



MASSACHUSETTS
Tufts Medicare Complement
Evidence of Coverage



This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. However, Medicare is a plan that meets MCC standards. Because you have Medicare Part A and Part B, you meet MCC standards and will not be subject to a tax penalty.

1 Wellness Way, Canton, MA 02021

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MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

This plan is not intended to provide comprehensive health care coverage and does not meet Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans. However, Medicare is a plan that meets MCC standards. Because you have Medicare Part A and Part B, you meet MCC standards and will not be subject to a tax penalty.

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

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN

1 Wellness Way
Canton, Massachusetts 02021

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

IMPORTANT PHONE NUMBERS:

Emergency Care

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

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

Liability Recovery

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

For questions related to subrogation, call a Member Representative at 1-800-462-0224. If you are uncertain which department can best address your questions, call Member Services.

Member Services Department

Call our Member Services Department at 1-800-462-0224 for general questions, assistance in choosing a *Primary Care Provider (PCP)*, benefit questions, and information regarding eligibility for enrollment and billing.

Medicare

Contact your local Social Security office or visit Medicare's website at www.medicare.gov.

Behavioral Health Services

If you need assistance obtaining a *Provider* or receiving information regarding behavioral/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

IMPORTANT ADDRESSES:

Appeals and Grievances Department

If you need to call Tufts HP about a concern or appeal, contact a Member Representative at 1-800-462-0224. To submit your appeal or grievance in writing, send your letter to the P.O. Box address below. Or you may fax it to us at 617-972-9509. You may also submit your appeal or grievance electronically via the secure online member portal.

Tufts Health Plan

Attn: Appeals and Grievances Department

P.O. Box 474

Canton, MA 02021

Or 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 *Tufts Health Plan* and to learn more about the self-service options that are available to you, please see the *Tufts Health Plan* Web site at www.tuftshealthplan.com.

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**](https://tuftshealthplan.com/covid-19/member/latest-updates)

Fraud, Waste And Abuse

You may have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud or abuse, or if you have questions, please call Member Services, or email fraudandabuse@point32health.org. 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

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/2023-EOC-Amendments> on the *Tufts Health Plan* website.

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 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 κάρτα 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) សម្រាប់សេវាកម្មប្រយោជន៍ឥតគិតថ្លៃ ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

Korean 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

Laotian ສໍາລັບການແປພາສາລາວທີ່ບໍ່ໄດ້ຮັບຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo báhá ilíní da Diné k'ehjí álnéehgo, hodiilnih béesh bee hani'é bee née ho' dílzingo nantinígíí bikáá'.

Persian برای ترجمه رایگان فارسی به شماره تلفن مندرج در کارت شناسایی 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.

TDD Telecommunications Devices for the Deaf: 711

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Chapter 1 - How Your HMO Plan Works

Overview

Introduction

Welcome to the *Tufts Health Plan ("Tufts HP")* Medicare Complement Plan ("TMC Plan"). We are pleased you have chosen *Tufts HP*. We look forward to working with you to help you meet your health care needs. Your satisfaction with *Tufts Health Plan* is important to us. If at any time you have questions, please call a Member Representative at 1-800-462-0224 and we will be happy to help you.

The Tufts Medicare Complement Plan, in conjunction with Medicare, offers a comprehensive package of medical benefits. The TMC Plan is designed to add to existing Medicare coverage (Parts A and B of the Original Medicare Program), subject to the terms, conditions, exclusions and limitations of Medicare eligible services.

Any services covered under Parts A and B of Original Medicare are covered under this TMC Plan, even if those Medicare-covered services are not specifically listed in this *Evidence of Coverage*. We pay the charges for the Part A or B *Deductibles* and/or *Coinsurance* that Medicare requires you to pay for those services.

Under the TMC Plan, coverage is also provided for certain services which are not covered under Medicare. Those services include:

- Certain preventive care services, including annual vision and hearing screenings
- prescription drug coverage.

