectable, infused, or inhaled medications".		
Chiropractic medicine		
	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Diagnostic laboratory tests and x-rays provided during a chiropractic visit are covered as described under "Laboratory tests" and "Diagnostic imaging."		
Clinical Trials		
	See applicable *Covered Services*	See applicable *Covered Services*
Notes: Coverage includes 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.		
Colonoscopies		
	See Diagnostic and preventive screening procedures	See Diagnostic and preventive screening procedures
Day Surgery (AR)		
	Facility services: *In-Network Deductible* then $75 *Copayment* per visit **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diabetes self-management training and education services		
	***PCP*:** $35 *Copayment* per visit **Any other *Network Provider*:** $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic imaging		
General imaging, such as x-rays & ultrasound	$40 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
MRI/MRA, CT/CTA, PET, nuclear cardiology **(AR)**	*In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Certain diagnostic imaging may be covered in full (after *Deductible*, as applicable) when the imaging is required as part of an active treatment plan for a cancer diagnosis. Call Member Services for details.		
Diagnostic or preventive screening procedures (for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies)		

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic procedure only (for example, colonoscopies associated with symptoms) **(AR)**	*In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic procedure accompanied by treatment/ surgery (for example, polyp removal) **(AR)**	See *Day Surgery*	See *Day Surgery*
Note: In accordance with Rhode Island law, certain procedures may be covered in full when performed by a *Network Provider* to diagnose colorectal cancer; for example, a follow-up colonoscopy if results of the initial colorectal cancer screening are abnormal. Call Member Services for details.		
Diagnostic testing (AR)		
	$40 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
***Durable Medical Equipment* (AR)**		
	In-Network Deductible then 30% *Coinsurance*	*Out-of-Network Deductible* then 30% *Coinsurance*
Early intervention services for a *Dependent Child*		
	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Extended care (AR) Services are provided up to 100 day(s) per *Contract Year*. Coverage is combined for *In-Network* and *Out-of-Network Levels of Benefits*.		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Family planning (procedures, services & contraceptives)		
Day surgery **(AR)**	See Day Surgery	See Day Surgery
Office visits	***PCP*:** $35 *Copayment* per visit **Any other *Network Provider*:** $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Women's preventive health services, including contraceptives and female sterilization procedures, are covered in full, in accordance with the ACA.		
Hearing Aids Coverage is provided for 1 hearing aid per ear every 3 years for any *Member.* Coverage is combined for *In- Network* and *Out-of-Network Levels of Benefits.*		

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
	In-Network Deductible then 30% *Coinsurance*	*Out-of-Network Deductible* then 30% *Coinsurance*
Hemodialysis		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Home health care (AR)		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Hospice care (AR)		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Hospital *Inpatient* (Acute care) (AR)		
	Hospital facility services: *In-Network Deductible* then $150 *Copayment* per admission **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
House calls to diagnose and treat illness or injury		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Human leukocyte antigen (HLA) testing (AR)		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Immunizations		
	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Preventive immunizations, including those for travel, that and recommended by the Center for Disease Control (CDC) and listed on their website at: **https://www.cdc.gov/vaccines/index.html**		
Infertility Services (AR)		
	20% *Coinsurance*	*Out-of-Network Deductible* then 20% *Coinsurance*
Injectable, infused or inhaled medication (AR)		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Laboratory tests (AR)		

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
	$25 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Laboratory tests performed as part of preventive care are covered in full in accordance with the ACA. All Genetic and Molecular Diagnostic laboratory tests require prior approval from an *Authorized Reviewer* at the *In-Network* and *Out-of Network Levels of Benefits*.		
Lead screening		
	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Lyme disease - *Medically Necessary* diagnosis and treatment of chronic Lyme disease		
	***PCP*:** $35 *Copayment* per visit **Any other *Network Provider*:** $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Mammograms		
Routine mammograms	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic mammograms	$40 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Mastectomy care		
	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Note: In accordance with Rhode Island law, Mastectomy *Covered Services* are provided for mastectomy surgery (prior approval by an *Authorized Reviewer* required); breast reconstruction surgery, breast prostheses and treatment of physical complications for all stages of mastectomy.		
Maternity care		
Routine maternity care, including pre-natal & post-natal visits	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Non-routine maternity care	See applicable *Covered Services*	See applicable *Covered Services*
Doula services	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Note: See **Maternity care** in Chapter 3 for more details.		
Inpatient	**Hospital facility services:** *In-Network Deductible* then $150 *Copayment* per admission **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*

Notes: When provided by a *Network Provider*, routine laboratory tests associated with maternity care are covered in full, in accordance with the ACA. *Member* cost sharing will apply to diagnostic test and diagnostic laboratory tests when ordered during a routine maternity care visit.
Medical supplies (AR)

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Nutritional counseling		
Preventive nutritional counseling	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
All other nutritional counseling services	***PCP*:** $35 *Copayment* per visit **Any other *Network Provider*:** $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Certain nutritional counseling services are covered in full in accordance with ACA preventive services requirements; included are obesity counseling and healthy diet counseling for adults with hyperlipidemia and other risk factors for cardiovascular disease and diet-related chronic disease.		
Office visits to diagnose and treat illness and injury		
	***PCP*:** $35 *Copayment* per visit **Any other *Network Provider*:** $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Note: A telemedicine services visit with a *Network* or *Non-Network Provider* will apply the same *Cost Sharing Amount* that applies to an in-person office visit with that *Provider*. See **Telemedicine services** later in this section for information about services from *Our* telemedicine vendor (also called telehealth).		
Oral health services		
Day Surgery **(AR)**	See *Day Surgery*	See *Day Surgery*
Inpatient services **(AR)**	See Hospital *Inpatient*	See Hospital *Inpatient*
Emergency room	See Emergency room	See Emergency room
Surgery in a *Provider*'s office **(AR)**	See Surgery in a *Provider*'s office	See Surgery in a *Provider*'s office
Orthoses and prosthetic devices (AR)		
	In-Network Deductible then 20% *Coinsurance*	*Out-of-Network Deductible* then 20% *Coinsurance*
Note: Breast prostheses following mastectomy are covered in full. Prior approval is not required.		
Pap test (cervical cancer laboratory test)		
Routine annual Pap test	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic Pap test	$25 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Preventive health care		
	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
Notes: Visit *Our* website at **https://tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for a list of preventive services. Also see **Important Information About Your *Cost Sharing Amounts*** at the f ront of this Benefit Overview and Chapter 3, *Covered Services.*		
Private duty nursing services in a *Member's* home (AR)		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Radiation therapy (AR)		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Respiratory therapy or pulmonary rehabilitation		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Scalp hair prosthesis or wigs		
	In-Network Deductible then 20% *Coinsurance*	*Out-of-Network Deductible* then 20% *Coinsurance*
Smoking cessation counseling services		
	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Special formulas		
Low protein foods **(AR)**	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Non-prescription enteral formulas **(AR)**	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Speech, physical and occupational therapy services (includes rehabilitative and *Habilitative* services) (AR) Rehabilitative services are covered up to 2 evaluations and 30 visit(s) for each therapy type per *Contract Year*; and *Habilitative* services are covered up to 2 evaluations and 30 visit(s) for each therapy type per *Contract Year*. Coverage is combined for *In-Network* and *Out-of-Network Levels of Benefits*. Visit limits do not apply to the treatment of autism spectrum disorders or for therapy provided as part of home health care. See "Autism spectrum disorders" and "Home Health Care".		
	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Surgery – in a *Provider's* office (AR)		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Surgery – Hematopoietic stem cell and human solid organ transplants (AR)		

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
	Hospital facility services: *In-Network Deductible* then $75 *Copayment* per visit **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Surgery – Gender reassignment surgery and related services (AR)		
	Hospital facility services: *In-Network Deductible* then Covered in full **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: See *Day Surgery* for surgery provided on an *Outpatient* basis. Medications are covered as described under "Prescription Drug Benefit". *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) are covered as described under "Behavioral health and substance use disorder services". Gender reassignment surgery and related services only qualify as *Covered Services* when (i) authorized in advance by an *Authorized Reviewer* at the *In-Network* and *Out-of-Network Levels*. Service must be obtained within the 50 United States.		
Surgery – Reconstructive procedures (AR)		
	Hospital facility services: *In-Network Deductible* then $75 *Copayment* per visit **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Note: See Mastectomy Care for mastectomy related coverage and cost sharing information.		
Telemedicine services		
When provided by *Our* designated telemedicine vendor (also called telehealth)	**General medicine and behavioral health:** Covered in full **Dermatology:** Covered in full	See Note below

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
When provided by a *Provider*	***PCP*:** $35 *Copayment* per visit **Any other *Network Provider*:** $35 *Copayment* per visit **Remote Patient Monitoring:** *In-Network Deductible* then Covered in full **Remote Medical Data Transfer/Evaluation:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Note: The same *Cost Sharing Amount* applies to a telemedicine visit with a *Network* or *Non-Network Provider* as an in-person office visit with that *Provider*.		
Urgent Care		
PCP or a behavioral health/ substance use disorder *Provider's* office	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Any other *Provider* (e.g., a specialist)	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Participating *Limited Services Medical Clinic*	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Free-standing Urgent Care Center	$50 *Copayment* per visit	$50 *Copayment* per visit
PCP in a Hospital walk-in clinic	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Other *Provider* in a Hospital walk-in clinic	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: See "Follow these guidelines for receiving *Urgent Care*" in Chapter 1 for more information. 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. See Chapter 1.		
Vision care services Adult routine eye examination services are limited to 1 visit(s) per 12 months. Coverage is combined for *In-Network* and *Out-of-Network Levels of Benefits*.		
Adult routine eye exam	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Adult vision care services – EyeMed Optometrist	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Adult vision care services – Ophthalmologist **(AR)**	$35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Service	**Your Cost**	
	In-Network Levels of Benefits	***Out-of-Network Levels of Benefits***
Adult lenses and frames after cataract surgery (see Note)	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Notes: Each *Contract Year*, coverage includes one pair of eyeglass lenses and standard frames following cataract surgery or other surgery to replace the natural lens of the eye when the *Member* does not receive an intraocular implant. Also, *Cost Sharing Amounts* apply to diagnostic tests or laboratory services when ordered during a vision care services visit.		

(AR) This service or certain services in this benefit category require prior approval by an *Authorized Reviewer*. Your *Tufts Health Plan Provider* will obtain this approval for you.

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Covered Services	**Your Cost**	
	In Network Level of Benefits	***Out-of-Network Level of Benefits***
Pediatric vision care services for *Members* under age 19 One routine eye exam is covered per *Contract Year*, including contact lens fittings and follow-up. One pair of eyeglass lenses and one pair of frames from a limited collection are covered each *Contract Year.* Coverage includes one pair of contact lenses (materials only) in lieu of eyeglasses. Contact lenses are provided when 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. Covered low vision services include: (i) one comprehensive low vision evaluation every five years; (ii) coverage for items such as high-power spectacles, magnifiers and telescopes; and (iii) follow-up care of up to four visits in any five-year period.		
Routine eye exam	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic eye exam	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Lenses & frames	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Low vision	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*

Covered Services	**Your Cost**	
	In Network Level of Benefits	***Out-of-Network Level of Benefits****
Pediatric dental care services for *Members* under age 19		
Basic services	Covered in full	Covered in full
Intermediate services	25% *Coinsurance*	*Deductible* then 25% *Coinsurance*
Major restorative services	50% *Coinsurance*	*Deductible* then 50% *Coinsurance*
Orthodontia **(AR)**	50% *Coinsurance*	*Deductible* then 50% *Coinsurance*
Note: **Covered Services* received from a *Provider* who is not part of the DentaQuest network are subject to a $50 per *Member Deductible* per *Contract Year*. See Chapter 3, *Covered Services* for details about service frequency and limitations and where to find more information about services and providers.		

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Prescription Drug Benefit	Your Cost
Prescription Drug Deductible This Deductible does not apply to a covered generic drug on any tier.	*Individual Plan*: $250/Individual *Family Plan*: $250/*Member* $500/Family
Prescription Drug *Out of Pocket Maximum*	See the *Out-of-Pocket-Maximum* at the beginning of the Benefit Overview

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Drugs Obtained at Retail Pharmacy: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a *Tufts Health Plan* designated retail pharmacy	
Up to a 30 - day supply	
Tier 1 Drugs	$30 *Copayment* per fill
Tier 2 Drugs	*Deductible* then $75 *Copayment* per fill
Tier 3 Drugs	*Deductible* then $90 *Copayment* per fill
Tier 4 Drugs	*Deductible* then 25% *Coinsurance* up to a maximum of $250
Up to a 60 - day supply	
Tier 1 Drugs	$60 *Copayment* per fill
Tier 2 Drugs	*Deductible* then $150 *Copayment* per fill
Tier 3 Drugs	*Deductible* then $180 *Copayment* per fill
Up to a 90 - day supply	
Tier 1 Drugs	$90 *Copayment* per fill
Tier 2 Drugs	*Deductible* then $225 *Copayment* per fill
Tier 3 Drugs	*Deductible* then $270 *Copayment* per fill

Drugs Obtained Through A Mail Service for up to a 90-day supply: Your cost sharing for most maintenance medications, when mailed to you through a *Tufts Health Plan* designated mail services pharmacy	
Up to a 30 - day supply	
Tier 1 Drugs	$30 *Copayment* per fill
Tier 2 Drugs	*Deductible* then $75 *Copayment* per fill
Tier 3 Drugs	*Deductible* then $90 *Copayment* per fill
Tier 4 Drugs	*Deductible* then 25% *Coinsurance* up to a maximum of $250
Up to a 60 - day supply	
Tier 1 Drugs	$60 *Copayment* per fill
Tier 2 Drugs	*Deductible* then $150 *Copayment* per fill
Tier 3 Drugs	*Deductible* then $180 *Copayment* per fill
Up to a 90 - day supply	
Tier 1 Drugs	$60 *Copayment* per fill
Tier 2 Drugs	*Deductible* then $225 *Copayment* per fill
Tier 3 Drugs	*Deductible* then $270 *Copayment* per fill

Infertility Drugs	
	20% *Coinsurance* for up to a 30-day supply

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Oral Chemotherapy Drugs	
	Covered in full

Low cost generic drugs	
	$5 *Copayment* per fill for up to a 30-day supply and then $10 *Copayment* per fill for up to a 90-day supply
Prescription Insulin Medication	
	Prescription Insulin medications on our formulary for the treatment of diabetes may take a separate *Cost Sharing Amount* from those described above. These medications are not subject to a *Deductible* and a *Member's* total cost will not exceed $40 for each 30-day supply. Please contact Member Services for additional information.

