TUFTS Health Plan

Small Group Plan

MASSACHUSETTS

EVIDENCE OF COVERAGE

Underwritten by Tufts Insurance Company.

Advantage PPO 2000

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

THIS *EVIDENCE OF COVERAGE* IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from *Tufts Health Plan*

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE

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

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

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

***Note:** This includes health plans approved by the Massachusetts Health Insurance Connector as meeting its Minimum Creditable Coverage standards.

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 your 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 that 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.

Massachusetts Relay (MassRelay)
711 or 1-800-720-3460

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 visit *Our* website at **www.tuftshealthplan.com.**

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

Treatment Cost Estimator
In compliance with Massachusetts law, *Tufts Health Plan* offers a cost transparency estimator tool to help *Members* estimate the cost of *Covered Services*. In order to access this tool, you must register at **www.tuftshealthplan.com/members**. Once you have registered, enter the member portal to access the tool. Examples of information you can find by using the treatment cost estimator include:

- the estimated or maximum *Allowed Cost* for a proposed admission, procedure or service; and
- the estimated amount you will be responsible for paying for admissions, procedures, or services that are *Covered Services* (including *Facility Fees* and *Cost Sharing Amounts*), based on information available to at the time the request is made.

The cost estimates generated by the tool are binding to the extent required by Massachusetts law. The actual amount you may be responsible for paying may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

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* or *Individual Contract*. It applies to persons covered under the *Group Contract* or *Individual 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.

CHANGES TO THIS *EVIDENCE OF COVERAGE("EOC")*
From time to time, certain sections in this *EOC* may change. This may happen to comply with a state or federal law or regulation. Or, this may happen to reflect an enhancement to your plan with us during the year. To check to see whether this *EOC* has been amended, please go to **https://tuftshealthplan.com/MA-2022-EOC-amendments** on the website.

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 in the *Tufts Health Plan* network PPO network 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*. (In the event you require *Inpatient* behavioral health or Inpatient substance use disorder services, you may go to any Network Hospital and receive coverage at the *In-Network Level of Benefits*. See "Inpatient Behavioral Health and Substance Use Disorder Services" in Chapter 1 for more information.)

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. (In the case of Inpatient behavioral health and Inpatient substance use disorder services, if you go to any facility which is not a Network Hospital, your coverage will be at the Out-of-Network Level of Benefits. See "Inpatient Behavioral Health and Substance Use Disorder Services" in Chapter 1 for more information.)

Covered Services Outside of the 50 United States: *Emergency* care services provided to you outside of the 50 United States qualify as *Covered Services*. 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.

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

10-Day Right to Examine and Return this *Individual Contract*
Please read this *Individual Contract*. If you are not satisfied, you may return the *Individual Contract* within 10 days after you received it. Mail or deliver it to *Tufts Health Plan*. Any *Premiums* you have paid will be refunded to you. This *Individual Contract* will then be void from its *Effective Date*.

THIS IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from *Tufts Health Plan*.

Please read this *Evidence of Coverage* carefully

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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 *Network Provider* who is a physician, physician assistant, or nurse practitioner you have chosen from the *Directory of Health Care Providers*. This *PCP* has an agreement with *Us* to provide primary care *Covered Services*.

In-Network Level of Benefits is the level of benefits that you receive when *Covered Services* are provided by a *Network Provider*. *Cost Sharing Amounts* at this level are listed under "*In-Network Level of Benefits*" in this Benefit Overview.

Out-of-Network Level of Benefits is the level of benefits that you receive when *Covered Services* are provided by *Non-Network Providers. Cost Sharing Amounts* at this level are listed under "*Out-of-Network Level of Benefits*" in this Benefit Overview. You are also responsible for any amount a *Non-Network Provider* bills beyond the *Reasonable Charge.*

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 is not subject to a *Deductible*) -Some services are not subject to the *Deductible*, as indicated below.	<u>*Individual Plan*</u>: $2,000/Individual <u>*Family Plan*</u>: $2,000/*Member* $4,000/Family	<u>*Individual Plan*</u>: $4,000/Individual <u>*Family Plan*</u>: $4,000/*Member* $8,000/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.

The following amounts do not count towards the *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>: $8,000/Individual <u>*Family Plan*</u>: $8,000/*Member* $16,000/Family	<u>*Individual Plan*</u>: $16,000/Individual <u>*Family Plan*</u>: $16,000/*Member* $32,000/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*.

<u>Note</u>: *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.

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***
Emergency room		
	In-Network Deductible then $300 *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 must call *Us* within 48 hours to be covered at the *In-Network Level of Benefits*. 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. An Emergency room *Cost Sharing Amount* may apply if you register in an Emergency room but leave that facility without receiving care.		
Acupuncture		
	In-Network Deductible then $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)		
	Paraprofessional: Covered in full **Board Certified Behavior Analyst (BCBA):** Covered in full **Licensed physical, speech language or occupational therapist:** *In-Network Deductible* then $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".		

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***
Behavioral health and substance use disorder services		
Office visits	*In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Inpatient **(AR)**	**Hospital facility services:** *In-Network Deductible* then $250 *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)**	*In-Network Deductible* then 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		
	In-Network Deductible then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Chemotherapy administration		
	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		
	In-Network Deductible then $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."		
Cleft lip & cleft palate treatment and services for Children		
Medical or facial surgery	See Hospital *Inpatient*, Surgery - Reconstructive, or *Day Surgery*	See Hospital *Inpatient*, Surgery - Reconstructive, or *Day Surgery*

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***
Oral surgery	See Oral surgery services	See Oral surgery services
Dental surgery or orthodontic treatment & management	Covered in full	Covered in full
Preventive and restorative dentistry	Covered in full	Covered in full
Speech therapy and audiology services	Covered under Speech, hearing and language disorders	Covered under Speech, hearing and language disorders
Nutrition services	Covered under Nutritional counselling	Covered under Nutritional counselling
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 $200 *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*:** *In-Network Deductible* then $35 *Copayment* per visit **Any other *Network Provider*:** *In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic imaging		
General imaging, such as x-rays & ultrasound	*In-Network Deductible* then $75 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
MRI/MRA, CT/CTA, PET, nuclear cardiology **(AR)**	*In-Network Deductible* then $125 *Copayment* per visit	*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*
Diagnostic testing (AR)		
	In-Network Deductible then $75 *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*:** *In-Network Deductible* then $35 *Copayment* per visit **Any other *Network Provider*:** *In-Network Deductible* then $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 Covered up to $2,000 per ear every 36 months (*In- Network* and *Out-of-Network Levels* combined). This includes both the amount *Tufts Health Plan* pays and the *Member's Cost Sharing Amount*.		
	In-Network Deductible then 30% *Coinsurance*	*Out-of-Network Deductible* then 30% *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***
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 $250 *Copayment* per admission **Physician surgical & medical services:** *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		
Office visits	***PCP*:** *In-Network Deductible* then $35 *Copayment* per visit **Any other *Network Provider*:** *In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Approved Assisted Reproductive Technology (ART) services	See applicable *Covered Services* including "Hospital *Inpatient*" and "*Day Surgery*"	See applicable *Covered Services* including "Hospital *Inpatient*" and "*Day Surgery*"
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***
	In-Network Deductible then $35 *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*
Mammograms		
Routine mammograms	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic mammograms	*In-Network Deductible* then $75 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
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*
Inpatient	**Hospital facility services:** *In-Network Deductible* then $250 *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)		
	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*:** *In-Network Deductible* then $35 *Copayment* per visit **Any other *Network Provider*:** *In-Network Deductible* then $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***
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*:** *In-Network Deductible* then $35 *Copayment* per visit **Any other *Network Provider*:** *In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Note: Also see Telemedicine services.		
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
Pap test (cervical cancer laboratory test)		
Routine annual Pap test	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Diagnostic Pap test	*In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Physical & occupational therapy services (including 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".		
	In-Network Deductible then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Preventive health care		
	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
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 front of this Benefit Overview and Chapter 3, *Covered Services*.		
Prosthetic devices (AR)		
	In-Network Deductible then 20% *Coinsurance*	*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***
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 30% *Coinsurance*	*Out-of-Network Deductible* then 30% *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*
Special medical formulas **(AR)**	Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Speech, hearing, and language disorders treatment (including rehabilitation and *Habilitative* services) (AR)		
	In-Network Deductible then $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 and bone marrow transplants for breast cancer (AR)		
	Hospital facility services: *In-Network Deductible* then $200 *Copayment* per visit **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
Surgery – Reconstructive procedures (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 $200 *Copayment* per visit **Physician surgical & medical services:** *In-Network Deductible* then Covered in full	*Out-of-Network Deductible* then 20% *Coinsurance*
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
When provided by a *Provider*	***PCP*:** *In-Network Deductible* then $35 *Copayment* per visit **Any other *Network Provider*:** *In-Network Deductible* then $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	*In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Any other *Provider* (e.g., a specialist)	*In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Participating *Limited Services Medical Clinic*	*In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Free-standing Urgent Care Center	$40 *Copayment* per visit	$40 *Copayment* per visit
PCP in a Hospital walk-in clinic	*In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
Other *Provider* in a Hospital walk-in clinic	*In-Network Deductible* then $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***
Notes: If services are (i) received from a *Non-Network Provider* and (ii) meet the definition of *Urgent Care*, then cost sharing is at the *In-Network Level of Benefits*. If these services do not meet the definition of *Urgent Care*, then cost sharing is at the *Out of Network Level of Benefits*.		
Vision care services Adult routine eye examination services are limited to 1 visit(s) every 24 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)**	*In-Network Deductible* then $35 *Copayment* per visit	*Out-of-Network Deductible* then 20% *Coinsurance*
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.		

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		
Preventive & Diagnostic services (Type 1)	Covered in full	20% *Coinsurance*
Basic services (Type II)	25% *Coinsurance*	*Deductible* then 45% *Coinsurance*
Major restorative services (Type III)	50% *Coinsurance*	*Deductible* then 70% *Coinsurance*
Orthodontia (Type IV) **(AR)**	50% *Coinsurance*	*Deductible* then 70% *Coinsurance*
Note: **Covered Services* received from a *Provider* who is not part of the Delta Dental 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
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	$60 *Copayment* per fill
Tier 3 Drugs	$90 *Copayment* per fill
Tier 4 Drugs	$160 *Copayment* per fill
Up to a 60 - day supply	
Tier 1 Drugs	$60 *Copayment* per fill
Tier 2 Drugs	$120 *Copayment* per fill
Tier 3 Drugs	$180 *Copayment* per fill
Up to a 90 - day supply	
Tier 1 Drugs	$90 *Copayment* per fill
Tier 2 Drugs	$180 *Copayment* per fill
Tier 3 Drugs	$270 *Copayment* per fill
Important Note: If you choose to obtain a covered prescription drug at a retail pharmacy which is not a *Tufts Health Plan* designated pharmacy, you will be required to pay for the entire cost of the drug up front. Call *Tufts Health Plan* to be reimbursed. You will be responsible only for the *Member Cost Sharing Amount* listed above.	