Eligibility for Benefits under this TMC Plan

You have chosen to participate in a managed health care network in which you and your *Primary Care Provider ("PCP")* play the most important roles. *Tufts HP* is a health maintenance organization which arranges for your health care through a network of health care professionals and hospitals. When you join *Tufts HP* you will need to choose a *Primary Care Provider ("PCP")* to manage your care. Your *PCP* is a physician or nurse practitioner in private practice who personally cares for your health needs, and if the need arises, refers you to a specialist within the *Tufts HP* network.

By joining the TMC Plan, you agree to receive your care from *Tufts HP Providers*. If you fail to do this:

- *Tufts HP* will not provide benefits for either Medicare-eligible services or the additional *Covered Services* available under this plan, and
- you will be responsible for any Medicare *Deductible* and *Coinsurance* amounts.

Tufts HP covers only the services and supplies described as *Covered Services* in Chapter 3. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

Evidence of Coverage

This book, called your *Evidence of Coverage*, will help you find answers to your questions about *Tufts Health Plan* benefits. *Tufts HP* certifies that you have the right to services and supplies described in this *Evidence of Coverage* which are *Medically Necessary* and authorized by your *PCP*.

The benefits described in this *Evidence of Coverage* are available as established by Massachusetts General Law Chapter 176G. Under the provisions of the Tufts Medicare Complement Plan, Medicare is the primary insurer and *Tufts HP* is the secondary insurer.

Coverage will be subject to the terms, conditions, exclusions, and limitations of eligible services and supplies under the Original Medicare Plan. That coverage is subject to change per Medicare's guidelines. This *Evidence of Coverage* is not intended as a full explanation of Medicare's benefits. Information and guidelines established for Medicare by the federal Centers for Medicare and Medicaid Services may be obtained:

- by contacting your local Social Security office; or
- via the internet on the official Medicare Web site at www.medicare.gov.

In addition, please refer to your Medicare Handbook for any questions pertaining to the Medicare portion of your health care under this TMC plan.

Please note that words with special meanings appear as italicized words in this *Evidence of Coverage*. Those words are defined in the Glossary in Appendix A.

Calls to Member Services

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

How the Plan Works

Primary Care Providers

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

Medically Necessary services and supplies

Tufts HP will pay for *Covered Services* and supplies when they are *Medically Necessary*.

Important: *Tufts HP* will not pay for services or supplies which are not *Covered Services*, even if they were provided or authorized by your *PCP*.

Service Area

In most cases, you must receive your care in the *Tufts HP Service Area*. The exceptions are for an *Emergency*, or *Urgent Care* while traveling outside of the *Service Area*.

See the *Tufts Directory of Health Care Providers* for *Tufts HP's Service Area*.

Changes to Tufts HP Provider network

Tufts HP offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*. Although *Tufts HP* works to ensure the continued availability of *Tufts HP Providers*, our network of *Providers* may change during the year.

This can happen for many reasons, including a *Provider's* retirement, moving out of the *Service Area*, or failure to continue to meet *Tufts HP's* credentialing standards. In addition, because *Providers* are independent contractors who do not work for *Tufts Health Plan*, this can also happen if *Tufts HP* and the *Provider* are unable to reach agreement on a contract.

If you have any questions about the availability of a *Provider*, please call a Member Representative at 1-800-462-0224.

Comparison of coverage

The table below tells you if coverage exists, depending on the type of care you receive and the place you receive care.

| IF you... | AND you are... | THEN... |
|--------------------------------------|---------------------------------|--|
| receive routine health care services | in the <i>Service Area</i> | you are covered, if you receive care through your <i>PCP</i> . |
| | outside the <i>Service Area</i> | you are <u>not</u> covered. |
| are ill or injured | in the <i>Service Area</i> | you are covered, if you receive care through your <i>PCP</i> . |
| | outside the <i>Service Area</i> | you are covered for <i>Urgent Care</i> . |
| have an <i>Emergency</i> | in the <i>Service Area</i> | you are covered. |
| | outside the <i>Service Area</i> | you are covered. |

Continuity of Care

If you are an existing Member

If your *Provider* is involuntarily disenrolled from *Tufts Health Plan* for reasons other than quality or fraud, you may continue to see your *Provider* in the following circumstances:

- Pregnancy. If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* through your first postpartum visit.
- Terminal Illness. If you are terminally ill (having a life expectancy of 6 months or less), you may continue to see your *Provider* as long as necessary.