Coverage When Drugs **Are Not Obtained** Through a Tufts Health Plan Designated Retail Pharmacy:

You may choose to obtain a covered prescription drug at a retail pharmacy that is not a *Tufts Health Plan* designated pharmacy. If so, you will need to pay for the prescription up front and submit a claim for reimbursement. Prescription drug claim forms can be obtained by contacting a Member Specialist. You can also get one at *Our* website at **www.tuftshealthplan.com**.

Important Note: The following table provides basic information about your benefits under this plan. Please see Chapter 3 for detailed explanations of *Covered Services.* **(AR)** means that a service or certain services in a benefit category require prior approval by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits*.

Notes:

- **The *Tufts Health Plan* website has a list of covered drugs with their tiers.**
  ***Our* formulary is updated regularly.** See *Our* website at:
  https://tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy/pharmacy-programs/ri-4-tier-pharmacy-copayment-program.
  There may be limited circumstances when we may change a drug's tier which can happen at any time throughout the year. For example, a brand drug's patent may expire. In this case, we may change the drug's status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) no longer covering the brand drug when a generic alternative becomes available. In such cases, we will make the generic available at the same tier (i.e., Tier-2) or a lower tier (i.e., Tier-1).
- Certain day supply limits apply to prescription fills and refills. You may fill or refill prescriptions up to a 90-day supply at one time, provided that (i) the prescription is for a *Covered Service;* (ii) the quantity is ordered by your physician; and (ii) the prescription does not require prior approval by an *Authorized Reviewer*. Otherwise, Retail Pharmacy and Specialty Pharmacy purchases may be limited to a 30-day supply per fill or refill.
- Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered. See cost sharing listed above.
- Smoking cessation agents (both prescription and generic over-the-counter agents when prescribed by a *Provider*) are covered in full.
- Certain drugs on our formulary are designated as part of our low cost drug program. See cost sharing listed above. Also, see *Our* website or call Member Services for more information.
- If the cost of a drug is less than the minimum *Cost Sharing Amount*, you pay only for the cost of the drug.
- If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorized the generic equivalent, you will pay the applicable tier *Cost Sharing Amount* plus the difference in cost between the brand-name drug and the generic drug.

Chapter 1 -- How Your PPO Plan Works

Eligibility for Benefits

When you need health care services, you may choose to obtain these services from either a *Network Provider* (*In-Network Level of Benefits*); or a *Non-Network Provider* (*Out-of-Network Level of Benefits*). Your choice will determine the level of benefits you receive for your health care services. *We* cover only the services and supplies described as *Covered Services* in Chapter 3.

Important Notes:

- There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.
- In accordance with federal law (45 CFR § 148.180), *Tufts Health Plan* does not:
  - adjust *Premiums* based on genetic information;
  - request or require genetic testing; or
  - collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes
- You may be a *Member* living outside of Rhode Island. If so, your coverage may also include benefits required by the laws of your state. For more information, call Member Services.

Changes to *Our Provider* Network

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* may retire; move out of the *Network Contracting Area*, or fail to continue to meet *Our* credentialing standards. This may also happen if *Tufts Health Plan* and the *Network Provider* are unable to reach agreement on a contract. *Network Providers* are independent contractors; they do not work for *Tufts Health Plan*. Call Member Services with questions about *Network Provider* availability.

In-Network Level of Benefits

You may choose to receive care from a *Network Provider*. If so, you are covered at the *In-Network Level of Benefits*. This includes behavioral health/substance use disorder services, and services at a participating *Limited Service Medical Clinic* or *Free-standing Urgent Care Center*.

You pay a *Cost Sharing Amount* for certain *Covered Services* you receive at the *In-Network Level of Benefits*. See the "Benefit Overview". You do not have to submit any claim forms when you receive care from a *Network Provider*. The *Network Provider* will submit the claim forms to *Us* for you.

Selecting a *Provider*

To receive coverage at the *In-Network Level of Benefits*, you must receive care from a *Network Providers*. You can find *Network Providers* through *Our* searchable directory on *Our* website. You should choose a *Provider* in a location convenient to you. If you have difficulty or need assistance finding a *Provider*, call Member Services or Our Behavioral Health Department (800-208-9565).

No *Inpatient Notification* by You

When your *Inpatient* hospitalization is provided by a *Network Hospital*, you do not have to notify *Tufts Health Plan* about the *Inpatient* hospitalization or transfer. The *Network Hospital* will provide notification for you.

Canceling appointments

If you need to cancel an appointment be sure to give at least a 24-hour notice. If you do not, and your *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.

Out-of-Network Level of Benefits

You may choose to receive *Covered Services* from a *Non-Network Provider*. This included behavioral health/substance use disorder services. You will be covered at the *Out-of-Network Level of Benefits*. *Tufts Health Plan* will pay up to the *Reasonable Charge* for *Covered Services* you receive from a *Non-Network Provider*.

Note: Please see the "*Urgent Care*" section in this chapter for additional information.

When a *Non-Network Provider* provides your care, you must submit a claim form to *Tufts Health Plan.* For more information, see "Bills from *Providers*" in Chapter 6.

Covered Services Not Available from a *Network Provider*

If a *Covered Service* is not available from a *Network Provider* (as determined by *Us*) you must obtain *Our* approval to go to a *Non-Network Provider*. With *Our* prior approval, you will receive *Covered Services* at the *In-Network Level of Benefits* up to the *Reasonable Charge*. You are responsible for any costs in excess of the *Reasonable Charge*, as well as any applicable *Cost Sharing Amount*. You may receive a bill for these services. If you receive a bill, please see "Bills from *Providers*" later in this *Evidence of Coverage* or call Member Services for more information about what to do if you receive a bill.

Inpatient Notification by You

If you receive *Inpatient services* that are not provided by a *Network Provider*, you must notify *Tufts Health Plan* of these services. See *Inpatient Notification* later in this chapter. If you do not notify *Tufts Health Plan* of these services, you will be subject to a *Notification Penalty*. See "*Inpatient Notification*" later in this chapter for more information.

If You Received *Covered Services* Outside of the 50 United States

Emergency care services provided to you outside of the 50 United States qualify as *Covered Services.* In addition, *Urgent Care* services provided to you while traveling outside of the 50 United States also qualify as *Covered Services.* However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan.

Continuity of Care

If your Provider's contract with *Tufts Health Plan* terminates for reasons other than quality or fraud, you may continue to receive care from that *Provider* for the following continuing care conditions for up to 90 days from the date *We* notify you of your *Provider's* termination:

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

Note:
Serious and Complex Condition means:

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

Prior Approval by an *Authorized Reviewer* and *Inpatient Notification*

Prior approval by an *Authorized Reviewer*

Prior approval by an *Authorized Reviewer* is required for certain *Covered Services.* This is an approval request usually sent to *Us* by a *Network Provider.* It asks *Us* to determine in advance if certain services are *Covered Services* under your benefit plan. *We* require prior approval for services identified by **(AR)** in the Benefit Overview. **Note**: *Emergency Care* does not require approval by an *Authorized Reviewer.*

When you receive services from *Network Providers*:
They are responsible for obtaining any required approval from an *Authorized Reviewer*.

When you receive services from a *Non-Network Provider*:
You are responsible for making sure your *Provider* obtains prior approval from an *Authorized Reviewer* when required. If you receive services that *We* (or *Our* delegate) determine are: (1) not *Medically Necessary*; or (2) not *Covered Services*; then you will be responsible for the full cost of those services.

Call Member Services
- to request prior approval by an *Authorized Reviewer*; or
- to confirm with *Us* that your *Provider* obtained this approval.

Call *Our* Behavioral Health Department at 1 (800) 547-5186 for behavioral health and substance use disorder services.

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

Inpatient Notification

Inpatient Notification is a process that informs *Us* about all *Inpatient* admissions and transfers to another hospital. *We* or *Our* delegate evaluate the expected hospital stay and proposed medical care; and (2) verifies *Medical Necessity*. *We* or *Our* delegate may assess the need for a care management program after discharge. Or *We* or *Our* delegate may recommend an alternative treatment setting.

Inpatient Notification to *Tufts Health Plan* by your *Provider* does not guarantee payment. *We* will not pay claims for: (i) persons who fail to meet eligibility criteria; (ii) services that are not *Medically Necessary;* or (iii) services that are not *Covered Services.*

When Care is Provided by a *Network Provider*
Your *Network Provider* or Hospital is responsible for notifying *Us* of your *Inpatient* admission or transfer.

When Care is Provided by a *Non- Network Provider*
You are responsible for making sure *We* are notified of any *Inpatient* admission or transfer when a *Non-Network Provider* provides your care. If you receive services that *We* (or *Our* delegate) determine are not *Medically Necessary* or are not *Covered Services*, you will be responsible for the full cost of these services.

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

For questions, contact Member Services at 800-463-8080. Or for behavioral health and substance use disorder services, call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565.

Emergency Care and *Urgent Care*

Emergency Care

***Definition of Emergency*:**
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 needed. If 911 services are not available in your area, call the local number for emergency medical services.

Go to the nearest emergency medical facility.

If you receive *Emergency* care as an *Outpatient*:

- At a *Network Hospital*, you will be covered at the *In-Network Level of Benefits.* You will pay a *Cost Sharing Amount* for each Emergency room visit
- At a *Non-Network Hospital*, *We* will pay up to the *Reasonable Charge for Covered Services* you receive. You only pay the applicable *Cost Sharing Amount*.

If you are admitted as an *Inpatient* after receiving *Emergency* care:

- A *Network Hospital* will notify *Us* of your admission. You will be covered at the *In-Network Level of Benefits*. You will pay the applicable *Cost Sharing Amounts* for the *Inpatient* stay.
- If you are admitted to a *Non-Network Hospital:*
  - notify *Us* within 48 hours. The attending *Provider* or a family member can do this for you.
  - you will be covered at the *In-Network Level of Benefits*.
  - *We* will pay up to the *Reasonable Charge.*
  - you will pay the *Hospital Inpatient Cost Sharing Amounts.*
  - you will be covered at the *Out-of-Network Level of Benefits*: **IF:**
    - *We* (or *Our* delegate) determine that transfer to a *Tufts Health Plan Hospital* is medically appropriate; and
    - you refuse the transfer and decide to remain at the *Non-Network Hospital*.

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

Urgent Care

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

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* located in Massachusetts, New Hampshire or Rhode Island	*Non-Network Provider* located outside of Massachusetts, New Hampshire and Rhode Island
Limited Service Medical Clinic or *Free-Standing Urgent Care Center*	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*	You are covered for *Urgent Care* at the *Out-of-Network Level of Benefits.*	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*
Provider's office or hospital-based walk-in clinic	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*	You are covered for *Urgent Care* at the *Out-of-Network Level of Benefits.*	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*
Behavioral Health/Substance Use *Provider's* office	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*	You are covered for *Urgent Care* at the *Out-of-Network Level of Benefits.*	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*
Emergency room	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*	You are covered for *Urgent Care* at the *Out-of-Network Level of Benefits.*	You are covered for *Urgent Care* at the *In-Network Level of Benefits.*

Inpatient Behavioral Health and Substance Use Disorder Services

In-Network Level of Benefits: You may need *Inpatient* or intermediate behavioral health or substance use disorder services and wish to receive coverage for these services at the *In-Network Level of Benefits*, your *Inpatient* or intermediate behavioral health or substance use disorder services must be provided by a *Network Hospital*. You may go to any *Network Hospital* and receive coverage at the *In-Network Level of Benefits*. There is no need to contact *Us* first. Simply call or go directly to any *Network Hospital*. Identify yourself as a *Tufts Health Plan Member*. The *Network Hospital* is responsible for providing notification for all *Inpatient*/intermediate behavioral health and substance use disorder services. You are not responsible for notifying *Tufts Health Plan* of your admission at a *Network Hospital*.

Out-of-Network Level of Benefits: You may choose to receive *Inpatient* or intermediate behavioral health or substance use disorder services from *Non-Network Provider* or *Hospital*. Your coverage will be at the *Out-of-Network Level of Benefits*.

- *Authorized Review* may be required for certain Covered Services. You are responsible for making sure your *Provider* notifies *Us* if you are admitted. Your *Provider* must obtains any required approval from an *Authorized Reviewer*.
- *We* can let you know in advance if the services you want to receive are *Covered Services*.
- If you receive services that *We* (or *Our* delegate) determine are not *Covered Services*, you will be responsible for the full cost of these services.
- Call *Tufts Health Plan Behavioral Health Department* at 1-800-208-9565 for more information.

Note: For *Emergency* and *Urgent Care services* and admissions, **see *Emergency* Care and *Urgent* Care** above.