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	$60 *Copayment* per fill
Tier 3 Drugs	$90 *Copayment* per fill
Up to a 60 - day supply	
Tier 1 Drugs	$60 *Copayment* per fill
Tier 2 Drugs	$120 *Copayment* per fill
Tier 3 Drugs	$180 *Copayment* per fill
Up to a 90 - day supply	
Tier 1 Drugs	$60 *Copayment* per fill
Tier 2 Drugs	$120 *Copayment* per fill
Tier 3 Drugs	$270 *Copayment* per fill

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

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.
- In compliance with Massachusetts law, opioid medications listed as Schedule II or Schedule III controlled substances will be filled at a lesser quantity than prescribed if the *Member* requests it. If the *Member* requests the lesser quantity, no additional cost or penalty will be enforced on the *Member*. If the *Member* fills a lesser quantity than is prescribed of a Schedule II opioid controlled substance, and then decides to fill the remainder of the original prescription at the same pharmacy within 30 days of the original prescription date, no additional *Copayment* or other cost sharing will be applied. See Appendix C, "Schedule II and III Opioid Medications", for a list of these medications.
- Pursuant to Massachusetts law, naloxone (an opioid antagonist) is available without a prescription when obtained from a Massachusetts pharmacy. Whoever requests naloxone at a pharmacy will be billed for the medication, even if that person is picking up the medication for someone else
- 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.
- See the formulary on Our website at: **https://tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy/pharmacy-programs/ri-4-tier-pharmacy-copayment-program**

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
- If you live outside of Massachusetts and are a *Member* under a *Group Contract*, your benefits under this plan may also include benefits required under applicable state law. For more information, please call 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).

Notes

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

No *Inpatient Notification* by You

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 includes 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 may be 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 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 you are an existing *Member*

If your *Provider* is disenrolled from *Tufts Health Plan* for reasons other than quality or fraud, you may continue to see your *Provider* for *Covered Services* at the *In-Network Level of Benefits* for the following continuing care conditions for up to 90 days from the date we notify you of your *Provider's* termination:

- If you are receiving treatment for a Serious or Complex Condition.
- If you are pregnant, you may continue to receive care from your *Provider* through your first postpartum visit.
- If you are an *Inpatient*.
- If you are scheduled to undergo urgent or emergent surgery, including postoperative.
- If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your *Provider* as long as necessary.

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.

Note:- If you have a complex care need, you may continue to see your *Provider* for up to 90 days to allow your care to be transitioned to a *Tufts Health Plan Provider*. The "Conditions for coverage of continued treatment" section below does not apply to *Providers* treating *Members* with complex care needs.

If you are enrolling as a new *Member*

When you enroll as a *Member*, if none of the health plans offered by the *Group* at that time include your *Provider*, you may continue to see your *Provider* if:

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* for up to 30 days from your *Effective Date;*
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* through your first postpartum visit; or
- you are terminally ill. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* as long as necessary.

Conditions for coverage of continued treatment

Tufts Health Plan may condition coverage of continued treatment upon the *Provider's* agreement:

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

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 verify *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.

How to Notify *Us* of a Hospital Admission.
Call the Member Services number on your ID card to report your hospital admission. You, or someone acting on your behalf, will need to provide the following information:
- Patient name, address and phone number (work and home).
- Hospital name, address and phone number.
- Member identification number (from your member ID card).
- *Group*.
- Diagnosis and proposed procedure.
- Proposed admission and discharge dates.
- Admitting *Provider's* name, address and phone number.

When to Notify *Us* for Elective Hospitalization or Transfers.
Notify *Us* at least five (5) days prior to admission for elective hospitalizations or transfer. After you notify *Us, We* may consult with your *Provider*. *We* will notify you or your *Provider* of *Our* determination. *We* may recommend an alternative treatment setting.

When to Notify *Us* of an Urgent or *Emergency* Admission
Notify *Us* as soon as possible for an urgent admission, but no later than one business day after the admission. An urgent admission is one that requires prompt medical intervention; but there is reasonable opportunity to notify *Us* prior to the admission, or at the time of admission. Notification for an *Emergency* admission should be completed within one business day following the admission. See the definition of *Emergency* in the next section and in Appendix A.

When to Notify *Us* for Deliveries.
Notification to *Tufts Health Plan* for delivery of your newborn *Child* should occur within 30 days of your due-date.

When to Notify *Us* for a Newborn *Child*

Notification to *Tufts Health Plan* for delivery of your newborn *Child* should occur within 30 days of your due-date.

- If the newborn is discharged with the mother after delivery, notification to *Us* of the newborn stay is not required.
- If the newborn remains in the hospital after the mother is discharged, and a *Non-Network Provider* provides the newborn's care, notify *Us* immediately of the newborn's hospital stay.

Important Note: In order to be covered for any *Medically Necessary* care, the newborn *Child* must be enrolled under the *Group Contract* or *Individual Contract* within 30 days after birth. See Chapter 2 for more information.

After You Notify *Tufts Health Plan* of a Hospital Admission

After you call with the necessary admission information, your *Provider* or the hospital will be notified of the decision made by *Tufts Health Plan.*

Changes to Hospital Admission Information

Notification of your hospital admission is valid only for the diagnosis, procedure, admission date and medical facility specified at the time of the notification. You must notify Us of any delays, changes or cancellations of your proposed admission. You must provide *Us* separate notification for a new admission date, readmission, hospitalization, transfer or surgery for conditions other than those designated during the initial hospital admission.

Extension of Hospitalization

All *Inpatient* hospitalizations are monitored. When it is *Medically Necessary* to extend hospitalization beyond the originally determined stay, *Our* staff or *Our* delegate will request additional clinical information from your attending physician or hospital for additional *Medically Necessary* hospital days.

Note: If the review team, after talking with your *Provider*, determines that Inpatient hospitalization is no longer *Medically Necessary*, you will be notified that: (i) any additional hospital days will not be covered; and (ii) you will be responsible to pay for all hospital and physician charges if you choose to remain in the hospital beyond the discharge date.

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 *In-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 for all hospital and *Provider* charges if you choose to stay in the hospital beyond the discharge date.

Care Management

Some *Members* with Severe Illnesses or Injuries may need care management. The 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 by *Tufts Health Plan* or its delegate 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.

Information Resources for *Members*

Obtaining information about *Tufts Health Plan*

The following information about *Tufts Health Plan* will be available from the Massachusetts Health Policy Commission's Office of Patient Protection:

- A list of sources of independently published information assessing *Member* satisfaction and evaluating the quality of health care services offered by *Tufts Health Plan*.
- The percentage of physicians who voluntarily and involuntarily terminated participation contracts with *Tufts Health Plan* during the previous calendar year for which such data has been compiled. This information will contain the three(3) most common reasons for voluntary and involuntary disenrollment of those physicians.
- The percentage of premium revenue spent by *Tufts Health Plan* for health care services provided to *Members* for the most recent year for which information is available.
- A report that details the following information for the previous calendar year:
  - the total numbers of filed appeals, appeals denied internally, and appeals withdrawn before resolution; and
  - the total number of external appeals pursued after exhausting the internal appeal process, as well as the resolution of all those external appeals.

How to obtain this information about *Tufts Health Plan*

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

Phone: 1-800-436-7757.

Write a letter to the Office:
Health Policy Commission
Office of Patient Protection
50 Milk St., 8th Floor
Boston, MA 02109

Fax #: 1-617-624-5046.

Email: HPC-OPP@state.ma.us.

Website:**www.mass.gov/hpc/opp**

Chapter 2 -- Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule under *Group Contracts*

You are eligible as *Subscriber* only if you are an employee of a *Group* and you:

- meet your *Group's* and *Tufts Health Plan's* eligibility rules; and
- live, work, or reside in the *Network Contracting Area.*

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.
- *Children* are not required to live, work or reside in the *Network Contracting Area.*

Eligibility rule under *Individual Contracts*

You are eligible as a *Subscriber* only if you:

- meet the eligibility rules of *Tufts Health Plan* and your *Individual Contract*; and
- 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 the eligibility rules of *Tufts Health Plan* and your *Individual Contract*; and
- lives, works or resides in the *Network Contracting Area.*

Note:

- In some cases, *Dependents* who live, work or reside outside the *Network Contracting Area* can be eligible for coverage under this plan. See "If you live, work or reside outside the *Network Contracting Area*" below for more information.
- *Children* are not required to live, work or reside in the *Network Contracting Area.*

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* for whom *Tufts Health Plan* is required to provide coverage.

Proof of Eligibility

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

Enrollment

When to enroll

You may enroll yourself and your eligible *Dependents*, if any, for this coverage only: (i) during the annual *Open Enrollment Period;* or (ii) 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 will apply only if you:

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

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

If *We* accept your application and receive the needed *Premium*, coverage starts on either the date chosen by your *Group* or in accordance with your *Individual Contract*, whichever applies. Enrolled *Dependents* coverage starts when the *Subscriber's* coverage starts; or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

If you or your enrolled *Dependent* is an *Inpatient* on your Effective Date, your coverage starts on the later of:
- the Effective Date; or
- the date *We* are notified and given the chance to manage your care.

Adding *Dependents* Under *Family Coverage*

When *Dependents* may be added

After you enroll, you may apply to add any *Dependents* who are not currently enrolled in *Tufts Health Plan* only during the *Open Enrollment Period* that applies to you; or within 30 days after any of the following events:
- a change in your marital status;
- the birth of a *Child*;
- the adoption of a *Child* as of the earlier of the date the *Child* is placed with you for the purpose of adoption or the date you file a petition to adopt the *Child*;
- a court orders you to cover a *Child* through a qualified medical child support order;
- a *Dependent* loses other health care coverage involuntarily;
- a *Dependent* moves into the Network Contracting Area; or
- if your *Group* has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add *Dependents*

If you have *Family Coverage*, fill out either a group-approved form or *Tufts Health Plan* form listing the *Dependents*. Give this form to your *Group* (if you enrolled in a *Group Contract*) or to *Tufts Health Plan* (if you have an *Individual Contract*) 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 *Family Coverage*, ask your *Group* or *Tufts Health Plan*, whichever applies, to change your *Individual Coverage* to *Family Coverage* and then proceed as described above

Effective Date of *Dependents'* coverage

If *We* accept your application to add *Dependents*, *We* will send you a Member ID card for each *Dependent*. *Effective Dates* will be no later than the date of the *Child's* birth, adoption or placement for adoption or in the case of marriage or loss of prior coverage, the date of the qualifying event.