If your *PCP* disenrolls, we will provide you notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud, you may continue to see your *PCP* for up to 30 days after the disenrollment.

To choose a new *PCP*, call a Member Representative at 1-800-462-0224. The Member Representative will help you to select one from the *Tufts Health Plan Directory of Health Care Providers*. You can also visit the *Tufts Health Plan* Web site at www.tuftshealthplan.com to choose a *PCP*.

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* for up to 30 days from your *Effective Date*.
- the *Provider* is your *PCP*. In this instance, you may continue to see your *PCP* 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* through your first postpartum visit;
- you are terminally ill. In this instance, you may continue to see your *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 *Tufts HP* with necessary medical information related to the care provided; and
- to adhere to *Tufts Health Plan's* policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by *Tufts HP*.

About Your Primary Care Provider

Importance of choosing a PCP

Each *Member* must choose a *PCP* when he or she enrolls. Until you choose a *PCP*, only *Emergency* care is covered. You are eligible for all *Covered Services* when you have chosen your *PCP*. The *PCP* you choose will be associated with a specific *Tufts HP Provider Organization*. This means that you will usually receive *Covered Services* from health care professionals and facilities associated with that *Tufts HP Provider Organization*.

What a PCP does

A *PCP*:

- provides routine health care (including routine physical examinations),
- arranges for your care with other *Tufts HP Provider*, and
- provides referrals for other health care services. See "*Outpatient* mental health/substance abuse services" later in this chapter for more information about these services.

Your *PCP*, or a *Covering Provider*, is available 24 hours a day.

Your *PCP* will coordinate your care by: treating you, or referring you to specialty services.

Choosing a PCP

You must choose a *PCP* from the list of *PCPs* in our searchable *Tufts HP Directory of Health Care Providers*. If you already have a *Provider* who is listed as a *PCP*, in most instances you may choose him or her as your *PCP*.

If you do not have a *Provider* or your *Provider* is not listed in the *Tufts HP Directory of Health Care Providers*, call a Member Representative at 1-800-462-0224 for help in choosing a *PCP*. If you have difficulty choosing *PCP*, please contact Member Services.

Notes:

Under certain circumstances required by law, if your *Provider* is not in the *Tufts HP network*, you will be covered for a short period of time for services provided by your *Provider*. A Member Representative can give you more information. Please see "*Continuity of Care*".

For additional information about a *PCP* or specialist, the **Massachusetts Board of Registration in Medicine** provides information about *Providers* licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 654-9800 or www.massmedboard.org.

Contacting your new *PCP*

If you have chosen a new *Provider* as your *PCP*, you should:

- contact your new *PCP* as soon as you join and identify yourself as a new *Tufts HP Member*,
- ask your previous *Provider* to transfer your medical records to your new *PCP*, and
- make an appointment for a check-up or to meet your *PCP*.

If you can't reach your PCP

Sometimes you may not be able to reach your *PCP* by phone right away. The table below explains what you should do if this happens.

| IF... | THEN... |
|---|---|
| your <i>PCP</i> cannot take your call at once | always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call. |
| you need medical services after hours | please contact your <i>PCP</i> or a <i>Covering Provider</i> . Your <i>PCP</i> , or a <i>Covering Provider</i> , is available 24 hours a day, 7 days a week. If you need <i>Inpatient</i> mental health or substance abuse services after hours, please call 1-800-208-9565 for assistance. |

Note: If you are experiencing a medical emergency, you do not have to contact your *PCP* or a *Covering Provider*; instead, proceed to the nearest emergency medical facility for treatment (see "*When You Need Emergency or Urgent Care*" below for more information).