Utilization Management

Tufts Health Plan has a utilization management program. This is employed to evaluate 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 the *Network Contracting Area;*
- developed in accordance with the standards adopted by government agencies and national accreditation organizations;
- updated annually or more often as new treatments, applications, and technologies are adopted as generally accepted professional medical practice; and
- scientific evidence-based, if practicable.

Tufts Health Plan considers these guidelines as well as the *Member*'s individual health care needs to evaluate on a case-by-case basis if a service or supply is *Medically Necessary*.

The utilization management program sometimes includes prospective, concurrent, and retrospective review of health care services for *Medical Necessity* (collectively, this comprises *Authorized Review*) and is performed by an *Authorized Reviewer*.

Prospective review is used to determine whether proposed treatment is *Medically Necessary* before that treatment begins. Prospective review is also referred to as "Pre-Service Review".

Concurrent review is used to:

- monitor ongoing admissions (the course of treatment) as they occur; and
- to determine when that treatment is no longer *Medically Necessary*.

Retrospective review is used to evaluate the *Medical Necessity* of care after it has been provided. In some circumstances, *We* perform in retrospective review to more accurately determine if a *Member*'s health care services are appropriate. Retrospective review is also called as "Post-Service Review".

TIMEFRAMES TO REVIEW YOUR REQUEST FOR COVERAGE

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.

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

Prospective and concurrent reviews let *Members* know if proposed health care services are *Medically Necessary* and covered under their plan. This allows *Members* to make informed decisions about their care.

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

Extension of Hospitalization

All *Inpatient* hospitalizations are monitored. It may be *Medically Necessary* for you to stay in the hospital longer than the originally approved stay. If this happens, *Tufts Health Plan* or its delegate will request additional clinical information from your attending *Provider* or hospital for additional *Medically Necessary* hospital days. Or after consulting your *Provider*, it may be determined that *Inpatient* hospitalization is no longer *Medically Necessary*. If this happens, you will be notified that any additional hospital days will not be covered. You will be responsible for paying f or all hospital and *Provider* charges if you choose to stay in the hospital beyond the discharge date.

Care Management

Some *Members* with Severe Illnesses or Injuries may need care management. The care management program:

- encourages use of the most appropriate and cost effective treatment; and
- 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 *Network 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:

- qualify as *Covered Services*;
- are cost effective; and
- are appropriate for the *Member*.

In this case, the *Member* and his/her *Network Provider* will be contacted to discuss alternatives.

A Severe Illness or Injury may be medical or behavioral health related and may include, but are 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, *We* 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 approval.

Financial Arrangements between *Tufts Health Plan Provider* and *Network Provider*

Methods of payment to *Network Provider*

Our goal in compensation of *Providers* is to encourage preventive care and active management of illnesses. *We* strive to be sure that the financial reimbursement system *We* use encourages appropriate access to care and rewards *Providers* for providing high quality care to *Our Members*. *We* use a variety of mutually agreed upon methods to compensate *Network Provider*.

The *Tufts Health Plan Directory of Health Care Providers* indicates the method of payment for each *Provider*. 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 It also 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. You should feel free to discuss with your *Provider* specific questions about how he or she is paid.

Member Identification Card

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 a *Member* Services Representative.

Identifying yourself as a *Tufts Health Plan Member*. Your Member ID card is important because it identifies you as a *Tufts Health Plan Member*. Carry your *Member* ID card at all times. Have your *Member* ID card with you for medical, hospital and other appointments. Show your *Member* ID card to any *Provider* before you receive health care services.

Important Note: When you receive services, you must tell the office staff that you are a *Tufts Health Plan Member*. If you do not, *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 for you to receive 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 Representative.

Chapter 2 -- Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule under a *Group Contract*

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
- lives, works, or resides in the *Network Contracting Area*.

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

- qualifies as a *Dependent*, as defined in this *Evidence of Coverage;* and
- meets your *Group's* and *Tufts Health Plan's* eligibility rules; and
- live, work or reside in the *Network Contracting Area*

Note: In some cases, *Dependents* who live, work or reside outside the *Network Contracting Area* can be eligible for coverage under this plan. See "If you live, work or reside outside the *Network Contracting Area*" below for more information.

If you do not live, work or reside in the *Network Contracting Area*

You can be covered only if :

- you are a *Child*;
- 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: Routine care obtained outside the *Network Contracting Area* is covered at the *Out of Network Level of Benefits.*

Proof of Eligibility

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

Eligibility Requirements under Rhode Island and Federal Law

- An eligible *Child* is defined based on his or her relationship with the participant.
- Limiting eligibility is prohibited based on: financial dependency on the *Subscriber*; residency; student status; employment; eligibility for other insurance; or marital status.
- The terms of coverage for a *Child* under this *Group Contract* 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.

Note: If you fail to enroll for this coverage when first eligible, you may be eligible to enroll yourself and your eligible *Dependents,* (if any), at a later date. This applies only if you did not enroll in this coverage when first eligible because:

- you or your eligible *Dependent* were covered under another group health plan or other health care coverage at that time; or
- you have acquired a *Dependent* through marriage, birth, adoption, or placement for adoption.

In these cases, you or your eligible *Dependent* may enroll for this coverage within 30 days after any of the following events: (i) your coverage under the other health coverage ends involuntarily; (ii) your marriage; or (iii) the birth, adoption, or placement for adoption of your *Dependent Child*.

In addition, you or your eligible *Dependent* may enroll for this coverage within 60 days after either:

- 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*, coverage starts on the date chosen by your *Group*. Coverage for enrolled *Dependents* starts when the *Subscriber's* coverage starts; or at a later date if the *Dependent* becomes eligible for coverage after the *Subscriber*. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

If you or your enrolled *Dependent* is an *Inpatient* on your Effective Date, your coverage starts on the later of:

- the Effective Date; or
- the date *We* are notified and given the chance to manage your care.

Adding *Dependents* Under *Family Coverage*

When *Dependents* may be added

After you enroll, you may apply to add any *Dependents* who are not currently enrolled in *Tufts Health Plan* only as follows:

- during the *Open Enrollment Period* that applies to you; or
- within 30 days after any of the following events:
  - a change in your marital status;
  - the birth of a *Child*;
  - the adoption of a *Child* as of the earlier of:
    - the date the *Child* is placed with you for the purpose of adoption; or
    - the date you file a petition to adopt the Child;
- a court orders you to cover a *Child* through a qualified medical child support order;
- a *Dependent* loses other health care coverage involuntarily;
- a *Dependent* moves into the *Network Contracting Area;* or
- if your *Group* has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add *Dependents*

If you have *Family Plan*, f ill out either a group-approved form or *Tufts Health Plan* form listing the *Dependents*. Give this form to your *Group* either:

- during your *Open Enrollment Period*; or
- within 30 days after the date of an event listed above, under "When *Dependents* may be added".

If you do not have a *Family Plan*, you must ask your *Group* or *Tufts Health Plan* to change your coverage to a *Family Plan*. If you do not, your *Dependents(s)* will not be covered.

Effective Date of *Dependents'* coverage

If *We* accept your application to add *Dependents*, *We* will send you a Member ID card for each *Dependent*.

Effective Dates will be no later than:

- the date of the *Child's* birth, adoption or placement for adoption; or
- 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* that are provided on or after your *Effective Date.*

Newborn *Children* and *Adoptive Children*

Importance of enrolling newborn *Children* and *Adoptive Children*

Newborn Child: You must notify *Tufts Health Plan* of the birth of a newborn *Child* and pay the required *Premium* within 31 days after the date of birth. Otherwise, that *Child* will not be covered beyond the 31-day period. No coverage is provided for a newborn *Child* who remains hospitalized beyond the 31-day period and has not been enrolled in this plan.

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

- Choose a *PCP* from the list of *PCPs* in the searchable *Directory of Health Care Providers* (available on *Our* website) or call a Member Services for help.
- Call the *Provider* and ask him or her to be your newborn or *Adoptive Child's PCP*.
- If he or she agrees, call a 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. 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 coverage. Or the Child may be able to enroll in *Individual Coverage.* See Chapter 5 for more information.

How to continue coverage for *Disabled Dependents*

- About 30 days before the *Child* no longer meets the definition of *Dependent*, call Member Services.
- Give proof*, acceptable to *Us*, of the *Child's* disability.

When coverage ends for a *Disabled Dependent.*

Disabled Dependent coverage ends when the *Dependent* no longer meets the definition of *Disabled Dependent*,; or the *Subscriber* fails to give *Us* proof of *Dependent's* continued disability.

Coverage after termination for a *Disabled Dependent*

The former *Disabled Dependent* may be eligible for federal or state continuation coverage or to enroll in coverage; under an *Individual Contract*. See Chapter 5 for more information.

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

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

Coverage for your divorced *Spouse* continues until:

- either you or your divorced *Spouse* remarry;
- 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 to tell *Us* about your divorce.
- Send *Us* proof of your divorce or separation when asked.

Keeping *Tufts Health Plan's* records current

You must notify *Us* of any changes that affect your or your *Dependents'* eligibility. Examples of these changes are:

- birth, adoption, changes in marital status, or death;
- your remarriage or the remarriage of your former *Spouse*, when the former *Spouse* is an enrolled *Dependent* under your *Family* Coverage;
- moving out of the *Network Contracting Area* or temporarily residing out of the *Network Contracting Area* for more than 90 consecutive days;
- address changes; and
- changes in an enrolled *Dependent's* status as a *Child* or *Disabled Dependent.*

Forms to report these changes are available from your *Group* or Member Services.

Chapter3 -- *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 front of this *Evidence of Coverage* for *Cost Sharing Amounts* and any benefit limits that apply under this plan.

Certain *Covered Services* described in this chapter require **prior approval by an *Authorized Reviewer*.** If prior approval is not obtained, you may have to pay the full cost of those services and supplies

When health care services are *Covered Services*

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

- listed as *Covered Services* in this chapter;
- *Medically Necessary*, as determine by *Tufts Health Plan* or *Our* designee;
- consistent with applicable state or federal law;
- consistent with the *Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available on *Our* website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview** Or you may call Member Services;
- provided to treat an injury, illness, or pregnancy, except for preventive care; and
- obtained within the 50 United States. The only exceptions are *Emergency* care or *Urgent Care* services while traveling, which are *Covered Services* when provided outside of the 50 United States.

Note: Certain services may be available when you are traveling outside of the 50 United States through the *Tufts Health Plan* telemedicine vendor. For more information, visit *Our* website or contact Member Services

https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/digital-tools/telehealth

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

- ***In-Network Level of Benefits*** and ***Out-of-Network Level of Benefits***
- **Prior approval by an *Authorized Reviewer*** and ***Inpatient Notification***
- ***Emergency* care *and Urgent Care***
- ***Inpatient* and Intermediate Behavioral Health and Substance Use Disorder Services**

Acupuncture services

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

The following acupuncture services are not covered:

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

Allergy testing and treatment

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

Ambulance services

- Ground, sea, and air ambulance transportation for *Emergency* care are *Covered Services.*
  - Air ambulance services means transportation by helicopter or fixed wing plan (for example Medflight)
- Non-*Emergency* ambulance transportation is covered only when an *Authorized Reviewer* determines in advance that such services are *Medically Necessary*.

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

Autism spectrum disorders services, including applied behavior analysis (ABA) services

In accordance with Rhode Island law *We* cover diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive *Developmental* disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include:

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

Tufts Health Plan provides coverage for the following *Covered Services.*

- *Habilitative* or rehabilitative services, which are professional, counseling, and guidance services; and
  - treatment programs necessary to develop, maintain and restore an individual's functioning. These programs may include, but are not limited to, applied behavioral analysis (ABA) supervised by a *Board-Certified Behavior Analyst (BCBA)* who is a licensed clinician. Prior approval by an *Authorized Reviewer* is required at both the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*. Under this benefit, ABA includes:
    - the design, implementation, and evaluation of environment modifications,
    - using behavioral stimuli and consequences,
    - to produce socially significant improvement in human behavior;
    - this includes use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
    - For more information call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565.
- Services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers. **Note**: There are no visit limits when services are provided for autism spectrum disorders. Prior approval by an *Authorized Reviewer* is required at both the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.
- Prescription drugs, covered under your "Prescription Drug Benefit".
- Psychiatric and psychological care, covered under your "Behavioral Health and Substance Use Disorder Services" benefit.

Behavioral Health and Substance Use Disorder Services (*Outpatient, Inpatient*, and Intermediate)

*Certain services in this benefit category may require approval by an *Authorized Reviewer*. Your *Tufts Health Plan Provider* is responsible for obtaining any required approval on your behalf. See Behavioral Health and Substance Use Disorder Services in Chapter 1 for more information.

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

***Outpatient* behavioral health services**

Outpatient services to diagnose and treat *Mental Disorders.* This includes individual, group, and family therapy services.

- Individual, group, and family therapies do not require prior approval.
- Prior approval by an *Authorized Reviewer* is required for:
  - Psychological and neuropsychological testing services (covered as "Office visits to diagnose and treat illness or injury");
  - Repetitive transcranial magnetic stimulation (rTMS); and
  - Applied behavioral analysis (ABA).

***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.

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

***Outpatient* substance use disorder services**

Outpatient services to diagnose and treat substance use disorder, including methadone maintenance or methadone treatment related to chemical dependency disorders. Prior approval by an *Authorized Reviewer* is not required at both the *In-Network Level of Benefits* and *Out-of-Network Level of Benefits.*

***Inpatient* and intermediate substance use disorder services**

Inpatient services 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 day treatment/partial hospital programs and intensive *Outpatient* programs. Also see AIS/CFIT above.

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

Cardiac rehabilitation services

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

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

Note: Prior approval by an *Authorized Reviewer* is required at both the *In-Network Level of Benefits* and *Out-of-Network Level of Benefits*

Chemotherapy administration

Administration of chemotherapy. For information about coverage for the medications used in chemotherapy, please see “Injectable, infused, or inhaled medications”.