Availability of benefits after enrollment

Covered Services for an enrolled *Dependent* are available as of the *Dependent's Effective Date*. There are no waiting periods. Maternity benefits are available even if the pregnancy began before your *Effective Date*.

Note: *We* will only pay for *Covered Services* that are provided on or after your *Effective Date.*

Newborn *Children* and *Adoptive Children*

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

You must enroll your newborn *Child* within 30 days after the *Child's* birth for the *Child* to be covered from birth. Otherwise, you must wait until the next *Open Enrollment Period* to enroll the *Child*.

You must enroll your *Adoptive Child* within 30 days after the *Child* has been adopted or placed for adoption with you for that *Child* to be covered from the date of his or her adoption. Otherwise, you must wait until the next *Open Enrollment Period* to enroll the *Child*.

Continuing Eligibility for *Dependents*

When coverage ends

Dependent coverage for a *Child* ends on the last day of the month in which the *Child's* 26th birthday occurs.

Coverage after termination

When a *Child* loses coverage under this *Evidence of Coverage*, he or she may be eligible for federal or state continuation coverage or 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 or legally separate, your former *Spouse* divorce may continue coverage as a *Dependent* under your *Family Coverage* in accordance with Massachusetts law.

Note: If you remarry, your former *Spouse's* coverage as a *Dependent* under your *Family Plan* will end. However, your former *Spouse* may continue coverage under an *Individual Contract*. If your former *Spouse* remarries, coverage will end unless continuation coverage is still available under federal law. (See Chapter 5.)

How to continue coverage for former *Spouses for Group Contracts*

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.

*Important Note about *Disabled Dependent* and former *Spouses* coverage

If you enrolled for coverage directly with *Tufts Health Plan*, this proof must be provided to *Us*. If you enrolled through the Connector, please call **1-877-MA-ENROLL**.

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.*

Chapter 3 -- *Covered Services*

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

See the **Benefit Overview** at the 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**

In compliance with Massachusetts law, *Tufts Health Plan* offers coverage for services and medications for pain management that are alternatives to opioids. Services include, but are not limited to chiropractic medicine, acupuncture services, physical therapy and nutrition counseling

To find a *Provider* for these services, see *Our* website. Click on "Find a Doctor or Hospital" to start your search. You may also call Member Services for help finding a *Provider*.

Prior approval for these services may be required. See the "Benefit Overview" to determine if these services require prior approval.

Medications for pain management that are alternatives to opioids include, but are not limited to:

- Non-steroidal anti-inflammatory agents, such as ibuprofen
- Cyclooxygenase-2 (Cox-2) inhibitors, such as celecoxib

For information about medication alternatives to opioids, call Member Services.

Acupuncture services

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

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

- *Habilitative* or rehabilitative services, which are (i) professional, counseling, and guidance services; and (ii) 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 health care clinician. Prior approval by an *Authorized Reviewer* is required. 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.
- 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.

For more information call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565.

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

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 and substance use disorder services for *Behavioral Health Disorders

Services you receive from the following *Network Providers* to diagnose and treat *Behavioral Health Disorders* (including diagnosis, detoxification, and treatment of substance use disorders):

- Licensed mental health counselors
- Licensed independent clinical social workers
- Licensed psychiatric nurses who are certified as clinical specialists in psychiatric and behavioral health nursing
- Psychiatrists and psychologists

Outpatient treatment of substance use disorders includes methadone maintenance or methadone treatment related to chemical dependency disorders.

Psychological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury" as described earlier in this chapter. Prior approval by a *Tufts Health Plan* Behavioral Health *Authorized Reviewer* is required for these testing and assessment services at both the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*. Contact the Tufts Health Plan Behavioral Health Department at 1-800-208-9565.

Inpatient* and intermediate behavioral health and substance use disorder services for *Behavioral Health Disorders

- *Inpatient* behavioral health and substance use disorder services for *Behavioral Health Disorders* in a facility that is licensed as a general hospital, behavioral health hospital, substance use disorder facility.

- Intermediate behavioral health and substance use disorder services: *Medically Necessary* behavioral health and substance use disorder services that are more intensive than traditional *Outpatient* behavioral health and substance use disorder services, but less intensive than 24-hour hospitalization. Some examples of covered intermediate behavioral health and substance use disorder services are:
  - level III community-based detoxification;
  - crisis stabilization;
  - intensive outpatient programs;
  - partial hospital programs.

Inpatient and intermediate services for child-adolescent *Behavioral Health Disorders*

In addition to the *Outpatient* and *Inpatient* and intermediate behavioral health and substance use disorder services listed above, the following services are available to **children and adolescents until age 19**, and their parents and/or appropriate caregiver, when *Medically Necessary*:

- **Intensive community based acute treatment (ICBAT)** is covered as *Inpatient* behavioral health services*. ICBAT provides the same services as CBAT (see below) for children and adolescents, but of higher intensity, including:
  - more frequent psychiatric and psychopharmacological evaluation and treatment; and
  - more intensive staffing and service delivery.

  ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs can treat children and adolescents with clinical presentations similar to those referred to *Inpatient* mental health services, but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to ICBAT directly from community as an alternative to *Inpatient* hospitalization. ICBAT is not used as step-down placement following discharge from a locked, 24-hour hospital setting.

  These services do not require prior approval of a *Tufts Health Plan* Behavioral Health *Authorized Reviewer.**

- **Intermediate behavioral health services:** The following services are covered and require the prior approval of a *Tufts Health Plan* Behavioral Health *Authorized Reviewer*, except as designated below.* Services may be provided by an appropriate health care professional under the supervision of a licensed behavioral health *Provider*:
  - **Community based acute treatment (CBAT)** – Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while provided intensive therapeutic services including, but not limited to:
    - daily medication monitoring ;
    - psychiatric assessment;
    - nursing availability;
    - specialing (as needed);
    - individual, group and family therapy;
    - case management;
    - family assessment and consultation;
    - discharge planning; and
    - psychological testing, as needed.

    These services may be used as an alternative to or transition from *Inpatient* services.

    These services do not require the prior approval of a *Tufts Health Plan* Behavioral Health *Authorized Reviewer**, unless services are a step-down from a more intensive level of care.

  - **Mobile crisis intervention –** A short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to:
    - identify, assess, treat and stabilize a situation;
    - reduce the immediate risk of danger to the *Child* or others; and
    - make referrals and linkages to all *Medically Necessary* behavioral health services and supports and the appropriate level of care.

    The intervention shall be consistent with the child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan. Mobile crisis intervention does not require the prior approval of a *Tufts Health Plan* Behavioral Health *Authorized Reviewer*.

  - **In-home behavioral services –** A combination of *Medically Necessary* behavioral management therapy and behavioral management monitoring. These services shall be available, when indicated, where the *Child* resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:

- Behavior management monitoring: Monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the *Child's* parent or other caregiver.
- Behavior management therapy: Therapy that addresses challenging behaviors that interfere with a C*hild's* successful functioning. "Behavior management therapy" shall include:
  - a functional behavioral assessment and observation of the youth in the home and/or community setting;
  - development of a behavior plan; and
  - supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy**.**

"Behavior management therapy" may include short-term counseling and assistance.

- **In-home therapy services –** *Medically Necessary* therapeutic clinical intervention or ongoing training, as well as therapeutic support. The intervention or support shall be provided where the child resides, including in the *Child's* home, a foster home, a therapeutic foster home, or another community setting. The following services are covered intermediate behavioral health services and require the prior approval of a *Tufts Health Plan Behavioral* Health *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels* of Benefits.
  - Therapeutic clinical intervention: These services include a structured and consistent therapeutic relationship between a licensed clinician and a child and the *Child's* family to treat the child's behavioral health needs. This may include improvement of the family's ability to provide effective support for the *Child* and promote healthy functioning of the *Child* within the family; the development of a treatment plan; and the use of established psychotherapeutic techniques, working with family members to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.
  - Ongoing therapeutic training and support: These services include those that support implementation of a treatment plan that involves therapeutic interventions that teach the *Child* to understand direct, interpret, and manage and control feelings and emotional responses to situations and assisting the family in supporting the *Child* and addressing the *Child's* emotional and behavioral health needs.
- **Intensive care coordination (ICC) –** A collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes. This service includes:
  - an assessment;
  - the development of an individualized care plan;
  - referrals to appropriate levels of care;
  - monitoring of goals; and
  - coordinating with other services and social supports and with state agencies, as indicated.

The service shall be based on a system of care philosophy. The individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate. You or your *Provider* must notify *Tufts Health Plan* within three (3) days of your initial visit by calling *Tufts Health Plan's* Behavioral Health Department at 1-800-208-9565.

- **Family support and training* – *Medically Necessary* services provided to a parent or other caregiver of a child to improve the capacity of the parent(s) or caregiver(s) to improve or resolve the child's emotional or behavioral needs.** This benefit is provided where the child resides, which may include the child's home, a foster home, a therapeutic foster home, or another community setting.

  Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include:
  - educating parent(s)/caregiver(s) about the youth's behavioral health needs and resiliency factors
  - teaching parent(s)/caregiver(s) how to navigate services on behalf of the *Child*
  - identifying formal and informal services and supports in their communities, including parent support and self-help groups

- **Therapeutic mentoring services*** – *Medically Necessary* services provided to a child, designed to support age-appropriate social functioning or to improve deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis**.** Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment plan. This benefit includes:
  - supporting, coaching, and training the child in age-appropriate behaviors;
  - interpersonal communication, problem solving, conflict resolution; and
  - relating appropriately to other children and adolescents and to adults.

  Such services are provided, when indicated, where the child resides, which may include the child's home, a foster home, a therapeutic foster home, or another community setting to enable the youth to practice desired skills in appropriate settings.

  *Prior approval will not be required for these services; however, the *Member* must be approved by *Tufts Health Plan* to receive services through a clinical hub provider (i.e., a provider for outpatient therapy, in-home therapy, or intensive care coordination). The clinical hub provider serves as the primary behavioral health care provider for the youth and will coordinate with other service providers to meet the child's clinical needs.

For more information about the services available under this benefit, call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565. You may also see the *Medical Necessity* Guidelines on *Our* website **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview**.

Important Note: *Inpatient* and Intermediate behavioral health and substance use disorder services must be obtained at a *Network Hospital* in order to receive benefits at the *In-Network Level of Benefits*. See "*Inpatient* Behavioral Health and Substance Use Disorder Services" in Chapter 1 for more information. To receive care at the *Out-of-Network Level of Benefits*, you must receive approval for *Inpatient* and intermediate behavioral health services from an *Authorized Reviewer*. Please contact the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565 for more information on how to receive this approval.

Cardiac rehabilitation services

Outpatient treatment of documented cardiovascular disease that:
- meet the standards promulgated by the Massachusetts Commissioner of Public Health; and
- is initiated within 26 weeks after diagnosis of cardiovascular disease.