Changing your PCP You may change your *PCP* or, in certain instances, *Tufts HP* may require you to do so. The new *Provider* will not be considered your *PCP* until:

- you choose a new *PCP* from the *Tufts HP Directory of Health Care Providers*;
- you report your choice to a Member Representative at 1-800-462-0224; and
- *Tufts HP* approves the change in your *PCP*.

Then, *Tufts HP* will send you a new Member ID card listing your new *PCP*.

Note: You may not change your *PCP* while you are an *Inpatient* or in a partial hospitalization program.

Canceling appointments

If you must cancel an appointment with any *Provider*:

- always provide as much notice to the *Provider* as possible (at least 24 hours), and
- if your *Provider's* office charges for missed appointments that you did not cancel in advance, *Tufts HP* will not pay for the charges.

Referrals for specialty services

Every *PCP* is associated with a specific *Provider Organization*. If you need to see a specialist (including a pediatric specialist), your *PCP* will select the specialist and make the referral. Usually, your *PCP* will select and refer you to another *Provider* in the same *Provider Organization* (as defined in Appendix A). Because the *PCP* and the specialists already have a working relationship, this helps to provide quality and continuity of care.

If you need specialty care that is not available within your *PCP's Provider Organization* (this is a rare event), your *PCP* will choose a specialist in another *Provider Organization* and make the referral. When selecting a specialist for you, your *PCP* will consider any long-standing relationships that you have with any *Tufts HP Provider*, as well as your clinical needs. (As used in this section, a long-standing relationship means that you have recently been seen or been treated repeatedly by that *Tufts HP* specialist.)

If you require specialty care that is not available through any *Tufts HP Provider* (this is a rare event), your *PCP* may refer you, with the prior approval of an *Authorized Reviewer*, to a *Provider* not associated with *Tufts HP*. We will pay up to the *Reasonable Charge*. You will be responsible for any applicable cost share. You may receive a bill for these services. Please call Member Services or see "Bills from Providers" in Chapter 6 for information on what to do if you receive a bill.

Notes:

- A referral to a specialist must be obtained from your *PCP* before you receive any *Covered Services* from that specialist. If you do not obtain a referral prior to receiving services, you will be responsible for the cost of those services.
- *Covered Services* provided by non-*Tufts HP Providers* are not paid for unless authorized in advance by your *PCP* and approved by an *Authorized Reviewer*.
- For mental health and substance abuse services, you do not need a referral from your *PCP*. See "*Outpatient* mental health/substance abuse services" later in this chapter for more information.

Referral forms for specialty services

Except as provided below, your *PCP* must complete a referral every time he or she refers you to a specialist. Sometimes your *PCP* will ask you to give a referral form to the specialist when you go for your appointment. Your *PCP* may refer you for one or more visits and for different types of services. Your *PCP* must approve any referrals that a specialist may make to other *Providers*. Make sure that your *PCP* has made a referral before you go to any other *Provider*. A *PCP* may authorize a standing referral for specialty health care provided by a *Tufts HP Provider*.

Authorized Reviewer approval

If the specialist refers you to a non-*Tufts HP Provider*, the referral must be approved by your *PCP* and an *Authorized Reviewer*. If you do not obtain that approval, *Tufts HP* will not cover those services and supplies.

When referrals are not required

The following *Covered Services* do not require a referral or prior authorization from your *Primary Care Provider*. Except as detailed earlier in this chapter, or for *Urgent Care* outside of the *Tufts HP Service Area*, or for *Emergency* care, you must obtain these services from a *Tufts HP Provider*.