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, this 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 *Covered Services* furnished in connection with participation in the trial. These include *Covered Services* that are typically covered for a patient who is not enrolled in a clinical trial.

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

- For information about office visits, see "Office visits to diagnose and treat illness or injury"
- For surgical procedures see "*Hospital Inpatient Services*"
- For lab, radiology, and machine tests see "Laboratory Tests" and "Diagnostic Imaging".
- For prescription drugs, see "Prescription Drug Benefit"

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

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

Day Surgery

- *Outpatient* surgery done under anesthesia in an operating room of a facility licensed to perform surgery.
- You must be expected to be discharged the same day and be shown on the facility's census as an *Outpatient*.
- Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.

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*:

- Diabetes self -management education, including medical nutrition therapy.
- 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" later in this chapter);
- Therapeutic/molded shoes for the prevention of amputation (covered under *Durable Medical Equipment* later in this chapter).

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

Coverage includes general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA and PET tests and nuclear cardiology. Diagnostic MRI/MRA, CT/CTA, and PET tests and nuclear cardiology imaging services require approval of an *Authorized Reviewer*. This approval is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.

Diagnostic or preventive screening procedures

Note: Your coverage level will be different for preventive screenings (covered in full) versus diagnostic services (subject to *Member Cost Sharing*).

Coverage for preventive services

Routine screenings and exams are covered in full when provided by a *Network Provider*. This is in accordance with current recommendations of the U.S. Preventative Services Task Force (USPSTF) regarding breast cancer screening, mammography, and prevention.

- Preventive screenings for colon and colorectal cancer. Examples include colonoscopy and sigmoidoscopy screenings.
- Routine annual (Pap test) (cervical cancer screening)
- Routine mammograms. Examples include mammography screenings using 3-D tomosynthesis.
- Routine prostate and colorectal examinations and laboratory tests.

Diagnostic Procedures & Exams:

Diagnostic procedures and exams may be subject to prior approval by an *Authorized Reviewer* and/or *Member Cost Sharing*. For more information, see "Diagnostic or Preventive Screening Procedures" in the "Benefit Overview". Examples include, but are not limited to:

- Diagnostic colon or colorectal procedures. Examples include colonoscopy and proctosigmoidoscopy procedures.
- Diagnostic cytology (Pap test) examinations.
- Diagnostic mammograms. Examples include mammography using 3-D tomosynthesis.
- Diagnostic prostate and colorectal examinations and laboratory tests.

Diagnostic testing

Coverage includes, but is not limited to, ambulatory EKG testing, sleep studies (performed in the home or a sleep study facility), and diagnostic audiological testing. Prior approval by an *Authorized Reviewer* may be required at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*. Call Member Services with questions about specific tests.

Durable Medical Equipment

Equipment must meet this 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, equipment must also be:

- the most appropriate amount, supply, or level of service available for the *Member;*
- considering potential benefits and harms to that individual;
- as determined by *Tufts Health Plan*.

Equipment that *We* determine to be non-medical in nature and used primarily f or non-medical purposes (even though that equipment may have some limited medical use) will not be considered *Durable Medical Equipment* and will not be covered under this benefit.

Note:

- Certain *Durable Medical Equipment* may require *Authorized Reviewer* approval at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits.*
- You may be responsible for paying towards the cost of *Durable Medical Equipment* covered under this plan. See the "*Benefit Overview*" section at the front of this *Evidence of Coverage.*

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

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

- the purchase of a manual or electric (non-hospital grade) breast pump or the rental of a hospital grade electric breast pump for pregnant or post-partum *Members*, when prescribed by a physician (Note: These breast pumps are covered in full at the *In-Network Level of Benefits*);
- gradient stockings (up to three pairs every 365 days);
- oral appliances for the treatment of sleep apnea;
- oxygen concentrators (stationary and portable);
- power/motorized wheelchairs
- prefabricated orthoses such as knee orthosis, ankle orthosis, cervical collar, wrist and/or hand orthosis;
- therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease.

We will decide whether to purchase or rent the equipment for you. At the *In-Network Level of Benefits*, this equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with *Us* to provide such equipment.

Examples of items that are not covered (this list is not all-inclusive). Call Member Services for all questions regarding coverage of *Durable Medical Equipment*:

- air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers;
- articles of special clothing, mattress and pillow covers, including hypo-allergenic versions;
- bath and toilet aids, including, but not limited to: tub seats/benches/stools, raised toilet seats, commodes, rails;
- bed-related items, including bed trays, bed pans, bed rails, bed cradles, over-the-bed trays, and bed wedges;
- car seats; car/van modifications;
- certain wearable devices (e.g. smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g. Fitbit, Biostamp, Embrace smartwatch, Smartmonitor smartwatch, Garmin Vivofit 4, Garmin Vivosmart 3, Samsung Galaxy Fit);
- comfort or convenience devices;
- dentures; ear plugs;
- emergency response systems (e.g., LifeAlert);
- exercise equipment and saunas;
- externally powered exoskeleton assistive devices and orthoses;
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts or stair climbers;
- foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease;
- heat and cold therapy devices, including, but not limited to: hot packs, cold packs and water pumps with or without compression wrap;
- heating pads, hot water bottles, paraffin bath units and cooling devices;
- hot tubs, Jacuzzis, swimming pools, or whirlpools;
- manual home blood pressure monitors with cuff and stethoscope;
- mattresses, except for mattresses used in conjunction with a hospital bed and ordered by *Provider*. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g.,Tempur-Pedic® or Posturepedic® mattresses) are not covered. This is the case even if used in conjunction with a hospital bed, are not covered;
- breast prostheses and prosthetic arms and legs. For more information, see “Orthoses and prosthetic devices” later in this chapter;
- scalp hair prostheses made specifically for an individual, or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury;
- wheelchair trays;

Early intervention services

Services provided to *Members* from birth until their third birthday 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:

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

Emergency care

- Emergency room

Notes:

- See the Benefit Overview about cost sharing (i) for Emergency room services; (ii) for *Observation* services; (iii) if you are admitted as an *Inpatient* after receiving *Emergency* services; (iv) if you receive *Day Surgery* services; or (v) if you register in an Emergency room but leave that facility without receiving care.
- If you receive *Emergency Covered Services* from a *Non-Network Provider*, *We* will pay the *Provider* up to the *Reasonable Charge*. You will only be responsible for the applicable *Cost Sharing Amount*. You may receive a bill for these services. If you receive a bill, see "*Bills from Providers*" in Chapter 6; or call Member Services.

Extended care services

Extended care services are *Skilled* nursing, rehabilitation or chronic disease hospital services that are provided in a Medicare-certified:

- *Skilled* nursing facility;
- rehabilitation hospital; or
- chronichospital.

Notes:

- Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*
- *Custodial Care* is not covered.

Family planning

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

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

Notes:

- Prior approval by an *Authorized Reviewer* is required for family planning procedures at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.
- *We* cover certain contraceptives, such as oral contraceptives, over-the-counter female contraceptives, and diaphragms, under the Prescription Drug Benefit. If those contraceptives are covered under that benefit, they are not covered here.
- In addition, please note that contraceptives and female sterilization procedures are covered in full. To determine whether a specific family planning service is covered in full or subject to a *Cost Sharing Amount*, see **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** and **https://www.hrsa.gov/womensguidelines2016/index.html** Or call Member Services.

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.

Note: Prior approval by an *Authorized Reviewer* is required to receive services from a *Non-Network Provider* at the *In-Network Level of Benefits*.

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. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out of Network Level of Benefits*. Coverage includes:

- home visits by a *Network 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;
- the use of *Durable Medical Equipment*, and
- the services of a part-time home health aide.

Notes:

- Home health care services for speech, physical and occupational therapies may follow an injury or illness. If this occurs, the services for rehabilitation are only covered to the extent provided to restore function lost or impaired. This is described under "Speech, physical and occupational therapy services." However, those 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

Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits.*

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

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

"Hospice care services" are defined as a coordinated licensed program of services provided, during the life of the *Member*, to a terminally ill *Member*. Such services can be provided (i) in a home setting; (ii) on an *Outpatient* basis; and (iii) a short-term *Inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.

Hospital *Inpatient* care (acute care)

- anesthesia;
- diagnostic tests and lab services;
- drugs;
- dialysis;
- intensive care/coronary care;
- nursing care;
- physical, occupational, speech, and respiratory therapies;
- *Provider's* services while hospitalized;
- radiation therapy;
- semi-private room (private room when *Medically Necessary*); and
- surgery (See "Surgery" later in this chapter)

Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Level of Benefits*.

House calls to diagnose and treat illness or injury.

This includes 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 or histocompatibility locus antigen testing

For use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability.

Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.

Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors.

Immunizations and vaccinations

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

Infertility services

Diagnosis and treatment of infertility in accordance with Rhode Island General Law §27-18-30 including 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 covered when provided in connection with an infertility evaluation when approved in advance by an *Authorized Reviewer* at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*.

(II.) Treatment of infertility: Infertility is defined as the condition of a *Member* who has been unable to conceive or produce conception during a period of one year . Attempts at conception to satisfy the diagnosis of Infertility may be done naturally or through artificial insemination. For purposes of meeting the criteria for infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year.

The following procedures are *Covered Services* when approved in advance by an *Authorized Reviewer* at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits* **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 or processing of donor sperm or eggs will be considered *Covered Services* to the extent such costs are not covered by the donor's health care coverage, if any.

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

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

Members who meet the criteria for infertility who also have a documented medical contraindication to pregnancy, are using their own eggs, and are self-paying for a gestational carrier or surrogate, may be authorized for ovarian stimulation, egg retrieval and fertilization. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*. For further details on what services are available to a *Member* who meets the definition of infertility, please see the *Medical Necessity* Guidelines on *Our* website at: **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview** Or call Member Services.

B. Other related treatments including:

- artificial insemination (intrauterine or intracervical);
- gonadotropin medication (FSH);
- artificial insemination (intrauterine or intracervical) used in conjunction with gonadotropin medication; and
- procurement and processing of eggs or inseminated eggs or storage of inseminated eggs when associated with active infertility treatment.
- cryopreservation of eggs (less than 90 days).

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

For more information, please call Member Services and see the *Medical Necessity* Guidelines on *Our* website.

(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 PGD testing at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*. For more information, call Member service. Also see the *Medical Necessity* Guidelines for "Preimplantation Genetic Diagnosis" on *Our* website at: **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview.**

Note: Oral and injectable drug therapies may be used in the treatment of infertility when associated with the *Covered Services* above. These therapies are considered *Covered Services* when (i) the *Member* is covered by a Prescription Drug Benefit; and (ii) the *Member* has been approved for associated infertility treatment. See the Prescription Drug Benefit section for your *Cost Sharing Amount*.

Injectable, infused, or inhaled medications

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

Notes:

- Prior authorization and quantity limits may apply.
- There are designated home infusion *Providers* for a select number of specialized pharmacy products and drug administration services. These *Providers* offer clinical management of drug therapies, nursing support, and care coordination to *Members* with acute and chronic conditions. Medications offered by these *Providers* include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency and enzyme replacement therapy. Please contact Member Services or see *Our* website for more information on these medications and *Providers.*
- Coverage includes the components required to administer these medications, including, but not limited to, hypodermic needles and syringes, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.
- Medications that are listed on *Our* website as covered under a *Tufts Health Plan* pharmacy benefit are not covered under this "Injectable medications" benefit. For more information, call Member Services or check *Our* website.

Laboratory tests

Coverage includes, but is not limited to, blood tests, urinalysis, throat cultures, glycosylated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles.

Notes:

- Laboratory tests must be ordered by a licensed *Provider* (e.g., a physician, physician assistant, or nurse practitioner) and performed at a licensed laboratory.
- Prior approval by an *Authorized Reviewer* is required for some laboratory tests at the *In-Network* and *Out-of-Network Levels*. An example of this is genetic testing. For a complete list of laboratory tests subject to prior approval, see the *Medical Necessity* Guidelines on *Our* website.
- Please note that 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 screening

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 anti-biotic 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 are covered:

- 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).

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

Note: Cosmetic surgery is not covered

Maternity care

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" for information on your *Cost Sharing Amounts* for these services,

Inpatient coverage includes:

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

The newborn *Child's* coverage consists of coverage of injury or sickness. This includes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, as well as routine well-baby care services.

No prior approval 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 and 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. (This may be the attending obstetrician, pediatrician, family practitioner, general practitioner, or certified nurse midwife attending the mother and newborn *Child*).

Under this Maternity benefit, you may choose to receive certain services from a doula**.** A "doula" or "perinatal doula" is a trained non-medical professional who provides physical, emotional, and informational support to pregnant individuals and their partners before, during, and after pregnancy. Doulas are not medical professionals. They do not deliver babies, provide medical diagnosis, treatment, or advice. They do not administer medications.

Doula services are covered per pregnancy as follows (no prior approval required). Please call Member Services at (802) 682-8059 to locate a doula.*

- Up to two (2) visits before birth (in-person or via telemedicine)
- Attendance during labor and delivery

After delivery, *Covered Services* (in-person or via telemedicine) include:

- one (1) home visit by a registered nurse, certified nurse midwife, or other *Provider* or
- two (2) home visits by a certified doula.

Additional home visits may be included when *Medically Necessary*. Examples of *Covered Services* include, but are not limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any clinical tests, as appropriate.

*When you choose a certified doula in *Our* network, you will be covered at the ***In-Network Level of Benefits***. If Covered Services are received from a non-contracted doula who is practicing in accordance with applicable laws (if any), services are covered at the *Out-of-Network Level of Benefits*.