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

Chemotherapy administration

Administration of chemotherapy. For information about coverage for the medications used in chemotherapy, please see "Injectable, infused, or inhaled medications" later in this document.

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, therapeutic exercise, and attended electrical stimulation (EMS).

Cleft lip or cleft palate treatment and services for *Children*

In accordance with Massachusetts law, the following services are covered for *Children* under the age of 18. Services must be prescribed by the treating physician or surgeon, and that *Provider* must certify that the services are *Medically Necessary* and are required because of the cleft lip or cleft palate.

- **Medical and facial surgery:** Covered as described under "*Day Surgery*", "Hospital *Inpatient* care", "Surgery – Reconstructive procedures". This includes surgical management and follow-up care by plastic surgeons. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits.*
- **Oral surgery**: Covered as described under "Oral health services". This includes surgical management and follow-up care by oral surgeons. Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits.*
- **Dental surgery or orthodontic treatment and management**
- **Preventive and restorative dentistry** to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy.
- **Speech therapy and audiology services:** Covered as described under "Speech, hearing and language disorders". Prior approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits.*
- **Nutrition services:** Covered as described under "Nutritional counseling".

Clinical trials - Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening disease or condition (*Inpatient* and *Outpatient*)

To the extent required by Massachusetts and federal law, coverage is provided under this plan for *Inpatient* and *Outpatient* care services received as part of a qualified clinical trial when conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions. Such patient care services are covered to the same extent as those *Outpatient* or *Inpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial. Prior approval by an *Authorized Reviewer* may be required at the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits.*

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 self-management training and educational services

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

Important Note: *We* will only cover these services at the *In-Network Level of Benefits* when provided by a *Network Provider* who is a certified diabetes health care provider.

Diagnostic imaging

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 Pap test (cervical cancer screening - lab test)
- 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 Pap test (laboratory test).
- 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* and *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. This is determined by *Tufts Health Plan.*

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

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 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*);
- Certain prosthetic devices, except breast prostheses and prosthetic arms and legs (in whole or in part), which are covered under "Prosthetic devices" later in this chapter;
- cranial helmets;
- the following equipment when used to diagnose or treat diabetes mellitus Type 1 (insulin-dependent diabetes), diabetes mellitus Type 2 (insulin or non-insulin dependent diabetes), or gestational diabetes:
  - test strips for glucose monitors and/or visual reading (covered under your "Prescription Drug Benefit"); **Note:** See "Prescription Drug Benefit" later in this chapter for other diabetes-related coverage.
  - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind,
  - therapeutic/molded shoes and shoe inserts for *Members* with severe diabetic foot disease; and
  - visual magnifying aids;
- 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

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).

- 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 a *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;
- wheelchair trays;

Note: See the separate "Scalp hair prostheses or wigs" benefit for information on coverage for those items.

Early intervention services

Services provided to *Members* from birth until their third birthday by early intervention programs that meet standards established by the Massachusetts Department of Public Health. Early intervention services include, but are not limited to, occupational therapy, physical therapy, speech therapy, nursing care, and psychological counseling.

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
- chronic disease hospital.

Notes:

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

- *We* cover certain contraceptives, such as oral contraceptives, FDA-approved over-the-counter female contraceptives, and diaphragms, and other hormonal contraceptives (e.g., patches, rings) 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 hearing aids (one per ear per prescription change) for *Children* age 21 or younger, including hearing aid evaluations, the fitting and adjustment of hearing aids, and supplies, including ear molds, as required under Massachusetts law.

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

Coverage is provided for the following services for *Members* who are homebound*:

- home visits by a *Provider*;
- *Skilled* nursing care and physical therapy; and
- the following services, if determined to be a *Medically Necessary* component of skilled intermittent nursing or physical therapy:
  - speech therapy;
  - occupational therapy;
  - medical/psychiatric social work;
  - nutritional consultation;
  - the use of *Durable Medical Equipment;* and
  - the services of a part-time home health aide.

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

Notes:

- Home health care services for physical and occupational therapies following an injury or illness are covered to the extent that those services are provided to restore function lost or impaired (see "Physical and occupational therapy services"). However, those home health care services are not subject to the 60-day period for significant improvement requirement for rehabilitative therapy services or the visit limits for physical and occupational therapy services.
- Prior approval by an *Authorized Reviewer* is requiredat the *In-Network Level of Benefits* and *Out-of-Network Levels of Benefits*.
- Sleep studies performed in the home are not covered under this "Home Health Care" benefit. Instead, 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) on a short-term *Inpatient* basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.

Hospital *Inpatient* 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

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

Human leukocyte antigen testing or histocompatibility locus antigen testing

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

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

Coverage includes costs of testing for A, B or DR antigens.

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 Massachusetts law.

(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 if the female is age 35 or younger or during a period of six months if the female is over the age of 35. 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 or six-month period, as applicable.

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 services 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.

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

(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 Massachusetts 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 used in the treatment of infertility 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 approval 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.*
- Intravenous Immunoglobulin (IVIg) therapy is covered for the treatment of Pediatric Autoimmune Neuropsychiatric Disorders and Pediatric Acute-Onset Neuropsychiatric Syndromes under this benefit
- Coverage includes the components required to administer these medications, including, but not limited to, *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 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

Mammograms

Provided at the following intervals:

- one baseline at 35-39 years of age,
- one every year at age 40 and older, or
- as otherwise *Medically Necessary*.

Maternity care

Maternity care - *Outpatient* routine and non-routine care

- prenatal care, exams, and tests;
- postpartum care provided in a *Provider's* office.

Notes:
- Routine prenatal tests associated with maternity care are covered in full at the *In-Network Level of Benefits*, in accordance with the ACA.
- *Member* cost-sharing will apply at the *In-Network Level of Benefits* to diagnostic tests or diagnostic laboratory tests when ordered as part of routine maternity care. See "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services.

Maternity care - *Inpatient*
- hospital and delivery services; and
- well newborn *Child* care in hospital.

Coverage includes *Inpatient* care in hospital for mother and newborn *Child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

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

For information about notifying *Tufts Health Plan* for a newborn *Child*, see Chapter 1.

Medical supplies

We cover the cost of certain types of medical supplies, including ostomy, tracheostomy, catheter supplies, and insulin pumps. The supplies must be provided by 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 "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 that 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 health 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

  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 *Our* guidelines 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."

Pap tests (cervical cancer screening)

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

Physical and occupational therapy services - *Rehabilitative* and *Habilitative*

- *Rehabilitative* physical and occupational therapy services are covered, including cognitive rehabilitation or cognitive retraining. Rehabilitative services are covered when provided to restore function lost or impaired as the result of an accidental injury or illness; the *Member's* condition is subject to significant improvement within a period of 60 days from the initial treatment as a direct result of these therapies.
- *Habilitative* physical and occupational therapy services are covered when provided to keep, learn, or improve skills and functioning for daily living that were never learned or acquired due to a disabling condition.
- Massage therapy may be covered as a treatment modality when administered as part of a physical therapy visit:
  - that is provided by a licensed physical therapist; and
  - that is in compliance with *Medical Necessity* guidelines, and, if applicable, the prior approval guidelines of *Tufts Health Plan* or its delegate.

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

Preventive health care

Services include, but are not limited to the following. Visit *Our* website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about preventive services.

Members under age 6

Preventive care services from the date of birth until age 6 are covered, including:

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

Coverage is also provided for:

- hereditary and metabolic screening at birth;
- appropriate immunizations and tuberculin tests;
- hematocrit, hemoglobin, or other appropriate blood tests;
- urinalysis as recommended by a *Network Provider*; and
- newborn auditory screening tests, as required by state law.

Members age 6 and older

- routine physical examinations, including appropriate immunizations and lab tests as recommended by a *Network Provider* and
- hearing exams and screenings for *Members* under age 18.

Routine annual gynecological exam .

Includes any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

About follow-up care:

Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or gynecological exam is subject to an office visit *Cost Sharing Amount. at the In-Network Level of Benefits. Member* cost-sharing will also apply at the *In-Network Level of Benefits* to diagnostic tests or diagnostic laboratory tests when these tests are ordered as part of a routine physical or gynecological exam. See "Diagnostic testing" and "Laboratory tests" for information about those services. See *Our* website for more information about which laboratory services are considered preventive: **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services.**

Prosthetic devices

We cover the cost (including repairs) of breast prostheses and prosthetic arms and legs. Coverage is provided for the most appropriate *Medically Necessary* model that adequately meets the *Member's* needs. Prior approval by an *Authorized Reviewer* is required. **Note:** Breast prostheses require prior approval, except when provided in connection with a mastectomy.

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 made specifically for an individual, or a wig, and provided for hair loss due to treatment of any form of cancer or leukemia, alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury.

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.

Special medical formulas

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.
- When *Medically Necessary*: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.

Special medical formulas: (prior approval by an *Authorized Reviewer* may be required)
For the treatment of phenylketonuria (PKU), tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, and methylmalonic acidemia, or when *Medically Necessary*, to protect the unborn fetuses of women with PKU.

Speech, hearing and language disorders

- Diagnosis and treatment are covered when *Medically Necessary*.
- Short-term cognitive retraining or cognitive rehabilitation services are covered when provided to restore function lost or impaired as the result of an accidental injury or sickness. Measurable improvement must be anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery.
- *Cost Sharing Amounts* for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).

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

Surgery -- Hematopoietic stem cell transplants, and human solid organ transplants, and bone marrow transplants for breast cancer

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

- Hematopoietic stem cell transplants and human solid organ transplants that are (i) generally accepted in the medical community; and (ii) provided at a *Tufts Health Plan* Designated facility, are covered for a *Member* who is the recipient. Also, the following services related to procurement of stem cells or a solid organ from the donor are covered for the *Member* (recipient); however, only to the extent that such services are not covered by any other plan of health benefits or health care coverage:
  - evaluation and preparation of the donor; and
  - surgical intervention and recovery services when those services relate directly to donating the stem cells or solid organ to the *Member*.

Notes:

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

Surgery -- in a *Provider's* office

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

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

Approval by an *Authorized Reviewer* is required at the *In-Network Level of Benefits a*nd *Out-of-Network Levels of Benefits*., except (i) for the treatment of cleft lip or cleft palate for *Children* under the age of 18; or (ii) in connection with a mastectomy.

Coverage is provided for:

- services required to relieve pain or to restore a bodily function that is impaired as a result of a congenital defect (including treatment of cleft lip or cleft palate for *Children* under the age of 18, as required under Massachusetts law) birth abnormality, traumatic injury or covered surgical procedure;
- the following services in connection with mastectomy:
  - reconstruction of the breast affected by the mastectomy,
  - surgery and reconstruction of the other breast to produce a symmetrical appearance, and
  - prostheses and treatment of physical complications of all stages of mastectomy (including lymphedema). Breast prostheses are covered as described under "Prosthetic devices".
- Removal of a breast implant is covered when any one of the following conditions exists:
  - the implant was placed post-mastectomy;
  - there is documented rupture of a silicone implant; or
  - there is documented evidence of autoimmune 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.