- *Emergency Care* (Note: If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts HP* within 48 hours after receiving care. Notification from the attending *Provider* satisfies this requirement.)
- Mammography screenings 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*.
- *Urgent Care* outside of the *Tufts HP Service Area* (Note: You must contact your *PCP* after *Urgent Care Covered Services* are rendered for any follow-up care.)
- Pregnancy terminations.
- Routine eye exams.
- Care in a limited service medical clinic.
- Spinal manipulation.
- Medical treatment provided by an optometrist.
- *Outpatient* mental health and substance abuse services.
- The following specialty care provided by a *Tufts HP Provider* who is an obstetrician, gynecologist, certified nurse midwife or family practitioner:
 - Maternity Care.
 - *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions.
 - Routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Financial Arrangements between *Tufts HP* and *Tufts HP Providers*

Methods of payment to *Tufts HP Providers*

Tufts HP's goal in compensation of *Providers* is to encourage preventive care and active management of illnesses. *Tufts HP* strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards *Providers* for providing high quality care to our *Members*. *Tufts HP* uses a variety of mutually agreed upon methods to compensate *Tufts HP Providers*.

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

Tufts HP oversees the provision of care through its 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

| | |
|--|--|
| Introduction | <i>Tufts HP</i> gives each <i>Member</i> a Member identification card (Member ID). |
| Reporting errors | When you receive your Member ID, check it carefully. If any information is wrong, call a Member Representative at 1-800-462-0224. |
| Using your card/ Identifying yourself as a <i>Tufts HP Member</i> | <p>Your Member ID card is important because it identifies your health care plan. Please:</p> <ul style="list-style-type: none">• carry your Member ID card at all times;• have your Member ID card with you for medical, hospital and other appointments; and• show your Member ID card to any <i>Provider</i> before you receive health care. <p>When you receive services, you must tell the office staff that you are a <i>Tufts HP Member</i>.</p> |
| IMPORTANT NOTE: If you do not do this, and, as a result, your <i>PCP</i> or <i>Tufts HP</i> does not manage your care, then | |
| <ul style="list-style-type: none">• <i>Tufts HP</i> 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 <i>Member</i> when you receive care. A Member ID alone is not enough to get you benefits. If you receive care when you are not a <i>Member</i> , you are responsible for the cost. |
| Membership Identification Number | If you have any questions about your Member Identification Number, please call Member Services at 1-800-462-0224. |

When You Are Ill or Injured (Non-Emergency Care) within the Tufts HP Service Area

Introduction This topic describes what to do when you are ill or injured and you are within the *Tufts HP Service Area*. This includes when you need *Urgent Care* within the *Service Area*.

Rule Always call your *PCP*. Without authorization from your *PCP*, services will not be covered by *Tufts HP*.
Important: Never wait until your condition becomes an *Emergency* to call.

Procedure If you are ill or injured, follow the steps in the table below.

| Step | Action |
|------|---|
| 1 | Contact your <i>PCP</i> and say you are a <i>Tufts HP Member</i> . |
| 2 | Explain the problem as clearly as possible to the office staff or your <i>PCP</i> . |
| 3 | After evaluating your problem, your <i>PCP</i> will: <ul style="list-style-type: none"> • provide you care, or • arrange for treatment and specialty care if necessary. |

Inpatient hospital services If you need Inpatient services, in most cases you will be admitted to your *PCP's Tufts HP Hospital*.

Transfer to a Tufts HP Hospital If you are admitted to a facility which is not the *Tufts HP Hospital* in your *PCP's Provider Organization*, and your *PCP* determines that transfer is appropriate, you will be transferred to:

- the *Tufts HP Hospital* in your *PCP's Provider Organization*, or
- another *Tufts HP Hospital*.

Important: *Tufts HP* may not pay for *Inpatient* care provided in the facility to which you were first admitted after your *PCP* has decided that a transfer is appropriate and transfer arrangements have been made.

Charges after discharge hour If you choose to stay as an *Inpatient* after a *Tufts HP Provider* has scheduled your discharge, *Tufts HP* will not pay for any costs incurred after the discharge hour.

Outpatient mental health/ substance abuse services You may obtain a referral to see an *Outpatient* mental health and substance abuse provider if you, your *PCP*, or a *Tufts HP* mental health Provider calls *Tufts HP's* Behavioral Health/Substance Abuse Referral Service at 1-800-208-9565.