Notes

- Travel expenses and mileage for an in-home visit by any *Provider,* including a doula*,* are not covered.
- Duplicative *Covered Services* within a doula's area of professional competence will not be reimbursed. If a doula provides a *Covered Service*, that same service will not also be covered when received from another *Provider*; and if another *Provider* provides a *Covered Service*, that same service will not also be covered when received from a doula. As an example, if you receive lactation services from a doula, we do not cover those services from another *Provider* such as a registered nurse or lactation consultant.
- The following are not covered doula services or expenses:
  - Any childcare services or services for children other than the newborn
  - Housekeeping assistance

Doula services provided in connection with home births (since home births are not *Covered Services* under this plan).

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

We cover the cost of certain types of medical supplies, including ostomy, tracheostomy, and catheter supplies, and insulin pumps. The supplies must come from an authorized vendor.

Note: Call Member Services with coverage questions. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*.

Nutritional counseling

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

- when *Medically Necessary*, for the purpose of treating an illness. See the "Nutritional Counseling" in the "Benefit Overview" for the applicable *Cost Sharing Amount*; or
- as preventive services, including preventive obesity screening and counseling services, healthy diet counseling, and behavior change and counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full at the *In-Network Level of Benefits*.

Note: Weight loss programs and clinics are not covered.

Office visits to diagnose and treat illness or injury

Coverage includes, but is not limited to, office visits for evaluations and consultations; *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions and visits to a *Limited Service Medical Clinic*. For coverage of services may be related to these office visits, see "Diagnostic imaging", "Diagnostic tests", and "Laboratory tests".

Oral health services

The services described in this section are in addition to services described under "Pediatric dental care for *Members* up to age 19" later in this chapter.

The following oral services are covered. Before receiving a service, call Member Services to determine if the service is a *Covered Service*.

- *Emergency* care

  X-rays and *Emergency* oral surgery in an Emergency room to temporarily stabilize damaged tissues or reposition sound, natural and permanent teeth that have moved or have broken due to injury. You must receive this care within 48 hours after the injury. The injury must have been caused by a source outside the mouth.
- Non-*Emergency* care (See "Pediatric dental care for *Members* under age 19" for coverage under that benefit)

  The following services are covered, with the prior approval of an *Authorized Reviewer*, in an *Inpatient* or *Day Surgery* setting, and include hospital/facility, *Provider*, and surgical charges:
  - Extraction of seven or more permanent teeth during one visit
  - Surgical treatment of skeletal jaw deformities
  - Surgical repair related to Temporomandibular Joint Disorder

  In addition, surgical removal of impacted or unerupted teeth when embedded in bone is covered in an *Inpatient, Day* Surgery, or office setting. *Covered Services* include hospital/facility, *Provider*, and surgical charges. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits* only if the services are received in an *Inpatient* or *Day Surgery* setting.

  Important Notes:
  - Certain services may be covered under the "Pediatric dental care for *Members* up to age 19" benefit later in this chapter. Please see that benefit for more information, including information about prior approval requirements.
  - See *Our* website **https://tuftshealthplan. com/member/employer -individual-or-family-plans/tools-resources/overview** to view guidelines for these services in an *Inpatient* setting, entitled "Dental Procedures Requiring Hospitalization". Call Member Services for additional information.
  - Coverage does not apply to Non-*Emergency* oral health services provided by a dentist. *Members* must receive these services from an oral surgeon.
  - X-rays performed in association with Non-*Emergency* oral health services are covered as described under "Diagnostic imaging."

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 approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out of Network Level of Benefits*.

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

Breast prostheses are covered as required by federal law. Breast prostheses require prior approval by an *Authorized Reviewer* EXCEPT when provided in connection with a mastectomy as required by Rhode Island law.

Pap tests (cervical cancer screening)

One annual screening for women age 18 and older, or as otherwise *Medically Necessary*.

Preventive health care

Important Information about Preventive Services:

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

- Preventive screenings are covered in full (1) In accordance with the Affordable Care Act and current recommendations of the U.S. Preventive Services Task Force (USPSTF) and (2) when received from a *Network Provider*. For a current list of preventive services, please see *our* website at: **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services**. If you have any questions about whether specific services are consid ered 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 through 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 office visit *Cost Sharing Amount*.

Preventive health care for *Members* age 20 and older

- Routine physical examinations, which include appropriate immunizations and lab tests as recommended by a *Network Provider* ;
- Routine annual gynecological exam, which includes any follow-up obstetric or gynecological care *We* decide is *Medically Necessary* based on that exam; 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* at the *In-Network Level of Benefits*.
- If you have any questions about whether specific services are considered preventive under the ACA, please call Member Services.

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

Coverage is provided for private duty nursing services that are:

- *Medically 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 approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits* 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.

Radiation therapy

Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*.

Respiratory therapy/pulmonary rehabilitation services

Scalp hair prostheses or wigs

Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.

Smoking cessation counseling services

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

- are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
- meet the requirements of the federal Patient Protection and Affordable Care Act.
- meet the requirements of the Rhode Island Office of the Health Insurance Commissioner Regulation 14.

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

Special medical formulas

A *Provider* must prescribe the following. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*.

Low protein foods:
When given to treat inherited diseases of amino acids and organic acids.

Non-prescription enteral formulas:
For home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

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

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 include cognitive rehabilitation and retraining. Prior approval by an *Authorized Reviewer* is required.

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* website. Or call Member Services.

Note: Separate speech, physical and occupational therapy visit limits for *Habilitative* services and rehabilitative services are described in the Benefit Limit section at the beginning of this document.

Surgery -- Hematopoietic stem cell transplants, and human solid organ transplants

Services provided to *Members*.

- Requires prior approval by an *Authorized Reviewer.*
- Must be provided at a *Tufts Health Plan* designated transplant facility.
- *We* pay for charges incurred by the donor in donating the 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 "*Outpatient* medical care" for more information.

Surgery -- in a *Provider's* office

Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.

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

Services must be approved in advance by an *Authorized Reviewer* at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*. *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.

Surgery -- Reconstructive surgery and procedures, and 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. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits.*

Telemedicine services

We cover *Medically Necessary* telemedicine services for the purpose of diagnosis, consultation, or treatment in the same manner as an in-person consultation. Telemedicine services substitute for an in-person consultation with a *Network Provider* when determined to be *Medically Necessary* and clinically appropriate. Visits are available for both medical and behavioral health/substance use disorder services.

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

You may receive telemedicine services from:

- A *Network* or *Non-Network Provider*. You will follow the same referral rules and pay the same *Cost Sharing Amount* for a telemedicine visit as an in-person office visit with that *Provider*.
- Our designated telemedicine vendor. These services are referred to as "telehealth services"

See "Telemedicine services" in the Benefit Overview for applicable *Cost Sharing Amounts.*

Important Note: Certain telemedicine services, for example, remote patient monitoring, are only available through a *Network Provider*, not through our designated telemedicine vendor.

Urgent Care

This plan covers *Urgent Care* services. These are services provided to you when your health is not in serious danger; but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed include:

- a broken or dislocated toe
- a cut that needs stitches but is not actively bleeding
- sudden extreme anxiety;

- symptoms of a urinary tract infection

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

Important Notes: See "*Emergency* and *Urgent Care*" in Chapter 1 for details. See "*Emergency* and *Urgent Care*" in Chapter 1 for details about *Urgent Care* at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*.

Vision care services

Routine eye examination for *Members* age 19 and over: Coverage is provided for one routine eye examination every Contract Year. (*In-Network* and *Out-of-Network Levels* combined.) **Note:** You must receive routine eye examinations from a *Provider* in the **EyeMed Vision Care** network. See Our website or contact Member Services for more information.

Other vision care services:
Coverage is provided for eye examinations and necessary treatment of a medical condition. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.

Note:

- One pair of eyeglass lenses and standard frames will be covered following a *Member's* cataract surgery or other surgery to replace the natural lens of the eye in each *Contract Year*, when the *Member* does not receive an intraocular implant. See "Benefit Overview" earlier in this document to determine the *Cost Sharing Amount* applicable to these lenses and frames. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*. 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

Pediatric vision care for *Members* under age 19

Limitations and *Cost Sharing Amounts* for pediatric vision care are described in the "Benefit Overview" section earlier in this document.

Note: For these pediatric services, "under age 19" means the last day of the month in which a *Member's* 19th birthday occurs.

Diagnostic Benefits

Eye Exam:

- New patient exam;
- Established patient exam;
- Routine eye exam with refraction for new or established patient.

Contact Lens Fit and Follow-Up:

- Standard contact lens fit and follow-up;
- 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 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

Other Pediatric 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
- Photochromatic/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. See "Benefit Overview" for more information

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.

Important *Providers* information : Call EyeMed at 1-866-939-3633 for the names of EyeMed providers and to receive a prior authorization number.

Pediatric dental care for *Members* up to 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 toll free at 844-241-5612. Or visit their website: **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 f rom 8:00 am – 5:00 pm. To find a participating provider you may also visit **http://www.dentaquest.com**.

Dental claims and written correspondence should be sent to:
DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906

The following are examples of covered dental services under the dental categories covered under this plan:

Basic services

Preventive and Diagnostic

- 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*
- 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*

Intermediate services

Minor restorative

- 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**

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

Major services:
Services listed in this section are subject to dental review and alternate benefit. Pre-treatment estimate is recommended.

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**

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*

Orthodontia

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

You will pay more for services received from a dentist who does not belong to the Denta Quest contracted network ("out-of-network" or non-participating dentist). If you visit a non-participating dentist (i.e., a dentist who is "out-of-network"), after you pay any applicable *Deductible* and the schedule amount, you may also pay the difference between the non-participating dentist's charge and the amount *We* pay. The Denta Quest payment varies.

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 will be considered *Covered Services* only if they comply with the "*Tufts Health Plan* Pharmacy Management Programs" section described below and are: (i) listed below under "What is Covered"; (ii) approved by the United States Food and Drug Administration (FDA); (iii) provided to treat an injury, illness, or pregnancy; and (iv) *Medically Necessary*;

The "Prescription Drug Benefit" table in the Benefit Overview describes your prescription drug . *Tier-1* drugs have the lowest level *Cost Sharing Amount*. *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 *Cost Sharing Amount*.

What is Covered

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

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that
  - by law require a prescription; and
  - are not listed under "What is Not Covered": (see "Important Notes" below).
- Test strips for glucose monitors and/or visual aid reading, Insulin, syringes, injection aids, cartridges for the legally blind; oral agents for controlling blood sugar levels, [and continuous glucose monitors (CGMs) and related CGM supplies. Some of these products may be subject to prior authorization].
- 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, contraceptive spermicides) when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription, are covered in full.
  - 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.
  - Certain brand-name contraceptives may be subject to prior authorization.

Note: This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, and other self -administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives (e.g., female condoms, contraceptive spermicides) when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription. See "Family planning" earlier in this chapter for information about other contraceptive drugs and devices that qualify as *Covered Services*.

- Fluoride for *Children*.
- Injectables and biological serum included in the list of covered drugs on *Our* website. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered. For more information, call Member Services or see *Our* website.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, in the medical literature, or by the commissioner of insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law and is FDA -approved. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, call Member Services.
- Over-the-counter drugs included in the list of covered drugs on the formulary applicable to your plan when prescribed by a *Provider*. You can find the formulary on *Our* website **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies** Or you can call Member Services for more information.
- Prescription smoking cessation agents.
- Certain medications used for bowel preparation in colonoscopy procedures are covered in full for *Members* ages 45 through 74. For more information, please call Member Services or see the formulary on *Our* website.

Note: Certain prescription drug products may be subject to one of the "*Tufts Health Plan* Pharmacy Management Programs" described below.

What is Not Covered

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

- Acne medications, unless *Medically Necessary*.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent (these are covered under your *Outpatient* care benefit earlier in this chapter), oral contraceptives, diaphragms and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved female over-the-counter contraceptives when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription.
- Compounded medications, if no active ingredients require a prescription by law.
- Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may also not be covered. For more information, call Member Services or check *Our* website.
- Drugs for asymptomatic onychomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Drugs that are dispensed in an amount or dosage that exceeds *Our* established quantity limitations.
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Homeopathic medications purchased with a prescription or over-the-counter.
- Immunization agents. These may be provided under "Preventive health care" earlier in this chapter.
- Medications for the treatment of idiopathic short stature.
- Oral non-sedating antihistamines.
- Over-the-counter medications if not included on the list of covered drugs on *Our* website.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check *Our* website.
- Prescription medications when co-packaged with non-prescription products.
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.
- Products that are FDA approved as devices, including therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Topical and oral fluorides for adults.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, and fluoride for *Children*
- [Weight-loss drugs.]
- Medications packaged for institutional use may be excluded from the pharmacy benefit coverage.

Tufts Health Plan Pharmacy Management Programs

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

Quantity Limitations Program

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

Prior Authorization Program:

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

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

Medication Synchronization (Med Sync)
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.

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

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

Formulary Exception Process

Your *Provider* may feel it is *Medically Necessary* for you to take medications that:

- are not on the formulary; or
- are restricted under any of the "*Tufts Health Plan* Pharmacy Management Programs".

An exception request may be submitted for any of O*ur* 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
1 Wellness Way
Pharmacy Utilization Management Department
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 medication will be covered on this 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.
  - 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 a *Member* Specialist at 800-463-8080
  By mail, submit your appeal in writing to:
  Tufts Health Plan
  Attn: Appeals and Grievances Department
  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.

***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* website has a list of covered drugs with their tiers.** *We* may change a drug's tier during the year. For example:

- If a brand drug's patent expires, *We* may change the drug's status by 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* website at **www.tuftshealthplan.com;** or call Member Services at 800-463-8080.