Except as described above in connection with a mastectomy or with treatment of a cleft lip or cleft palate, *Authorized Reviewer* approval is required before you receive any reconstructive surgery or procedure 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 appropriate. Visits are available for both medical and behavioral health/substance use disorder services. These services are provided through audio, video, or other electronic media communications.

Telemedicine services are provided by:

- A *Network Provider:* You will pay the same *Cost Sharing Amount* for a telemedicine visit as an in-person office visit with that *Network Provider*.
- *Our* designated telemedicine vendor. These services are referred to as "telehealth services." The *Cost Sharing Amount* for these services is listed in the Benefit Overview.

Audio only consultation services are available from a *Tufts Health Plan Provider* or *Our* telemedicine vendor. *Cost Sharing Amounts* and referral rules apply as indicated above. For more information, including services that may be available when you are traveling outside of the 50 United States, visit **https://tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth.** Or call Member Services.

Coverage also applies to telemedicine services that are not considered telemedicine visits. This includes:

- Remote patient monitoring services to collect and interpret clinical data while the *Member* remains at a distant site. These services may occur in real-time or not; and
- Remote evaluation of transferred medical data recorded on an electronic device. The data must be used for the purpose of diagnostic and therapeutic assistance in the care of the *Member.*

See the "Benefit Overview" for the *Cost Sharing Amounts* that apply to these additional telemedicine services.

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* Care 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 24 months. (*In-Network* and *Out-of-Network Levels* combined.) You must receive routine eye examinations from a *Provider* in the **EyeMed Vision Care network** to be covered for these services at the *In-Network Level of Benefits*. See *Our* website or contact Member Services for more information.

Other vision care services (for *Members* of all ages): Coverage is provided for eye examinations and necessary treatment of a medical condition.
No *PCP* referral is required for medical treatment performed by an optometrist.

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 a*nd *Out-of-Network Levels of Benefits*.

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.

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

This pediatric dental benefit is administered by Delta Dental of Massachusetts. Coverage is available to *Members* until the last day of the month in which the *Member*'s 19th birthday occurs. Participating network dentists will file claims for you. Delta Dental will pay the dentist directly. To check if your *Child's* dentist is in the network, or to find a new dentist, visit **www.deltadentalma.com**. Call Delta benefit for questions about what your pediatric dental benefit covers or how a claim was paid.

- Call the Delta Dental Customer Service Department toll free at 1-844-260-6095.
- Delta Dental's automated information line is available 24 hours a day, seven days a week.
- Customer service representatives are available Monday-Thursday from 8:30 am-8:00 pm and on Fridays from 8:30 am-4:30 pm.
- Or visit **www.deltadentalma.com** for coverage information, to check the status of a claim, print an ID card, or see your *Child's* dental claim history.

Dental claims and any written correspondence should be sent to:

Delta Dental of Massachusetts
P.O. Box 2907
Milwaukee, WI 53201-2907

Coverage. The following explains your coverage and benefit limits when you receive services from a participating Delta Dental network dentist.

Type I Services: Preventive & Diagnostic

- Oral Exams – 2 per *Contract Year*. Exams by specialists are not covered except for periodic oral exams.
- Comprehensive Exams – Once per lifetime per dentist location.
- Bitewing x-rays – two sets per *Contract Year*.
- Complete series of x-rays (full mouth) and panoramic x-ray once every 36 months*.
- Single tooth x-rays – as required.
- Cleanings – two per *Contract Year*.
- Fluoride Treatments – Once every 3 months.
- Space Maintainers.
- Sealants – once every 36 months on unrestored molars*.

Type II Services: Basic Covered Services

- Amalgam (silver) fillings – once per 12 months per tooth surface*.
- Composite (white) fillings – once per 12 months per tooth surface*.
- Recement crowns and on lays.
- Rebasing or relining of partial or complete dentures – once every 24 months*.
- Root canal therapy on permanent teeth – One procedure per tooth per lifetime.
- Vital pulpotomy – One procedure per tooth per lifetime.
- Apicoectomy – One procedure per tooth per lifetime.
- Prefabricated stainless steel crowns – once every 36 months*.
- Root planing and scaling – once per quadrant every 24 months*.
- Simple extractions.
- Surgical extractions when not covered by a patient's medical plan.
- Palliative (emergency) treatment of dental pain.
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures.

Type III Services: Major Restorative

- Crowns (over natural teeth when teeth cannot be restored with regular fillings). Stainless steel crowns are covered at a different *Coinsurance* amount – replacement limited to once every 60 months per tooth*.
- Partial and complete dentures – replacement limited to once every 60 months per tooth*.

Type IV Services: Orthodontia (must be approved in advance by an *Authorized Reviewer*)
Braces and related services. Covered only when *Medically Necessary*; patient must have severe and handicapping malocclusion as defined by HLD index score of 22 and/or one or more auto qualifiers.

* 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.

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 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 *Cost Sharing Amounts*. *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).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- 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.
  - Certain brand-name contraceptives may be subject to prior approval.

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 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 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 "Immunizations and vaccinations" 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*
- Medications packaged for institutional use may be excluded from the pharmacy benefit coverage unless otherwise noted in the formulary.

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 Approval 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.

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

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.

While *Tufts Health Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered.

Formulary Exception Process

- If your *Provider* feels it is *Medically Necessary* for you to take medications that are not on the formulary or restricted under any of the "*Tufts Health Plan* Pharmacy Management Programs" described above, he or she may submit a request for coverage. *We* will review the request and provide you with notification of *Our* coverage determination within 72 (seventy-two) hours after receiving the request. *We* will approve the request if it meets *Our* guidelines for coverage. For more information, you can call a Member Representative.
  Note: You or your prescribing *Provider* may request an expedited exception process based on exigent circumstances. *We* will notify you and your prescribing *Provider* of *Our* determination no later than 24 hours after receiving such a request. Exigent circumstances exist when a *Member*:
  - is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function; or
  - is undergoing a current course of treatment using a non-formulary drug.

  Additionally, if *Tufts Health Plan* denies a standard or expedited exception request for a drug not covered by the plan, you have the option of requesting an external review at the same time as filing an internal appeal. The external review determination must be made within 72 hours for standard requests and 24 hours for expedited requests. Please contact the *Tufts Health Plan* Appeals and Grievances Department at 888-880-8699, x. 59674 for more information regarding this external option.

- If a request is made to cover medications that are part of the "New-to-Market Drug Evaluation Process" program or the "Non-Covered Drugs with Suggested Alternatives" program, and that request is approved by *Tufts Health Plan*, the medications will generally be covered on the highest tier (e.g., Tier 3 on a 3-tier formulary, Tier-4 on a 4-tier formulary), with some exceptions. Please call Member Services for more information about on which tier your medication is covered.
- The *Tufts Health Plan* 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
  - moving the brand drug from Tier-2 to Tier-3 or
  - moving the brand drug to *Our* list of non-covered drugs when a generic alternative becomes available.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check *Our* website, or call Member Services.

Note: If you are affected by a deletion to the formulary, *Tufts Health Plan* will notify you at least 60 days before the change is made. Please be aware that advance notification will not be issued for prescription drugs deleted from the formulary that the Food and Drug Administration (FDA) have determined to be unsafe.

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
- for a select number of drug products, a small number of designated specialty pharmacy providers. (For more information about *Tufts Health Plan's* designated specialty pharmacy program, see "*Tufts Health Plan* Pharmacy Management Programs" earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the *Tufts Health Plan* Member Services Department.

How to Fill Prescriptions:

- When you fill a prescription, provide your Member ID to any *Tufts Health Plan* designated pharmacy and pay your *Cost Sharing Amount*.
- If the cost of your prescription is less than your *Copayment*, 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.*

Tufts Health Plan Member Discounts

As a *Member*, you may take advantage of *Tufts Health Plan* Member Discounts. See *Our* website for the most current list. *Tufts Health Plan* Member Discounts include the fitness reimbursement and weight management program reimbursement. Go to *Our* website for further details and required reimbursement forms at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/discounts-perks/overview.**

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.*
   - 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.**
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 applicable *Cost Sharing Amounts*.
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 she or 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. Examinations, evaluations, or services for educational purposes or *Developmental* purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in Chapter 3. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities, behavioral problems, and *Developmental* delays and services to treat speech, hearing and language disorders in a school-based setting. The term "*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.
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. These exclusions do not apply to the treatment of cleft lip or cleft palate for *Children* under the age of 18, as described under the **Cleft lip or cleft palate treatment and services for *Children*** benefit 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 not covered under **Pediatric dental care for *Members* under age 19:**

- An illness or injury that *We* decide is employment-related.
- Bone grafts.
- Consultations.
- Exams by specialists, except for periodic oral exams.
- General anesthesia or IV sedation given by anyone other than a dentist.
- Implants.
- Laboratory or bacteriological tests or reports.
- Occlusal guards.
- Orthodontia that is not *Medically Necessary.*
- Prescription drugs.
- Restorations due to bruxism, erosion, attrition, or abrasion.
- Services and treatments not prescribed by or under the direct supervision of your dentist.
- Services done by a dentist who is a member of your immediate family.
- Services done by someone who is not a licensed dentist or licensed hygienist working as authorized by applicable law.
- Services meant to change or improve appearance.
- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee, or similar person or group.
- Services related to TMJ, including night guards and surgery.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services or supplies that do not meet generally accepted standards of dental practice.
- Services to increase height of teeth or restore occlusion.
- Services that are not dentally necessary and appropriate according to Delta Dental of Massachusetts' review guidelines. Services subject to these guidelines include, but are not limited to, root canals, crowns and related services, bridges, periodontal services, and oral surgery. These guidelines help Delta Dental in making decisions about whether services are covered and whether a given service is the least costly, clinically acceptable method of prevention, diagnosis, or treatment. A service may not be covered under these guidelines even if it was recommended by a dentist. These guidelines can be found on the Delta Dental website at **www.deltadentalma.com** in the "Dentist" section and in the "Member" section. You can have your dentist send

Delta Dental a request for a Pre-treatment Estimate in advance of the service to see if the service meets the review guidelines.

- Services that you would not have to pay for if you did not have this health insurance plan.
- Splinting and other services to stabilize teeth.
- Temporary, complete dentures, or temporary, fixed bridges or crowns.

We can adopt apply policies that *We* deem reasonable when *We* approve the eligibility of *Members*, and the appropriateness of treatment plans and related changes.

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 Massachusetts and federal law, this exclusion does not apply to the following:

- Long-term antibiotic treatment of chronic Lyme disease.
- Bone marrow transplants for breast cancer.
- 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.