When You Need *Emergency* or *Urgent Care* (whether you are in or out of the Tufts HP Service Area)

Guidelines for receiving *Emergency* care

Follow these guidelines when you need *Emergency* care, whether in or out of the Tufts HP Service Area.

- 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.
- Go to the nearest emergency medical facility.
- You do not need approval from your *PCP* before receiving *Emergency* care.
- If you receive *Outpatient Emergency* care at an emergency facility, you or someone acting for you should call your *PCP* or Tufts HP within 48 hours after receiving care. You are encouraged to contact your *Primary Care Provider* so your *PCP* can provide or arrange for any follow-up care that you may need.
- If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or Tufts HP within 48 hours after receiving care. (Notification from the attending *Provider* satisfies that requirement.)
- If you receive *Emergency Covered Services* from a non-Tufts HP Provider, Tufts HP will pay up to the *Reasonable Charge*. You pay the applicable *Copayment*.

Guidelines for receiving *Urgent Care*

Follow these guidelines for receiving *Urgent Care*.

If you are in the Service Area

- Contact your *PCP* and tell him or her that you are a Tufts HP Member.
- Explain your problems as clearly as possible.
- Your *PCP* will either provide you with care or will arrange for treatment or specialty care if necessary.

If you are outside the Service Area

- You may seek *Urgent Care* in a Provider's office or the *Emergency* room.
- You or someone acting for you must contact your *PCP* to arrange for any necessary follow-up care.
- The *Urgent Care Provider* may bill Tufts HP directly or may require you to pay for the *Urgent Care* services at the time of service. If you are required to pay, Tufts HP will reimburse you up to the *Reasonable Charge* for *Urgent Care* services received outside of the Tufts HP Service Area. You are responsible for the applicable *Copayment*. Please see "Bills from Providers" in Chapter 6 for more information about how to get reimbursed for *Urgent Care Covered Services* received outside of the Service Area.

Important Notes:

- If you are admitted as an *Inpatient* after receiving *Urgent Care Covered Services*, you or someone acting for you must call your *PCP* or Tufts HP within 48 hours after receiving care. (Notification from the attending *Providers* satisfies this requirement.)
- *Urgent* or *Emergency Care* services received outside of the Service Area are covered. However, continued services after the *Emergency* or *Urgent* condition has been treated and stabilized may not be covered if Tufts HP determines, in coordination with the Member's providers, that the Member is safe for transport back into the Service Area.

What to Do When Traveling

Introduction This topic tells you what to do if you need care outside the *Tufts HP Service Area*. When traveling, you must know the types of services that are not covered by *Tufts HP*.

Coverage outside the Service Area The table below lists services that are and are not covered outside the *Service Area*. See the *Tufts HP Directory of Health Care Providers* for *Tufts HP's Service Area*.

| Type of Service | Example | Coverage |
|---|---|-------------|
| Routine care | <ul style="list-style-type: none"> • routine general physical examinations; • routine gynecological or obstetrical examinations; • diagnostic tests related to general physical and gynecological examinations; • ongoing treatment for a psychiatric condition; • immunizations to prevent disease; and • other preventive procedures. | Not covered |
| Elective <i>Inpatient Admissions/Day Surgery</i> | Admissions or surgery that can be safely delayed until you return to the <i>Service Area</i> . | Not covered |
| Care that could have been foreseen before leaving the <i>Service Area</i> | <ul style="list-style-type: none"> • deliveries within one month of the due date, including postpartum care; • removal of stitches; and • long-term conditions that need ongoing medical care. <p>Exceptions are on a case-by-case basis. Please call a Member Representative at 1-800-462-0224.</p> | Not covered |
| <i>Urgent Care</i> | <ul style="list-style-type: none"> • a dislocated toe; • a cut that is not bleeding heavily but needs stitches • sudden extreme anxiety • symptoms of a urinary tract infection | Covered |
| <i>Emergency care</i> | <ul style="list-style-type: none"> • a broken leg; • chest pains; • difficulty breathing; • heavy bleeding; • loss of consciousness; • vomiting blood | Covered |

Information Resources for *Members*

Obtaining information about *Tufts Health Plan*

Obtaining 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 *Providers* who voluntarily and involuntarily terminated participation contracts with *Tufts Health Plan* during the previous calendar year for which such data has been compiled. This information will contain the 3 most common reasons for voluntary and involuntary disenrollment of those *Providers*.
- 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 grievance process, as well as the resolution of all those external appeals.