Filling Your Prescription

Where to Fill Prescriptions:

Fill your prescriptions at a *Tufts Health Plan* designated pharmacy. *Tufts Health Plan* designated pharmacies include:

- for the majority of prescriptions, most of the pharmacies in Massachusetts, New Hampshire, and Rhode Island, and additional pharmacies nationwide; and

How to Fill Prescriptions:

- When you fill a prescription, provide your Member ID to any *Tufts Health Plan* designated pharmacy and pay your *Cost Sharing Amount*.
- If The cost of your prescription may be less than your *Copayment*, In this case, you are only responsible for the actual cost of the prescription.
- If you have any problems using this benefit at a *Tufts Health Plan* designated pharmacy, call Member Services.

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

Filling Prescriptions for Maintenance Medications:

You may need to take a "maintenance" medication If you do, *We* offer you two choices for filling your prescription:

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

  *The following may not be available to you through a *Tufts Health Plan* designated mail services pharmacy:
  - medications for short term medical conditions;
  - certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
  - medications that are part of *Our* Quantity Limitations program; or
  - medications that are part of *Our* Designated Specialty Pharmacy program.

Note: See the Benefit Overview at the front of this *Evidence of Coverage* for your prescription drugs *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. Any service, supply or medication is excluded:
   - That is not a *Covered Service* as defined in Appendix A and described in Chapter 3.
   - That is not *Medically Necessary* as defined in Appendix A and described in Chapter 3.
   - That is not essential to treat an injury, illness or pregnancy, except for preventive care services.
   - If it is obtained outside of the 50 United States. The only exception to this rule is for *Emergency* care services or *Urgent Care* services while traveling, which qualify as *Covered Services* when provided outside of the 50 United States.
   - That is related to non-*Covered Services.* This does not apply to complications of pregnancy terminations.
   - That is primarily for your, or another person's, personal comfort or convenience.
   - If there is a less intensive level of service, supply, or medication, or more cost-effective alternative, that can be safely and effectively provided.
   - If the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
   - That is required by a third party that is not otherwise *Medically Necessary* (examples of a third party are an employer, an insurance company, a school, or court).
   - That you are not legally obligated to pay for, or you would not be charged for if you have no health plan.
   - That is provided to you by a relative who is a *Provider;* or that is provided to you by an immediate family member (by blood or marriage), even if that relative is a *Provider* and the services are authorized by your *PCP.* Please note: if you are a *Provider*, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).
   - That is provided to a non-*Member*, except as described in Chapter 3 for the following:
     - bereavement counseling services under **Hospice care services.**
     - the costs of procurement and processing of donor sperm, eggs or inseminated eggs, or banking of donor sperm or inseminated eggs, under **Infertility services** (to the extent such costs are not covered by the donor's health coverage, if any).
     - organ donor charges under **Surgery – Hematopoietic stem cell transplants, and human solid organ transplants.**
2. *We* do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including, but not limited to: therapeutic schools, camps, wilderness, or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound. *We* will provide coverage for *Medically Necessary Outpatient* or intermediate behavioral health services provided by licensed behavioral health *Providers* while the *Member* is in a tuition-based program, subject to plan rules, including any network requirements or *Cost Sharing*.
3. Any additional fee a *Provider* may charge as a condition of access, or any amenities that access fee is represented to cover is excluded. Please consult with your *Provider* to see if he or charges such a fee.
4. Any care for conditions that (a) have benefits available under worker's compensation, Medicare, or other government programs (except Medicaid) or (b) must be treated in a public facility under state or local law.
5. Any drug, medicine, material or supply for use outside of the hospital or any other facility, except as described in Chapter 3.
6. Medications and other products that can be purchased over-the-counter except those listed as covered in Chapter 3.
7. Charges incurred when the *Member*, for his or her convenience, has chosen to remain an *Inpatient* beyond the discharge hour

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.

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

Acupuncture services are excluded except as described in Chapter 3. Excluded services include:

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

Dental care

The following dental care services, treatments, and supplies are not covered unless (a) an exception is specifically stated in these exclusions, or (b) such dental care services, treatments, and supplies are described as a *Covered Service* in Chapter 3; or for *Covered Services* described under the **Pediatric dental care for *Members* up to age 19** benefit in Chapter 3.

- 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 except as provided under **Pediatric dental care for *Members* under age 19** in Chapter 3.
- Restorative services including, but not limited to: crowns, fillings, root canals, and bondings.
- Skeletal jaw surgery, except as provided under **Oral health services** in Chapter 3.
- Splints and oral appliances (except for sleep apnea, as stated under ***Durable Medical Equipment*** in Chapter 3).
- Surgical removal or extraction of teeth, except as provided under **Oral health services** and **Pediatric dental care for *Members* up to age 19** in Chapter 3.
- TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies.

The following pediatric dental care services, treatments, and supplies are <u>not covered</u> 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.
- 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 change or 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.

Durable Medical Equipment (DME), orthoses, or prosthetic devices

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

- Air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers.
- Articles of special clothing, mattress and pillow covers, including hypo-allergenic versions.
- Bath and toilet aids, including, but not limited to: tub seats/benches/stools, raised toilet seats, commodes, and rails.
- Bed related items, including bed trays, bed pans, bed rails, bed cradles, over-the-bed tables, and bed wedges.
- Car seats.
- 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);
- Car/van modifications.
- Comfort or convenience devices.
- Dentures.
- Ear plugs.
- Emergency response systems (e.g., LifeAlert).
- Exercise equipment and saunas.
- Externally powered exoskeleton assistive devices and orthoses.
- Fixtures to real property, such as ceiling lifts, elevators, ramps, and stair lifts or stair climbers.
- Foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease.
- Heat and cold therapy devices, including, but not limited to: hot packs, cold packs and water pumps with or without compression wrap.
- Heating pads, hot water bottles, paraffin bath units, and cooling devices.
- Hot tubs, Jacuzzis, swimming pools, or whirlpools.
- Manual home blood pressure monitors with cuff and stethoscope.
- Mattresses, except for mattresses used in conjunction with a hospital bed and ordered by a *Provider*. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g., Tempur-Pedic® and Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered.
- Wheelchair trays.

Experimental or Investigative

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

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

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

Family planning

- Costs associated with home births.
- 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 are not covered except as described in Chapter 3. Specifically, such services are excluded for *Members* who do not meet the definition of infertility provided under **Infertility services** in Chapter 3, except for *Covered Services* described under section (III.) Preimplantation Genetic Diagnosis (PGD) testing with IVF. Other exclusions include:

- Costs associated with donor recruitment and compensation.
- Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an *Authorized Reviewer* and the *Member* is the sole recipient of the donor's eggs.
- Experimental infertility procedures.
- Infertility services necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
- Long-term (more than 90 days) sperm or embryo cryopreservation unless the *Member* is in active infertility treatment. *We* may approve short-term (less than 90 days) cryopreservation of sperm, oocytes, or embryos for certain medical conditions that may impact a *Member's* future fertility.
- Reversal of voluntary sterilization.
- The costs of surrogacy, which means all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*. These costs include but are not limited to: (1) use of donor egg and a gestational carrier; (2) costs for the drugs necessary to achieve implantation in a surrogate, embryo transfer, and cryo-preservation of embryos; and (3) costs for maternity care if the surrogate is not a *Member*.

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

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

Prescription drugs

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

- Acne medications, unless *Medically Necessary.*
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent (these are covered under your "Family planning" benefit earlier in this chapter).
- Compounded medications, if no active ingredients require a prescription by law.
- Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may also not be covered. For more information, call Member Services or check *Our* website.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).

- Drugs for asymptomatic onychomycosis, except for *Members* from diabetes, vascular compromise, or immune deficiency status.
- Drugs that by law do not require a prescription (unless listed as covered in the *What is Covered* section in Chapter 3).
- Drugs that are dispensed in an amount or dosage that exceeds *Our* established quantity limitations.
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Homeopathic medications purchased with a prescription or over-the-counter.
- Immunization agents. These may be provided under **Immunizations and vaccinations** in Chapter 3.
- Medications for the treatment of idiopathic short stature.
- Oral non-sedating antihistamines.
- Over-the-counter medications if not included on the list of covered drugs on the website.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered, and the entire class of prescription medications may also not be covered. For more information, call Member Services or check *Our* website.
- Prescription medications when packaged with non-prescription products.
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.
- Products that are FDA approved as devices, including therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Topical and oral fluorides for adults.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, and fluoride for *Children*).
- Medications packaged for institutional use may be excluded from the pharmacy benefit coverage.

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, procedures, supplies, medications or appliances.
- Hair removal (for example, electrolysis, laser hair removal), except when *Medically Necessary* (1) to treat an underlying skin condition; or (2) for skin preparation for transgender genital surgery that has been approved by an *Authorized Reviewer*.
- Liposuction or brachioplasty.
- Removal of tattoos.
- Reversal of gender reassignment surgery.
- Rhinoplasty, except as provided under **Reconstructive procedures and surgeries to treat functional deformity or impairment** in Chapter 3.
- Treatment of spider veins; removal or destruction of skin tags.

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

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

- Biofeedback, except for the treatment of urinary incontinence.
- Hypnotherapy.
- Massage therapies, cognitive rehabilitation programs and cognitive retraining programs, except as described under **Speech, physical and occupational therapy services (includes rehabilitative and *Habilitative* services)** in Chapter 3.
- Neuromuscular stimulators and related supplies.
- Psychoanalysis.

Transplants

Transplants are not covered except as described in Chapter 3.

Transportation

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

Vision care

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

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

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

- 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 covered 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 acceptable standards of optometric practice.
- Services provided after a date a *Member* ceases to be covered under the plan, except when covered vision materials ordered before coverage ended are delivered; and the services provided to the *Member* are within 31 days from the date of such order.
- Special lenses, designs, or coatings other than those described as *Covered Services.*
- Two pairs of eyeglasses in lieu of bifocals

Other exclusions under this plan

- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products are not covered, except for the following:
  - Blood processing.
  - Blood administration.
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency) and von Willebrand disease. Prior approval by an *Authorized Reviewer* is required for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological infectious conditions, and bleeding disorders. (Prior approval by an *Authorized Reviewer* is required for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*).
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually provided and/or able to be validated).
- *Custodial Care.*
- Facility charges or related services if the procedure being performed is not a *Covered Service*, except as provided under **Oral health services** in Chapter 3.
- Hearing aids, except as described in Chapter 3.
- *Inpatient* and *Outpatient* weight-loss programs and clinics; relaxation therapies; services by a personal trainer; and exercise classes (diagnostic services related to any of these excluded programs or procedures are also excluded).
- Laboratory tests ordered by a *Member* (online or through the mail), even if they are performed at a licensed laboratory.

- Lodging related to receiving any medical service, including lodging related to obtaining gender reassignment surgery or related services.
- Multi-purpose general electronic devices including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets and smartphones. All accessories for multi-purpose general electronic devices including USB devices and direct connect devices (e.g., speaker, microphone, cables, cameras, batteries, etc.). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet, and all related accessories.
- Nutritional counseling, except as described under **Nutritional counseling** in Chapter 3.
- Private duty nursing (block or non-intermittent nursing).
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.
- Service or therapy animals and related supplies.
- Snoring reduction devices and procedures, including, but not limited to: laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

Chapter 4 -- When Coverage Ends

Reasons coverage ends

This coverage is guaranteed renewable to the extent required by federal law (45 C.F.R. 148.122), and may only non-renew or cancel coverage under the plan for the following reasons, when applicable: non-payment of premiums, fraud, market exit, movement outside of the *Network Contracting Area*, or cessation of bona f ide association membership. Specifically, your coverage (including federal COBRA 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 *Network Contracting Area*; or
- you choose to drop coverage; or
- you commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to any *Provider*, any *Tufts Health Plan Member*, 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* and Notice" later in this chapter.)

Note: *Children* are not required to live, work, or reside in the *Network Contracting Area.* Please see "If you do not live, work or reside in the *Network Contracting Area*" in Chapter 2 for more information.

Benefits after termination

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 required medical care after your coverage ended.

Continuation

Once your coverage ends, you may be eligible to continue your coverage with your *Group* or to enroll in coverage under an *Individual Contract*. See Chapter 5 for more information.

When a *Member* is No Longer Eligible

Loss of eligibility

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

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

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.

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

If you are a *Subscriber* or *Spouse* coverage ends as of the date you no longer live, work, or reside As noted above, *Dependent* coverage ends when the *Subscriber's* coverage ends, See Chapter 2.

Before you no longer live, work, or reside in the *Network Contracting Area* tell your *Group* or call a Member Services to notify *Us.* Call Member Services for more information about coverage when you no longer live, work, or reside in the *Network Contracting Area* contact a Member Services. Also, see "If you do not live, work or reside in the Network Contracting Area" in Chapter 2 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* (or *Tufts Health Plan* if covered under an *Individual Contract)* at least 30 days before the date you want your coverage to end. You must pay *Premiums* up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

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

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

Membership Termination or Rescission for Misrepresentation or Fraud

Policy

We may terminate your coverage for misrepresentation or fraud. 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 a non-group or another employer's plan) or type of coverage (for example, coverage as a *Dependent* or *Spouse*).

Acts of misrepresentation or fraud

Examples of misrepresentation or fraud include:

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

Date of termination

If *We* terminate your coverage for misrepresentation or fraud, your coverage will end as of your *Effective Date* or 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 after termination for acts of misrepresentation or fraud

We will pay for all *Covered Services* you received between (i) your *Effective Date*; and (ii) your termination date, as chosen by *Us*. *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.