Family planning or Maternity care

- Costs associated with home births or with services provided by a doula.
- Over-the-counter contraceptive agents, except as described under **Family planning** in Chapter 3.
- Purchase of an electric hospital-grade breast pump; donor breast milk.

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 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, unless otherwise noted in the formulary.

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 except as provided under **Surgery - Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment** in Chapter 3.
- 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 **Surgery - Reconstructive procedures mastectomy surgeries, and surgeries to treat functional deformity or impairment** in Chapter 3.
- Treatment of spider veins; removal or destruction of skin tags.

Therapies

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

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

- With respect to child-adolescent behavioral health intermediate care and *Outpatient* services, *Tufts Health Plan* will not pay for the following programs:
  - Programs in which the patient has a pre-defined duration of care without *Tufts Health Plan's* ability to conduct concurrent determinations of continued *Medical Necessity* for an individual.
  - Programs that only provide meetings or activities that are not based on individualized treatment planning.
  - Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific *Behavioral Health Disorders.*

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.

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, broken or stolen 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 the date a *Member* ceases to be covered under the plan, except when covered vision materials ordered before coverage ended are delivered; and the services 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 and 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, except as described under **Laboratory tests** in Chapter 3.
- 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. **Note:** This exclusion does not apply to (1) therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member*'s treating doctor, and the shoes and inserts: (i) are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and (ii) are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist; or (2).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 fide association membership. Specifically, your coverage (including federal COBRA coverage and Massachusetts continuation coverage) ends when any of the following occurs:

- you lose eligibility because you:
  - enrolled under a *Group Contract* and no longer meet your *Group's* or *Tufts Health Plan's* eligibility rules, or
  - enrolled under an *Individual Contract* and no longer meet your *Individual Contract'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* or *Individual Contract* (whichever applies) with *Us* ends. (For more information, see "Termination of a *Group Contract* and Notice" or "Termination of an *Individual Contract*" later in this chapter.)

Note: *Children* are not required to live, work, or reside in the *Network Contracting Area.* In addition, there are a few exceptions in which *Dependents* are still eligible for coverage even if they do not 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

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.

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

Coverage ends as of the date you no longer live, work, or reside in the *Network Contracting Area.* Please note that *Children* are not required to live, work or reside in *the Network Contracting Area.*

Before you no longer live, work, or reside in the *Network Contracting Area* tell your *Group* or call Member Services to notify *Us.* For more information contact Member Services. Also, see "If you do not live, work or reside in the *Network Contracting Area*" in Chapter 2.

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* at least 30 days before the date you want your coverage to end. You must pay *Premiums* up through the day your coverage ends.

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.

*Note: There are a few exceptions in which *Dependents* are still eligible for coverage even if they do not 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.

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 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*.

Payment of claims
We will pay for all *Covered Services* you received between:
- *your Effective Date;* and
- 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*.

Termination of a *Group Contract* and Notice

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.

Notice of termination

If you enrolled through a *Group*, the *Group Contract* will terminate if your *Group* fails to pay *Premiums* on time. If this happens, *We* will notify you of the termination in writing within 60 days after the effective date of termination. The notice will tell you that you can elect to continue your coverage under Temporary Continuation of Coverage (TCC) and coverage under an *Individual Contract*, as well as how to elect that coverage. If you elect Temporary Continuation of Coverage and pay the required *Premium*, TCC coverage is available to you during the period between:

- the effective date of termination of your *Group* coverage; and
- the date *We* send you a written notice of termination.

The benefits available under Temporary Continuation of Coverage will be identical to those in your *Group* coverage. *We* may terminate your coverage back to the date the *Group Contract* terminated, if:

- *We* send you a written notice of termination;
- *We* offer you the opportunity to elect Temporary Continuation of Coverage under an *Individual Contract*; and
- you do not elect that coverage within the time period specified in the notice.

Upon termination of TCC, you may elect coverage under an *Individual Contract*. For more information, see "Coverage Under an *Individual Contract*" at the end of Chapter 5.

If the *Group Contract* terminates for any reason other than your *Group's* failure to pay *Premiums*, *We* will send a notice of termination to your *Group* with the effective date of termination. Your *Group* is responsible for notifying you of the termination. *We* are not responsible if your *Group* does not notify you.

Transfer to Other Group Health Plans

Conditions for transfer

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

- 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*.

Termination of an *Individual Contract*

End of *Tufts Health Plan's* and *Subscriber's* relationship under an *Individual Contract*

If you enrolled under an *Individual Contract*, coverage will terminate if your relationship with *Us* ends for any reason, including:

- your *Individual Contract* with *Us* terminates;
- you fail to pay *Premiums* on time*; or
- *We* stop operating.

Chapter 5 -- Continuation of *Group Contract* Coverage

31-Day Continuation Coverage When *Member* Leaves *Group*

Under Massachusetts law, a *Member* who leaves a *Group* shall be able to continue his or her coverage under the *Group Contract* for a period of 31-days. If that *Member* becomes entitled to other health insurance coverage during that 31-day period, this continuation coverage shall end as of the date he or she becomes entitled to the other health insurance coverage. For more information about this continuation coverage, please call your *Group* or Member Services.

Federal Continuation Coverage (COBRA)

Rules for federal COBRA continuation

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

Qualifying Events

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

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

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

When federal COBRA coverage is effective

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

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

Cost of Coverage

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

Duration of Coverage

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

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

When coverage ends

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

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

Massachusetts Continuation Coverage

How to qualify for coverage

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

- the *Subscriber's* death;
- termination of the *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 Massachusetts continuation coverage as described below.

Note: Same-sex marriages legally entered into in Massachusetts are recognized under Massachusetts law. Massachusetts continuation provisions do apply to same-sex *Spouses*. Contact your *Group* for more information.

When coverage begins

Massachusetts continuation coverage is effective on the date following the day *Group* coverage ends, in most cases.

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

Payment of *Premium*
In most cases, you are responsible for payment of 102% of the *Group Premium* for Massachusetts continuation coverage.

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

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

Coverage under an *Individual Contract*
When your coverage under federal COBRA continuation or Massachusetts continuation ends, you and your enrolled *Dependents* may be eligible to apply for coverage under an *Individual Contract*. See "Coverage under an *Individual Contract*" below for more information.

39-Week Continuation Coverage
Under Massachusetts law, when a *Member* becomes ineligible for coverage under the *Group Contract* because of involuntary layoff or death, that person may continue his or her coverage under the *Group Contract* until the earlier of:

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

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

Plant Closing

Description of continuation available under a *Group Contract*
Under Massachusetts law, *Subscribers* whose employment is terminated due to a state-certified plant closing or covered partial closing may be eligible, along with their enrolled *Dependents*, for continuation of coverage for a period of 90 days. The *Group* is responsible for notifying *Subscribers* of their eligibility. Contact your group or Member Services for more information.

Coverage under an *Individual Contract*
If *Group* coverage ends, the *Member* may be eligible to enroll in coverage under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority ("the Connector"). Please note that coverage under an *Individual Contract* may differ from *Group* coverage. For more information, call *Tufts Health Plan* Member Services or contact the Connector either by phone (1-877-MA-ENROLL) or on its website (**www.mahealthconnector.org**).

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 serve 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 anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your *Dependents* for up to 24 months while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (for example, pre-existing condition exclusions) except for service-connected illnesses or injuries.
- Service members may be required to pay up to 102% of the premium for the health plan coverage. If coverage is for less than 31 days, the service member is only required to pay the employee share, if any, for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

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

As described below, when you obtain care from a *Non-Network Provider*, 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 appropriate payment directly to you. If you have not already done so, you will be responsible for paying the *Non-Network Provider* for the services rendered. If you are responsible for any portion of the bill above what *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

Separate claim forms should be submitted for each family member.

Pharmacy Expenses

If you obtain a prescription at a non-designated or out-of-network pharmacy, you will need pay for the prescription up front; and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a *Member* Representative or through our website.

Member Satisfaction Process

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

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

All calls should be directed to *our* Member Services Department at **800-463-8080**. 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 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

Internal Inquiry:

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

We maintain records of each inquiry made by a *Member* or by that *Member's* authorized representative. The records of these inquiries and the response provided by *Tufts Health Plan* are subject to inspection by the Commissioner of Insurance and the Health Policy Commission.

Member Grievance Process

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

It is important that you contact us as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. If you choose to file a grievance verbally, please call a *Tufts Health Plan* Member Representative, who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing. Send it to the P.O. Box address provided 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.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify us that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your *Providers* to release medical information relevant to your grievance to *Us*. You must sign and return the form before *We* can begin the review process. If you do not sign and return the form to *Us* within thirty (30) days of the date you filed, *We* may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance that are in our possession and control.
- *We* will review your grievance and will send you a letter regarding the outcome as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law. upon mutual written agreement between you or your authorized representative and *Tufts Health Plan*.

Clinical Grievances

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

You may file your grievance verbally or in writing. *We* will notify you by mail, within five (5) business days after receiving your letter, that your 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 notify you in writing regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

Internal *Member* Appeals

An appeal is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by *Tufts Health Plan* 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 review all of the information submitted upon appeal, taking into consideration 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. If you would like to file a verbal appeal, call a Member Representative who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your appeal in writing and send it to the P.O. Box address provided 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.

Appeals Timeline

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

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

Note: If you need help, the Consumer Assistance Program in Massachusetts can help you file your appeal. Contact:
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
(800) 436-7757 || **www.mass.gov/hpc/opp**

When Medical Records are Necessary

If your appeal requires the review of medical records., you will receive a form that you will need to sign that authorizes your *Providers* to release to *Tufts Health Plan* medical information relevant to your appeal. You must sign and return the form before *Tufts Health Plan* 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 having reviewed the medical records. You will have access to any medical information and records relevant to your appeal that are in *Our* possession and control.

Who Reviews Appeals?

If the appeal involves a medical necessity determination, an actively practicing health care professional in the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment that is under review, and who did not participate in any of the prior decisions on the case, will take part in the review. In addition, a committee made up of managers and clinicians from various *Tufts Health Plan* departments will review your appeal. A committee within the Appeals and Grievances Department will review appeals involving non-*Covered Services.*

Appeal Response Letters

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

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

Expedited Appeals

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. Should you feel that your request meets the criteria cited above, you or your attending *Provider* should contact the Member Services Department. Under these circumstances, you will be notified of the decision within two (2) business days, but no later than seventy-two (72) hours (whichever is less) after the review is initiated. If your treating *Provider* (the practitioner responsible for the treatment or proposed treatment) certifies that the service being requested is *Medically Necessary*; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal appeal process, you will be notified of the decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for *Durable Medical Equipment (DME)* that was determined not to be *Medically Necessary*, you will be notified of the decision within less than forty-eight (48) hours of the receipt of certification. If you are an *Inpatient* in a hospital, *We* will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at our expense through the completion of the Internal Appeals Process. Only those services which were originally authorized by *Tufts Health Plan* or its delegate and which were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

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

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

If You are Not Satisfied with the Appeals Decision

"Reconsideration"

In circumstances where relevant medical information (1) was received too late to review within the thirty (30) calendar day time limit; or (2) was not received but is expected to become available within a reasonable time period following the written resolution, you may choose to request a reconsideration. *Tufts Health Plan* or its delegate may allow the opportunity for reconsideration of a final adverse determination. If you request a reconsideration, you must agree in writing to a new time period for review. The time period will be no greater than thirty (30) calendar days from the agreement to reconsider the appeal.