How to obtain this information

You can obtain this information about *Tufts Health Plan* by contacting the Massachusetts Health Policy Commission's Office of Patient Protection in the following ways:

- Call 1-800-436-7757
- Write a letter to the Office. Address it to:

**Health Policy Commission
Office of Patient Protection
50 Milk St., 8th Floor
Boston, MA 02109**

- Send an email to the Office. HPC-OPP@state.ma.us.
- Send a fax to the Office. Fax # 1-617-624-5046.
- View information at the Office's Web site. Go to <http://www.mass.gov/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection>.

Chapter 2 - Eligibility

Introduction This chapter tells you who is eligible, how to apply and when coverage starts.

Eligibility

Eligibility rule You are eligible as a *Member* only if you meet all of the following criteria, subject to federal law:

- You maintain primary residence in the *Service Area* and live in the *Service Area* for at least 9 months in each period of 12 months.*
- You are eligible for and enrolled in Medicare Parts A and B as either:
 - a person who is age 65 or older; or
 - a person who is disabled, under age 65, and receiving Social Security disability benefits.
- You meet your *Group's* and *Tufts HP's* eligibility rules.

*Note: The 12-month period begins with the first month in which you are not living in the *Service Area*.

Proof of eligibility *Tufts HP* may ask you for proof of your eligibility or continuing eligibility. You must provide *Tufts HP* proof when asked. This may include proof of:

- residence, and
- Medicare enrollment.

When to enroll You may enroll yourself for this coverage only:

- during the annual *Open Enrollment Period*; or
- within 31 days of the date you are first eligible for this coverage.

Effective Date of coverage If *Tufts HP* accepts your application and receives the needed *Premium*, coverage starts on the date chosen by your *Group*.

If you are an *Inpatient* on your *Effective Date*, your coverage starts on the later of:

- the *Effective Date*, or
- the date *Tufts HP* is notified and given the chance to manage your care.

Chapter 3 - Covered Services

Covered Services

When health care services are Covered Services

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

- listed as *Covered Services* in this chapter, or covered under Parts A and B of Original Medicare. Such Medicare-covered services are covered under this TMC Plan, even if they are not specifically listed in this *Evidence of Coverage*. We pay the charges for the Part A or B *Deductibles* and/or *Coinsurance* that Medicare requires you to pay for those services;
- *Medically Necessary*, as determined by Medicare (or *Tufts HP* for non-Medicare *Covered Services*);
- consistent with applicable state and federal law;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your *PCP*, except in an *Emergency* or for *Urgent Care* (see "When You Need *Emergency* or *Urgent Care*" for more information); and
- approved by an *Authorized Reviewer*, in some cases.

IMPORTANT NOTES:

1. If your care is provided or authorized by your *PCP*, *Tufts HP* will pay:

- the *Deductibles* and *Coinsurance* for Medicare-eligible services; and
- the applicable benefit amount for all other *Covered Services*.

Please see the *Covered Services* tables in Chapter 3 to determine whether you may be required to pay a *Copayment* to *Tufts HP* for any *Covered Service*.

2. If your care is not provided or authorized by your *PCP*, *Tufts HP* will not cover the costs of any services. Instead, you will be responsible for paying for:

- any *Deductibles* and *Coinsurance* for Medicare-eligible services; and
- the full amount of any other services which otherwise would have been covered by *Tufts HP* under this TMC Plan.