If the *Premium* is not enough to pay for that care, *Tufts Health Plan*, at its option, may:

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

If the *Premium* is more than is needed to pay for *Covered Services* you received after your termination date, *We* will refund the excess to your *Group*.

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

- the validity of the *Group Contract* will not be contested, except for non-payment of *Premiums*, after the *Group Contract* has been in force for two years from its date of issue; or

- no statement made for the purpose of effecting insurance coverage with respect to a *Member* under this *Group Contract* shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits thereunder after that *Member's* insurance under this *Group Contract* has been in force for a period of two years during his or her lifetime, nor unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to him or her.

Termination of a *Group Contract*

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

If you are 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.

*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 Contract* will apply during the extension of benefits.

The extension of benefits will end on the earliest of:

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

Transfer to Other Employer Group Health Plans

Conditions for transfer

If you enrolled under a *Group Contract*, you may transfer from *Tufts Health Plan* to any other health plan offered by your *Group* only as follows, if both your *Group* and the other health plan agree:

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

Chapter 5 -- Continuation of *Group Contract* Coverage

Federal Continuation Coverage (COBRA)

Rules for federal COBRA continuation

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

Qualifying Events

A *Member's Group* coverage under the *Group Contract* may end because he or she experiences a qualifying event. A qualifying event is defined as:

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

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

When federal COBRA coverage is effective

A *Member* who is eligible for federal COBRA continuation coverage is called a "qualified beneficiary." A qualified beneficiary must be given an election period of 60-days to choose whether to elect federal COBRA continuation coverage. This period is measured from the later of the date the qualified beneficiary's coverage under the *Group Contract* ends (see the list of qualifying events described above) or the date the plan provides the qualified beneficiary with a COBRA election notice.

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

Cost of Coverage

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

Duration of Coverage

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

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

When coverage ends

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

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

Rhode Island Continuation Coverage

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

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

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

Coverage under an *Individual Contract*

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

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military 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 had not been absent due to military service, or, in some cases, a comparable job.
- If you are a past or present member of the uniformed service, have applied for membership in the uniformed service, or are obligated to service in the uniformed service, then an employer may not deny you initial employment, reemployment, retention in employment, promotion, or any benefit of employment because of this status. In addition, an employer may not retaliate against any assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your *Dependents* for up to 24 months while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (for example, pre-existing condition exclusions) except for service-connected illnesses or injuries.
- Service members may be required to pay up to 102% of the premium for the health plan coverage. If coverage is for less than 31 days, the service member is only required to pay the employee share, if any, for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1 -866-4-USA-DOL or visit its website at **www.dol.gov/vets**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact your *Group.*

Chapter 6 -- How to File a Claim and *Member* Satisfaction

How to File a Claim

Network Providers

When you receive care from a *Network Provider*, you do not have to submit claim forms. The *Network Provider* will submit claim forms to *Us* for you. *We* will make payment directly to the *Network Provider*.

Non-Network Providers

When you receive care from a *Non-Network Provider*, you may have to file a claim form. Claim forms are available from the *Group* or *Tufts Health Plan* (see "To Obtain Claim Forms" below).

Hospital Admission or *Day Surgery*

When you receive care from a hospital that is a *Non-Network Provider*, have the hospital complete a claim form. The hospital should submit the claim form directly to us. If you are responsible for any portion of the hospital bill, *We* will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the *Non-Network Hospital*.

Outpatient Medical Expenses

When you receive care from a *Non-Network Provider*, you are responsible for completing claim forms. (Check with the *Non-Network Provider* to determine if he or she will submit the claim directly to *Us* for you or whether you will be required to submit the claim form directly to us yourself.)

If you sign the appropriate section on the claim form, *We* will make payment directly to the *Non-Network Provider*. If you are responsible for any portion of the bill, *We* will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the *Non-Network Provider*.

If you do not sign the appropriate section on the claim form, *We* will make the payment directly to you. If you have not already paid, you will be responsible for paying the *Non-Network Provider* for services you received. If you are responsible for any portion of the bill above what *We* pay, *We* will send you an explanation of benefits statement. The explanation of benefits statement will tell you how much you owe the *Non-Network Provider.*

To Obtain Claim Forms

Claim forms are available from the *Group* or by calling Member Services.

Where to Forward Medical Claim Forms

Send completed claim forms to:

Tufts Health Plan
Claims Department
P.O. Box 9185
Watertown, MA 02472-9185

Submit separate claim forms for each family member.

Pharmacy Expenses

If you obtain a prescription at a non-designated or out-of-network pharmacy, you must pay for the prescription up front; then you must submit a claim for reimbursement. Call Member Services for claim forms. Or visit *Our* website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/forms-documents/forms-documents#**

Member Satisfaction Process

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

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

Tufts Health Plan
Attn: Appeals and Grievances Dept.
P.O. Box 9193
Watertown, MA 02472-9193

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

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

You can also call us at **800-463-8080**. Alternatively, you may submit your appeal or grievance in person at the above address.

Internal Inquiry:

Call a *Tufts Health Plan Member* Specialist to discuss concerns you have about your health care coverage. *We* will make every effort to resolve your concerns you may choose to file a grievance or appeal. You will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

We maintain records of each inquiry made by a *Member* or by that *Member's* authorized representative.

Member Grievance Process

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

It is important that you contact us as soon as possible to explain your concern. Grievances may be f iled 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 Analyst 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 P.O. Box 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 (including relevant dates, any applicable medical information, and *Provider* names); and
- any supporting documentation.

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

Administrative Grievances

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

Administrative Grievance Timeline

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

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. You may have concerns about your medical care. If so, you should discuss them directly with your *Provider*. If you are not satisfied with your *Provider's* response (or do not wish to address your concerns directly with your *Provider*) 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* or its delegate based on:

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

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

It is important that you 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) to file an internal appeal.

Appeals may be filed either verbally or in writing. You may file a verbal appeal. To do this, call Member Services. A Member Specialist 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 P.O. Box address listed earlier in this section. You can also submit your appeal in person at the address listed at the beginning of this chapter.

Your explanation should include;

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

Appeals Timeline

- Within 48 hours of receiving your appeal, *We* will notify you in writing. *Our* letter will include the (1) name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your appeal; and (2) a summary of *Our* understanding of your concerns.
- *Tufts Health Plan* or its delegate will review your appeal and make a decision. *Tufts Health Plan* will send you a decision letter within thirty (30) calendar days of receipt.

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

When Medical Records are Necessary

Your appeal may require the review of medical records. In this event, you will receive a form. You must sign the form to authorize your *Providers* to release to medical information relevant to your appeal to *Tufts Health Plan*. You must sign and return the form to *Us* before *Tufts Health Plan* or its delegate can begin the review process. If you do not sign and return 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.

Note: Prior to issuing any adverse benefit determination, the review process will comply with Rhode Island law 27 -18.9-7 (b)(3).

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. If you feel that your request meets the criteria above, you or your attending *Provider* should contact *Member* Services. *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 the 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.

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) who perform independent external reviews. Assignment of IROs to perform these external reviews is on a rotational basis as directed by the 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.

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

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 (5) business days for standard appeals and two (2) business days of receipt of your written request, *Tufts Health Plan* will forward the complete review file, including the criteria utilized in rendering its decision, to the IRO.

The IRO'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 its external appeal decision to uphold or overturn the appeal:

- no more than 10 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 you of any additional procedures that you need to take in order to obtain the requested coverage or services;
- advise you of the date by which the payment will be made or the authorization for services will be issued by *Tufts Health Plan* or its delegate; 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

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

If you do pay the bill, you must send *Our Member* Reimbursement Medical Claims Department the following information:

- a completed, signed Member Reimbursement Medical Claim Form, which can be obtained from *Our* website or by contacting *Our* Member Services Department; and
- the documents required for proof of service and payment. These are listed on the Member Reimbursement Medical Claim Form.

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

Please note: You must contact *Tufts Health Plan* about 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 one (1) year on file.

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

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-Network Providers* at *Network Hospital* are reimbursable at the in-*Network Level of Benefits*. Some examples of these types of *Non-Network Providers* include:

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

You may receive a bill from a *Non-Network Provider*. If this happens, please follow the member reimbursement process described above.

Pharmacy Expenses

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

Notice to Michigan Residents

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

Limitation on Actions

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

Chapter 7 -- Other Plan Provisions

Subrogation

Tufts Health Plan's right of subrogation

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

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

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or rewards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy;
- premises or homeowner's medical payments coverage;
- premises or homeowner's insurance coverage; and
- any other payments from a source intended to compensate you for Third Party injuries.

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

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

Personal Injury Protection/MedPay Benefits

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

Tufts Health Plan's right of reimbursement

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

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy;
- premises or homeowner's medical payments coverage;
- premises or homeowner's 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.

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* 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 party, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from *Our* recovery;
- that *We* are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party; and
- that in the event you or your representative fails to cooperate with *Tufts Health Plan*, you shall be responsible for all benefits provided by this *Plan* in addition to costs and attorney's fees incurred by *Tufts Health Plan* in obtaining repayment.

Workers' compensation

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

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

We may pay for costs of health care services or medications for any work-related illness or injury. If *We* do this, then *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, please contact the Liability and Recovery Department at 1-888-880-8699, x. 21098.

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. shall be reduced by any medical benefits coverage under group or individual automobile contracts

Definitions

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

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

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

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. As permitted under Rhode Island law, *We* 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.
   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. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      a. If a court decree states that one of the parents is responsible for the health care expenses or health care coverage of the dependent child, and the plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree;
      b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Paragraph B(2) above shall determine the order of benefits;
      c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Paragraph B(2) above shall determine the order of benefits; or
      d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         i. The plan covering the Custodial Parent;
         ii. The plan covering the spouse of the Custodial Parent;
         iii. The plan covering the non-custodial parent; and then
         iv. The plan covering the spouse of the non-custodial parent.
   4. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Paragraph B(2) or B(3) above shall determine the order of benefits as if those individuals were the parents of the child.
   5. Parental and Spousal Coverage.
      a. For a *Dependent Child* who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph B(9) applies.
      b. In the event the *Dependent Child's* coverage under the spouse's plan began on the same date as the *Dependent Child's* coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Paragraph B(2) to the *Dependent Child's* parent(s) and the *Dependent's* spouse

6. Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's *Dependent*) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's *Dependent*). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored. This rule does not apply if the rule in Paragraph B(1) can determine the order of benefits.
7. COBRA or State Continuation.
    a. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a *Dependent* of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
    b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (8) is ignored.
    c. This rule does not apply if the rule in Paragraph B(1) can determine the order of benefits.
8. 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 single employer to that of multiple employer plan).
    d. The person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If the date is not readily available, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
9. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of "This Plan"

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

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

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 Member Services. That person can transfer your call to the Liability and Recovery Department.

Medicare Eligibility

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

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

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

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

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

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

Use and Disclosure of Medical Information

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

Relationships between *Tufts Health Plan* and *Providers*

Tufts Health Plan arranges health care services. *We* do not provide health care services. *We* have agreements with *Providers* practicing in their private offices throughout the *Network Contracting Area*. These *Providers* are independent. They are not *Tufts Health Plan* employees, agents or representatives. *Providers* are not authorized to change this *Evidence of Coverage* or assume or create any obligation for *Tufts Health Plan*.

We are not liable for acts, omissions, representations or other conduct of any *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 the reasonable control of *Tufts Health Plan*. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, *We* will make a good faith effort to arrange for the provision of services. In doing so, *We* will take into account the impact of the event and the availability of *Network Providers.*

Group Contract

Acceptance of the terms of the *Group Contract*

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

Exception: A change will not apply to you if you are an *Inpatient* on the *Effective Date* of the change until the earlier of your discharge date or the date *Annual Coverage Limitations* are used up.

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

Notice

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

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

Tufts Health Plan
P.O. Box 9173
Watertown, MA 02471-9173.

Enforcement of terms

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

When this *Evidence of Coverage* Is Issued and Effective

This *Evidence of Coverage* is issued and effective on your *Group Anniversary Date* on or after January 1, 2022. It supersedes all previous *Evidence of Coverages. We* will issue a copy of the *Evidence of Coverage* to the *Group* and to all *Subscribers* enrolled under this plan.

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. If the legal obligation ceases, the *Child* is no longer considered placed for adoption.

Note: As required by state law, a foster child is considered an Adoptive Child as of the date of placement for adoption was filed.

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

Anniversary Date
The date upon which the *Group Contract* and each successive annual renewal date.

Annual Coverage Limitations
Annual dollar or time limitations on *Covered Services*.

Authorized Review
Authorized Review refers to prospective, concurrent, and retrospective reviews of health care services for *Medical Necessity* and is performed by an *Authorized Reviewer*.

Authorized Reviewer
An Authorized Reviewer reviews and approves certain services and supplies to *Members*. He or she is *Tufts Health Plan's* Chief Medical Officer (or equivalent) or someone that person names (which may include a delegate).

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

Board-Certified Behavior Analyst (BCBA)
A Board-Certified Behavior Analyst (BCBA) meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. *BCBAs* must also be individually licensed by the Rhode Island Department of Health as a healthcare provider/clinician, and credentialed by *Tufts Health Plan*. A BCBA professional conducts behavioral assessment, 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*; or
- any other Child for whom the *Subscriber* has legal guardianship; or

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

- For services provided by a *Network Provider*, your share is a percentage of:
  - the applicable *Network* fee schedule amount for those services; or
  - the *Network Provider's* actual charges for those services, whichever is less.

Note: The *Member's* share percentage is based on the *Network Provider* payment at the time the claim is paid, and does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis. For services provided by a *Non-Network Provider*, your share is a percentage of the *Reasonable Charge* for those services. 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.*

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

Contract Year
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 (for example, July 1st in one calendar year through June 30th in the following calendar year).