External Review by the Office of Patient Protection

The Massachusetts Office of Patient Protection, which is not connected in any way with *Tufts Health Plan*, administers an independent external review process for final coverage determinations based on medical necessity (final adverse determination). Appeals for coverage of services specifically excluded in your *Evidence of Coverage* and payment disputes 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 request an external review by the Office of Patient Protection, you must file your request in writing with the Office of Patient Protection within four (4) months of your receipt of written notice of the denial of your appeal by *Tufts Health Plan* or its delegate. The letter from *Tufts Health Plan* notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection. The review panel will make a decision within forty-five (45) calendar days for standard reviews and within seventy-two (72) hours for expedited reviews.

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

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

You or your authorized representative will have access to any medical information and records relating to your appeal in our possession or under our control.

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

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

- include an acknowledgement of the decision of the review agency;
- advise you of any additional procedures that you need to take in order to obtain the requested coverage or services;
- advise you of the date by which the payment will be made or the authorization for services will be issued by *Tufts Health Plan* 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.

Please note: if you are not satisfied with *our* member satisfaction process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care at 617-521-7372 or the Health Policy Commission's Office of Patient Protection at:

Health Policy Commission
Office of Patient Protection
50 Milk St., 8th Floor
Boston, MA 02109
Phone: 1-800-436-7757
Fax: 1-617-624-5046
Internet: www.mass.gov/hpc/opp
Email: HPC-OPP@state.ma.us

Bills from *Providers*

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 the following information to the *Member* Reimbursement Medical Claims Department:

- 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 listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment.

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

Please note: You must contact *Tufts Health Plan* regarding your bill(s) or send your bill(s) to *Us* within twelve months from the date of service. If you do not, the bill cannot be considered for payment. Most completed reimbursement requests are processed within 30 days.

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.

Except as described earlier in this *Evidence of Coverage*, if you receive *Covered Services* from a non-*Tufts Health Plan Provider We* will pay up to the *Reasonable Charge*.

IMPORTANT NOTE: Certain services you receive from non-*Tufts Health Plan Providers* within *Our Network Contracting Area* may be reimbursable at the *In-Network Level of Benefits*. Some examples of these types of non-*Tufts Health Plans Providers* include;

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

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

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

Notice to Michigan Residents

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

Limitation on Actions

You cannot file a lawsuit against us for failing to pay or arrange for *Covered Services* unless you have completed the *Member* Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under this *Contract*, you must first complete *our Member* Satisfaction Process, and then file your lawsuit within two years after the date you were first sent a notice of the denial. Going through *our Member* Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage. However, if you choose to pursue external review by the Office of Patient Protection, the days from the date your request is received by the Office of Patient Protection until the date you receive the response are not counted toward the two-year limit.

Chapter 7 -- Other Plan Provisions

Subrogation

Tufts Health Plan's right of subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else (a "Third Party"). "Third Party" means any person or company that is, 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;
- no-fault, personal injury protection ("PIP"), or medical payments coverage ("MedPay") under any automobile policy to the extent permissible by law;
- 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.

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 an 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;
- no-fault PIP, or MedPay under any automobile policy to the extent permissible by law;
- 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 to the extent permissible by law, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

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

Workers' compensation

Employers provide workers' compensation insurance for their employees 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 any worker's compensation statute or equivalent employer liability; or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If *We* pay for the costs of health care services or medications for any work-related illness or injury, *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* (whether the payment of such benefits is made to you directly or made on your behalf, for example, to a *Provider*), you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to *Tufts Health Plan.*

Coordination of Benefits

Benefits under other plans

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

We have a coordination of benefits (COB) program that prevents duplication of payment for the same health care services. *We* will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with Massachusetts law, 211 CMR 38.00 *et seq*. As permitted under this law, *We* will coordinate benefits for prescription drug claims pursuant to *Our* secondary payer *Allowed Amount* in all cases.

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

Primary and secondary plans

We will coordinate benefits by determining which plan has to pay first when you make a claim and which plan has to pay second. *We* determine the order of benefits using the first applicable rule set forth in 211 CMR 38.05 and pay or provide benefits pursuant to the rules set forth in 211 CMR 38.04 and 211 CMR 38.06. These regulations are available on the Massachusetts state website, **www.mass.gov/code-of-massachusetts-regulations-cmr.**

Right to receive and release necessary information

When you enroll, you must include information on your membership application about other health coverage you have. After you enroll, you must notify *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). *We* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with *Our* COB program.

Right to recover overpayment

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

For more information

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

Medicare Eligibility

This provision does not apply to a *Member* enrolled under an *Individual Contract.*

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

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

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

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

- if you are age 65 or older and are not actively working;
- if you are age 65 or older and your employer has fewer than 20 employees;
- after the first 30 months you are eligible for Medicare due to end stage renal disease;
- if you are a *Member* who is enrolled under an *Individual Contract* (meaning not covered through an employer under a *Group Contract*); or
- if you are eligible for Medicare under age 65 due to disability but are not actively working or are actively working for an employer with fewer than 100 employees.

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

Use and Disclosure of Medical Information

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

Relationships between *Tufts Health Plan* and *Providers*

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 causing your membership application to be submitted to *Tufts Health Plan*, you apply for *Group* coverage and agree, on behalf of yourself and your enrolled *Dependents*, to all the terms and conditions of the *Group Contract*, including this *Evidence of Coverage*.

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: If your *Group* fails to pay the *Premium* on time, *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* and Notice" in Chapter 4.

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

Changes to this *Evidence of Coverage*

We may change this *Evidence of Coverage*. Changes do not require your consent. Notice of changes in *Covered Services* will be sent to your *Group* at least 60 days before the *Effective Date* of the modifications and will include information regarding any material changes in clinical review criteria and detail the effect of such changes on a Member's personal liability for the cost of such charges.

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

Note: If changes are made, they will apply to all *Members* in your *Group* not 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 02472-9173.

Enforcement of terms

We may choose to waive certain terms of the *Group Contract*, if applicable including 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 supersedes all previous *Evidence of Coverage.*

Individual Contract

Acceptance of the terms of the *Individual Contract*

By causing your membership application to be submitted to *Tufts Health Plan*, you apply for coverage under an *Individual Contract* and agree, on behalf of yourself and your enrolled *Dependents*, to all the terms and conditions of the *Individual Contract*, including this *Evidence of Coverage.*

Payments for coverage

We will bill you for coverage under an *Individual Contract and* you will be required to pay *Premiums* to us for that coverage. *We* are not responsible if *you fail to pay Premiums* in accordance with the *Individual Contract*.

Note: If you do not pay the *Premiums* on time, *We* may cancel your coverage in accordance with the *Individual Contract* and applicable state law.

We may change the *Premium*. If the *Premium* is changed, the change will apply to all *Members* under the *Individual Contract*.

Changes to this *Evidence of Coverage*

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

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

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.

Note: If changes are made, they will apply to all *Members* under the *Individual Contract*, not 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 02472-9173

Enforcement of terms

We may choose to waive certain terms of the *Individual Contract*, if applicable, including 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 *Anniversary Date* on or after January 1, 2022 and supersedes all previous *Evidence of Coverage*.

Appendix A -- Glossary of Terms And Definitions

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

Adoptive Child
A *Child* is an Adoptive *Child* as of the date he or she:

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

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

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* or *Individual Contract* first renews and each successive annual renewal date.

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*.

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. A BCBA professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessments 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
- the Child of an enrolled child; or
- any other Child who meets the IRS Code definition of a *Dependent* of the *Subscriber* or the *Spouse*.

Coinsurance
The percentage of costs you must pay for certain *Covered Services*.
- For services provided by a *Network Provider*, your share is the lesser of:
  - the applicable *Network* fee schedule amount for those services; or
  - the *Network Provider's* actual charges for those services.

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.*

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

Notes:
- For a *Group Contract*, the Contract Year is determined by the *Group.*
- For an *Individual Contract*, the Contract Year is designated by *Tufts Health Plan.*

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 fixed amount you pay for certain *Covered Services*. Copayments are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise.

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

Covered Service
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*; 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.

Note: Covered Services do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any *Provider*, *Member*, service, supply or medication.

Custodial Care

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

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 by *Tufts Health Plan* this *Evidence of Coverage*. The following do not apply to your Deductible.

- 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 Provider's* 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 to show changes in *Providers* affiliated with *Network* For more information *Providers* listed in the Directory of Health Care Providers, call the Member Services Department or check *Our* website.

Disabled Dependent

The *Subscriber's Child* who:

- became permanently physically or mentally disabled before the last day of the month in which the *Child's* 26th birthday occurs;
- is incapable of supporting himself or herself due to disability;
- lives with the *Subscriber* or *Spouse*; and
- was covered under the *Subscriber's Family Coverage* immediately before the last day of the month in which the *Child's* 26th birthday occurs or has been covered by other group health coverage since the disability began.

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

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

Individual Contract
The agreement between *Tufts Health Plan* and the *Subscriber* under which:
- *We* agree to provide individual coverage; and
- the *Subscriber* agrees to pay a *Premium* to *Us*.

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

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* (or, with respect to *Inpatient* mental health or *Inpatient* substance use disorder care, when care is provided or authorized by a *Network Hospital*). See Chapter 1 for more information.

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

Inpatient Notification (formerly known as "Preregistration")
Tufts Health Plan's process of validating all information required for all *Inpatient* admissions and transfers. Inpatient Notification is not a guarantee of payment. See Chapter 1 for more information.

Limited Service Medical Clinic

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

Medically Necessary (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:

- 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, is 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 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.

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

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 a *Group Contract* or *Individual Contract*. Also referred to as "you".

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*. This is also the period each year when *Tufts Health Plan* allows eligible individuals to apply for coverage in accordance with an *Individual 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.

Pre-Existing Condition
A condition which had during the six months immediately preceding your *Effective Date*, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received. Pregnancy and infertility are not considered pre-existing conditions.

Premium
Under a *Group Contract,* the total monthly cost of an *Individual* or *Family* Plan that the *Group* pays to *Tufts Health Plan.* Under an *Individual Contract,* the total monthly cost of an Individual or *Family Plan* 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 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, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental/behavioral health counselors, licensed independent clinical social workers, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental/behavioral health nursing, licensed alcohol and drug counselor I, licensed marriage and family therapists, licensed speech-language pathologists, and licensed audiologists.