Note: For a *Group Contract*, the Contract Year is determined by the *Group*.

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

Copayment
The cost you pay for certain *Covered Services*. Copayments are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. A *Member's* payment for certain *Covered Services* provided by either a *Network Provider* or a *Non-Network Provider*.

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

Covered Service
The services and supplies for which *We* will pay. They must be:

- described in Chapter 3 (subject to the "Exclusions from Benefits" section in Chapter 3); and
- *Medically Necessary*; and
- approved by an *Authorized Reviewer*.

These services include *Medically Necessary* coverage of pediatric specialty care, including behavioral health care, by *Providers* with recognized expertise in specialty pediatrics.

Custodial Care

- care provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety;
- care, 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, and with an expected departure the same day, or in some instances, within 24 hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care".

Deductible

For each *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 for services, supplies or medications that are not *Covered Services.*
- Costs in excess of the *Reasonable Charge.*
- The premium you pay for this plan.

See the "Benefit Overview" at the front of this *Evidence of Coverage* for additional information about the Deductible.

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

Dependent

The *Subscriber's Spouse*, *Child*, or *Disabled Dependent*.

Developmental

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

Directory of Health Care Providers

A searchable list of *Network Providers* and their affiliated *Network Hospitals* and certain other *Network Providers.*

Note: This list is updated from time to time with *Providers* changes. For more information about *Network Providers* listed in the Directory of Health Care Providers, call the Member Services Department or check *Our* website.

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
The date, according to *Our* records, when you become a *Member* and are first eligible for *Covered Services*.

Emergency
An illness or medical health condition, whether physical, behavioral, related to substance use disorders, 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 lay person, who possesses an average knowledge of health and medicine, to result in:

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

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

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;
- 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 Plan

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

Free-standing ambulatory surgery center or imaging center
Free-standing facilities such as 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 are not *Limited Service Medical* Clinics. To find a Free-standing Urgent Care Center in *Our* network, please visit *Our* website, and click on "Find a Doctor" or call Member Services.

Group
An employer or other legal entity with which *We* have an agreement to provide group coverage. An employer Group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. Under a *Group Contract,* the Group is your agent, not *Tufts Health Plan's* agent.

Group Contract
The agreement between *Tufts Health Plan* and the *Group* under which:
- *We* agree to provide *Group* coverage; and
- the *Group* agrees to pay a *Premium* to *Us* on your behalf.

The Group Contract includes this *Evidence of Coverage* and any amendments.

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 deteriorate of a life skill or function never learned or acquired due to a disabling condition. These services may include physical and occupational therapy, and speech-language pathology services in various *Inpatient* and *Outpatient* settings.

Individual Plan
Coverage for a *Subscriber* only (no *Dependents*).

In-Network Level of Benefits
The level of benefits that a *Member* receives when *Covered Services* are provided by a *Network Provider* See Chapter 1 for more information.

Inpatient
A patient who is admitted to a hospital or other facility licensed to provide continuous care and is classified as an *Inpatient* for all or a part of the day.

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

Medically Necessary (also Medical Necessity)

A service or supply that is consistent with generally accepted principles of professional medical practice. This is determined by whether that service or supply:

- required for the prevention, diagnosis, cure, or treatment of a health related condition, including such services necessary to prevent a decremental change in either medical or mental health status;
- is the most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual;
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- for services and interventions not in widespread use, as based on scientific evidence.

Medical Necessity Guidelines are used to determine coverage for *Medically Necessary* services. These Guidelines are:

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

Medical Necessity Guidelines are available on *Our* website at:
https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/digital-tools/telehealth

If you prefer, call Member Services. Or call *Our* Behavioral Health Department at 1-800-208-9565.

Member
A person enrolled in *Tufts Health Plan* under the *Group Contract*. Also referred to as "you".

Mental Disorders
Any mental/behavioral disorder and substance use disorder that is listed in the most recent revised publication or the most updated volume of either the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association or the *International Classification of Disease Manual* (ICO) published by the World Health Organization 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 Contracting Area
The geographic area within which *We* have developed or arranged for a network of *Providers* to provide *Members* adequate access to *Covered Services*.
Notes:

- For information about *Providers* in the *Network Contracting Area*, call Member Services or check *our* website.
- Certain services may be available outside of the *Network Contracting Area* through the *Tufts Health Plan* telemedicine vendor. For more information, please visit **https://tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth**

Network Hospital
A hospital that has an agreement either with *Tufts Health Plan* directly or with a *provider* network *We* have a contract with to provide certain *Covered Services* to *Members*. Network Hospitals are independent. They are not owned by *Tufts Health Plan*. Network Hospitals are not *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees. Network Hospitals are subject to change.

Network Provider
A *Provider* who has an agreement either with *Tufts Health Plan* directly or with a provider network with whom *We* have a contract to provide *Covered Services* to *Members*. Network Providers are located throughout the *Network Contracting Area*.

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 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).

Non-Network Provider

A *Provider* who does not have an agreement with *Tufts Health Plan* directly, or with a provider network with whom *We* have a contract, to participate as a *Network Provider*.

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
For a *Group Contract,* the period each year when *Tufts Health Plan* and the *Group* allow eligible persons to apply for *Group* coverage in accordance with the *Group Contract*.

Outpatient
A patient who receives care other than on an *Inpatient* basis. This includes services provided in:
- a *Provider's* office;
- a *Day Surgery* or ambulatory care unit; and
- an *Emergency* room or *Outpatient* clinic.

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

Out-of-Network Level of Benefits
The level of benefits that a *Member* receives when *Covered Services* are not provided by a *Network Provider*. See Chapter 1 for more information.

Out-of-Pocket Maximum
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:
- any amount paid for services, supplies or medications that are not *Covered Services*;
- costs in excess of the *Reasonable Charge;* or
- the premium you pay for this plan.

See "Benefit Overview" at the front of this *Evidence of Coverage* for your Out-of-Pocket Maximum under this plan.

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

Premium
Under a *Group Contract,* the total monthly cost of an *Individual* or *Family* Coverage that the *Group* pays to *Tufts Health Plan.* Under an *Individual Contract,* the total monthly cost of *Individual* or *Family Coverage* that the *Subscriber* pays to *Tufts Health Plan.*

Primary Care Provider (PCP)
A *Network Provider* who is a general practitioner, family practitioner, internist, pediatrician, physician assistant, nurse practitioner or obstetrician/gynecologist who provides primary care services.

Provider
A health care professional or facility licensed or certified in accordance with applicable law, including, but not limited to, hospitals, *Limited Service Medical Clinics*, if available, *Free-standing Urgent Care Centers*, physicians, doctors of osteopathy, physician assistants, nurse midwives, registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, mental/behavioral health counselors, independent clinical social workers, psychiatric nurses who are certified as clinical specialists in psychiatric and mental/behavioral health nursing, alcohol and drug counselor I, marriage and family therapists, speech- language pathologists, audiologists, tobacco treatment specialists, and doulas (to the extent licensure or certification is required).

Note: *We* will only cover services of a *Provider* if those services are listed as *Covered Services* and within the scope of the *Provider's* license.

Reasonable Charge
The lesser of:
- the amount charged by the *Non-Network Provider*; or
- the amount that *We* determine to be reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to: Medicare fee

schedules and *Allowed Amounts*, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.

Note: Any amount the *Member* pays in excess of the Reasonable Charge is not included in the *Deductible*, *Coinsurance* or *Out-of-Pocket Maximum*.

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

Spouse
The *Subscriber's* legal spouse, according to the law of the state in which you reside. *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 employed by the *Group*;
- who enrolls in *Tufts Health Plan* and signs the membership application form on behalf of himself or herself and any *Dependents*; and
- in whose name the *Premium* is paid in accordance with a *Group Contract*.

Tufts Health Plan or Tufts HP
Tufts Insurance Company (TIC) which is authorized to offer POS and PPO products. TIC has entered into an agreement with Tufts Benefit Administrators, Inc. (TBA) for TBA to administer the health benefits and make available a network of *Providers* described in this *Evidence of Coverage.*

Both TIC and TBA do business under the name *Tufts Health Plan*. *Tufts Health Plan* is also referred to as "*We*", "*Us*", and "*Our*".

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 referred to as " *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, and their staff are not *Tufts Health Plan's* employees.

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

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

Appendix B -- ERISA Information

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 (EBSA).
- 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 any preexisting 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 f ire 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.

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 published benefit determination procedure regulations for employee benefit plans governed under ERISA. Regulations set forth requirements regarding 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 decisions). **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 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 considers 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 after receipt of the claim. If *We* determine that an extension is necessary due to matters beyond *Our* control, *We* will notify you within 30 days informing you of the circumstances requiring the extension and the date by which We expect to render a decision (up to an additional 15 days). If you make a post-service claim, but do not submit enough information for Us to make a determination, *We* will notify you within 30 days and describe the information that you need to provide to *Us*. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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 only applies to groups with 50 or more employees.

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

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

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

- Qualifying Exigency Leave: Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. 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 up to 26 weeks of leave in a single 12-month period to care for the 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. Additional information is also available from the U.S. Department of Labor (1-866-487-9243, TTY: 1-877-899-5627 or **http://www.dol.gov/esa/whd/fmla/finalrule/FMLAPoster.pdf**) .

PATIENT PROTECTION DISCLOSURE

This plan generally requires the designation of a *Primary Care Provider*. You have the right to designate any primary care provider who participates in *Our* network and who is available to accept you or your family members. For information on how to select a *Primary Care Provider,* and for a list of the participating *Primary Care Providers,* contact Member Services or see *Our* website at **www.tuftshealthplan.com**.

For *Children*, you may designate a pediatrician as the *Primary Care Provider.*

You do not need prior approval from *Tufts Health Plan* or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in *Our* network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior approval for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or see *Our* website at **www.tuftshealthplan.com**.

NOTICE OF PRIVACY PRACTICES

Tufts Health Plan is committed to safeguarding the privacy of *Our* members' protected health information ("PHI"). PHI is information which:

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

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use, and disclose your PHI, and your rights concerning your PHI. This Notice applies to all members of Tufts Health Plan's commercial insured health benefit plans (including HMO, POS and PPO plans, and Medicare Complement plans) and to employees covered under the Tufts Associated Health Plans, Inc. group health plans. Unless your employer has notified you otherwise, this Notice of Privacy Practices also applies to all members of self -insured group health plans that are administered by a Tufts Health Plan entity.

How *We* Obtain PHI

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

How *We* Use and Disclose Your PHI

We use and disclose PHI in a number of ways to carry out *Our* responsibilities as a 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. The following corporate affiliates of Tufts Health Plan designate themselves as a single affiliated covered entity and may share your information among them: Tuft s Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., Tufts Associated Health Plans, Inc. group health plans, Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., and Harvard Pilgrim Group Health Plan.

- **Plan Sponsors:** If you are enrolled in *Tufts Health Plan* through your current or former place of work, you are enrolled in a group health plan. *We* may disclose PHI to the group health plan's 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 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.
- **Research; Death; Organ Donation:** *We* may disclose your PHI to researchers, provided that certain established measures are taken to protect your privacy. *We* may disclose PHI, in certain instances, to coroners, medical examiners and in connection with organ donation.
- **Workers' Compensation:** *We* may disclose your PHI when authorized by workers' compensation laws.
- **Family and Friends:** *We* may disclose PHI to a family member, relative, or friend – or anyone else you identify – as follows: (i) when you are present prior to the use of disclosure and you agree; or (ii) when you are not present (or you are incapacitated or in an emergency situation) if , in the exercise of *Our* professional judgment and in *Our* experience with common practice, *We* determine that the disclosure is in your best interests. In these cases, *We* will only disclose the PHI that is directly relevant to the person's involvement in your health care or payment related to your health care.
- **Personal Representatives:** Unless prohibited by law, *We* may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or health care benefits. For example an individual named in a durable power of attorney or a parent or guardian of an unemancipated minor, are personal representatives.
- **Communications:** *We* will communicate information containing 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 your PHI is maintained electronically, you will also have the right to request a copy in electronic format. *We* have the right to charge a reasonable cost-based fee for paper or electronic copies as established by state or federal law. Under certain circumstances, *We* may deny your request. If *We* do so, *We* will send you a written notice of denial describing the basis of *Our* denial. You may request that *We* send a copy of your PHI directly to another person that you designate. Your request must be in writing, signed by you, and clearly identify the person and the address where the PHI should be sent.
- **Right to Request Restrictions:** You have the right to ask that *We* restrict uses or disclosures of your PHI to carry out treatment, payment and health care operations, and disclosures to family members or friends. *We* will consider the request. However, *We* are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made verbally or in writing to *Tufts Health Plan*.
- **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* upon request.

How to Exercise Your Rights: To exercise any of the individual rights described above or for more information, please call a Member Services Representative at 800-463-8080 or write to:

Privacy Officer
Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Effective Date of Notice

This Notice takes effect February 1, 2021. *We* must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until *We* change it. This Notice replaces any other information you have previously received from *Us* with respect to privacy of your medical information.

Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that *We* maintain – whether created or received before or after the *Effective Date* of the new Notice. Whenever *We* make an important change, *We* will publish the updated Notice on *Our* website at **www.tuftshealthplan.com**. In addition, *We* will use one of *Our* periodic mailings to inform subscribers about the updated Notice.

Who to Contact for Questions or Complaints

If you would like more information or a paper copy of this Notice, please contact a Member Services Coordinator at the number listed above. You can also download a copy from *Our* website at **www.tuftshealthplan.com**. If you believe your privacy rights may have been violated, you have a right to complain to *Tufts Health Plan* by calling the Privacy Officer at 1-800-208-9549 or writing to:

Privacy Officer
Tufts Health Plan
1 Wellness Way
Canton, MA 02021

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

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