Notes:

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

Reasonable Charge
The lesser of:
- the amount charged by the *Non-Network Provider*; or
- the amount that *We* determine to be reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to: Medicare fee schedules and *Allowed Amounts*, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.

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

Routine Nursery Care
Routine hospital care provided to a well newborn child immediately following birth until discharge from the hospital.

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

Spouse
The *Subscriber's* legal spouse, according to the law of the state in which you reside or divorced spouse as required by Massachusetts law.

Subscriber
The person who:
- for a *Group Contract,* is employed by the *Group*;
- for an *Individual Contract,* is a Massachusetts resident;
- enrolls in *Tufts Health Plan* on behalf of himself or herself and any *Dependents*; and
- in whose name the *Premium* is paid in accordance with either a *Group Contract* or an *Individual Contract* (whichever applies).

Tufts Health Plan or Tufts HP
Tufts Insurance Company (TIC) which is authorized to offer POS and PPO products. TIC has entered into an agreement with Tufts Benefit Administrators, Inc. (TBA) for TBA to administer the health benefits and make available a network of *Providers* described in this *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 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 a condition or an unforeseen illness or injury, whether medical, physical, 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 and other State and Federal Notices

ERISA RIGHTS

Note: Applies to *Group Contracts* only.
If your plan is an ERISA plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Most plans are ERISA plans, but not all. Please contact your plan administrator to determine if your plan is an ERISA plan. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and prudent actions by plan fiduciaries.

Receiving Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

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

Continuing Group Health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

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

Prudent Actions by Plan Fiduciaries

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

Enforcing Your Rights

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

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

Note: Applies to *Group Contracts* only.

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

Who can submit a claim?

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

How do I designate an Authorized Claimant?

An authorized claimant can be designated at any point in the claims process – at the pre-service, post service or appeal level. Please contact a *Tufts Health Plan* Member Representative at the number on your ID card for the specifics on how to appoint an authorized claimant.

Types of claims

There are several different types of claims that you may submit for review. *Tufts Health Plan*'s procedures for reviewing claims depends upon the type of claim submitted (urgent care claims, pre-service claims, post-service claims, and concurrent care claims).

Urgent care claims: An "urgent care claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your provider's determination, would subject you to severe pain that cannot be adequately managed without the care or treatment being requested. For urgent care claims, *We* will respond to you within 72 hours after receipt of the claim*. If *We* determine that additional information is needed to review your claim, *We* will notify you

within 24 hours after the receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hours after that time to provide the requested information. *We* will evaluate your claim within 48 hours after the earlier of *Our* receipt of the requested information, or the end of the extension period given to you to provide the requested information.

Concurrent care decisions: A "concurrent care decision" is a determination relating to the continuation/reduction of an ongoing course of treatment to be provided over a period of time or number of treatments. If *We* have already approved an ongoing course of treatment for you and 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 15 days after receipt of the claim*. If *We* determine that an extension is necessary due to matters beyond *Our* control, *We* will notify you within 15 days informing you of the circumstances requiring the extension and the date by which *We* expect to render a decision (up to an additional 15 days). If you make a pre-service claim, but do not submit enough information for *Us* to make a determination, *We* will notify you within 15 days and describe the information that you need to provide to *Us*. You will have no less than 45 days from the date you receive the notice to provide the requested information.

Post-service claim: A "post-service claim" is a claim for payment for a particular service after the service has been provided. For post-service claims, *We* will respond to you within 30 days and describe the information that you need to provide to *Us*. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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

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

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

Note: Applies to *Group Contracts* only.

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

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, you may be required to provide notification to *Tufts Health Plan*. For information on notification requirements, contact your plan administrator.

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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

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

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

- Qualifying Exigency Leave: Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. 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 servicemember 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 servicemember. 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/whd/regs/compliance/posters/fmlaen.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 .

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 .

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: Tufts 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 plan 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 Representative 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.

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

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

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

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

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

You may file a written complaint using the DOI's Insurance Complaint Form. You may request the form by phone or by mail or find it on the DOI's webpage at **www.mass.gov/ocabr/docs/doi/consumer/css-complaint-form.pdf**

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

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

ANTI-DISCRIMINATION NOTICE

Tufts Health Plan **complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.** ***Tufts Health Plan*** **does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.**

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with *Us*, such as written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Member Services.

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

Tufts Health Plan
Attention: Civil Rights Coordinator Legal Dept.
1 Wellness Way, Canton, MA 02021
Phone: 888.880.8699 ext. 48000, TTY number — 800.439.2370 or 711
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

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

tuftshealthplan.com | 800.462.0224

Appendix C -- Schedule II and III Opioid Medications

Schedule II drugs are defined under Massachusetts law as drugs: (1) with a high potential for abuse; (2) with a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; and (3) whose abuse may lead to severe psychological or physical dependence.

Schedule III drugs are defined under Massachusetts law as drugs: (1) with a potential for abuse is less than the drugs in Schedules I and II; (2) that have a currently accepted medical use in treatment in the United States; and (3) whose abuse may lead to moderate or low physical dependence or high psychological dependence.

Effective January 1, 2021, the following opioid medications have been classified as Schedule II or Schedule III controlled substances by the state of Massachusetts. In accordance with Massachusetts law, if you are prescribed any of these medications and wish to have a quantity less than what was prescribed, no additional cost or penalty will be imposed on you. If the *Member* fills a lesser quantity that is prescribed of a Schedule II opioid controlled substance, and then decides to fill the remainder of the original prescription at the same pharmacy within 30 days of the original prescription date, no additional *Copayment* or other cost sharing will be applied. This list is subject to change throughout the year. Please call a Member Representative for the most current information about Schedule II and III medications covered by *Tufts Health Plan*.

Schedule II medications

- acetaminophen/hydrocodone
- acetaminophen/oxycodone
- aspirin/oxycodone
- belladonna/opium suppositories
- brompheniramine/hydrocodone/phenylephrine
- brompheniramine/hydrocodone/pseudoephedrine
- chlorpheniramine polistirex/hydrocodone polistirex
- chlorpheniramine/hydrocodone
- chlorpheniramine/hydrocodone/phenylephrine
- chlorpheniramine/hydrocodone/pseudoephedrine
- codeine sulfate
- dexbrompheniramine/hydrocodone/phenylephrine
- dexchlorpheniramine/hydrocodone/phenylephrine
- diphenhydramine/hydrocodone/phenylephrine
- fentanyl
- guaifenesin/hydrocodone/phenylephrine
- guaifenesin/hydrocodone/pseudoephedrine
- hydrocodone
- hydrocodone ER
- hydrocodone/homatropine
- hydrocodone/ibuprofen
- hydrocodone/phenylephrine/pyrilamine
- hydrocodone/potassium guaiacolsulfonate
- hydrocodone/pseudoephedrine
- hydromorphone
- hydromorphone ER
- ibuprofen/oxycodone
- levorphanol tartrate
- meperidine
- meperidine/promethazine
- methadone
- morphine
- morphine ER
- morphine sulfate ER

- morphine/naltrexone
- naltrexone/oxycodone
- opium tincture
- oxycodone
- oxycodone ER
- oxymorphone
- oxymorphone ER
- tapentadol

Schedule III medications

- acetaminophen/butalbital/caffeine/codeine
- acetaminophen/caffeine/dihydrocodeine
- acetaminophen/chlorpheniramine/codeine
- acetaminophen/codeine
- aspirin/butalbital/caffeine/codeine
- aspirin/caffeine/dihydrocodeine
- aspirin/carisoprodol/codeine
- aspirin/codeine
- brompheniramine/dihydrocodeine/pseudo-ephedrine
- chlorpheniramine/codeine
- codeine/guaifenesin
- codeine/guaifenesin/pseudoephedrine
- dihydrocodeine/guaifenesin
- dihydrocodeine/guaifenesin/phenylephrine
- dihydrocodeine/phenylephrine/pyrilamine

Appendix D -- COVID-19 Testing and Treatment

Your *Tufts Health Plan Evidence of Coverage* (EOC) has been amended as described below with respect to coverage for Coronavirus (COVID-19) testing, treatment, and vaccinations. The following *Covered Services* are provided in accordance with federal and Massachusetts law.

COVID-19 Testing

Medically Necessary COVID-19 polymerase chain reaction (PCR) and antigen testing is covered for symptomatic individuals, individuals identified as close contacts by state or local health officials, and asymptomatic individuals under circumstances in accordance with federal and Massachusetts law. COVID-19 testing solely intended for return to work, school, or other locations is not *Medically Necessary* and accordingly not covered.

Antibody tests will be covered when *Medically Necessary* to support COVID-19 treatments, or for a Member whose immune system is compromised and/or knowledge of COVID-19 antibodies may impact the future outcome of treatment. Antibody tests will not be covered when part of a "return to work" program or when not associated with treatment for COVID-19.

Medically Necessary COVID-19 testing will be covered with no out-of-pocket costs. This means that no *Copayment, Coinsurance,* or *Deductible* will apply. COVID-19 testing does not require prior approval by an *Authorized Reviewer*. Please contact Member Services for more information.

COVID-19 Treatment

Medically Necessary COVID-19-related treatment for all *Emergency, Inpatient, Outpatient,* and cognitive rehabilitation services—including all professional, diagnostic, and laboratory services—will be covered with no out-of-pocket costs. This means that no *Copayment, Coinsurance,* or *Deductible* will apply[1] . Please note that *Member Cost Sharing Amounts* may apply to *Covered Services* related to the treatment of reactions to COVID-19 vaccinations. *Members* are encouraged to see *Tufts Health Plan Providers* whenever possible. However, this policy is also applicable to treatment provided by *Non-Tufts Health Plan Providers*[2] . COVID-19-related treatment does not require prior approval by an *Authorized Reviewer*. Please contact Member Services for more information.

COVID-19 Vaccinations

Medically Necessary COVID-19-vaccinations are covered with no out-of-pocket costs. This means that no *Copayment, Coinsurance,* or *Deductible* will apply. COVID-19 vaccinations do not require prior approval by an *Authorized Reviewer*. Please contact Member Services for more information.

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

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[1] If you are covered under a Saver plan, your health insurance is designed to comply with the Internal Revenue Service requirements for a "High Deductible Health Plan." This means the *Deductible* may apply to certain services.

[2] *Members* on an HMO plan (or Tufts Medicare Complement plan) must receive all other non-emergency services from a *Tufts Health Plan Provider*. *Members* on a POS or PPO plan are covered to receive services from both *Tufts Health Plan* and *Non-Tufts Health Plan Providers*. To find a *Provider*, please visit our website at **www.tuftshealthplan.com.**. Click on "Find a Doctor or Hospital" to start your search.