Authorized Reviewer approval: Certain *Covered Services* described in the table below must be authorized in advance by an *Authorized Reviewer*. If such authorization is not received, *Tufts HP* will not cover those services and supplies.

In compliance with Massachusetts law, *Tufts HP* offers coverage for services and medications for pain management that are alternatives to opioids. Services include, but are not limited to:

- Acupuncture services (see "Tufts Health Plan Member Discounts")
- Physical therapy
- Nutrition counseling

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

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, please call Member Services.

Covered Services Health care services and supplies only qualify as *Covered Services* if they meet the requirements shown above for "When health care services are *Covered Services*".

The following table describes the *Covered Services* available to you under Medicare Part A of Original Medicare and the *Tufts HP* Medicare Complement Plan.

| Part A Benefits (<i>Inpatient</i>) Medicare Benefits | | | |
|--|---|---|---|
| BENEFIT | MEDICARE PAYS... | WHEN CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i>* | |
| | | <i>TUFTS HP</i> PAYS... | YOU PAY... |
| <p>Hospital <i>Inpatient</i> services provided at a Medicare-certified general hospital:</p> <ul style="list-style-type: none"> • Semi-private room (private room if <i>Medically Necessary</i>); • Regular nursing services (private duty nursing services are <u>not</u> covered); • <i>Inpatient Provider</i> services; • Surgery, including the following services in connection with a mastectomy: (1) reconstruction of the breast affected by the mastectomy; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema). <p>Notes:</p> <ul style="list-style-type: none"> • *Prosthetic devices are covered as described under "<i>Durable Medical Equipment</i>". • Removal of a breast implant is covered when any one of the following conditions exists: (1) the implant was placed post-mastectomy; (2) there is documented rupture of a silicone implant; or (2) there is documented evidence of auto-immune disease or infection. • No coverage is provided for the removal of intact or ruptured saline breast implants or intact silicone breast implants except as specified above. • Cosmetic surgery is not covered. | Days 1-60 in <i>Benefit Period</i> : All <i>Covered Services</i> , except the Part A <i>Deductible</i> . | The Part A <i>Deductible</i> | Nothing. |
| | Days 61-90 in <i>Benefit Period</i> : All covered costs, except the hospital <i>Coinsurance</i> . | The hospital <i>Coinsurance</i> . | Nothing. |
| | <i>Reserve Days</i> : All <i>Covered Services</i> , except the <i>Reserve Day Coinsurance</i> , for 60 extra lifetime <i>Reserve Days</i> . | The <i>Reserve Day Coinsurance</i> , for 60 extra lifetime <i>Reserve Days</i> . After the 60 extra lifetime <i>Reserve Days</i> are exhausted, <i>Tufts HP</i> pays all <i>Covered Services</i> . | Nothing for each of the 60 extra lifetime <i>Reserve Days</i> . Also, you pay nothing for all <i>Covered Services</i> after the <i>Reserve Days</i> are exhausted. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.

Part A Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|--|------------------|---|------------|---|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| Hospital <i>Inpatient</i> services provided at a Medicare-certified general hospital (continued): <ul style="list-style-type: none"> • Use of operating/recovery rooms; • Meals, including special diets; • Drugs and medications furnished by the hospital during your stay; • Laboratory tests; and X-rays and other radiological services; • Medical supplies, such as casts, surgical dressings, and splints; • Cost of special care units, including intensive care and coronary care units; • Rehabilitation services, such as physical therapy, occupational therapy, speech pathology services, nuclear medicine, and kidney dialysis; • Maternity care services (no <i>PCP</i> referral required); • Psychiatric and/or psychologist services in a general hospital; • Substance abuse detoxification and rehabilitation services; and • All other <i>Medically Necessary</i> services and supplies. | | <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> See page above for the amounts paid for these <i>Covered Services</i> by Medicare, by you, and by <i>Tufts Health Plan</i>. </div> | | |
| | | | | |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part A Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|---|--|--|-----------------|--|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <p><i>Inpatient blood services</i> The following services when provided as part of a covered <i>Inpatient</i> stay in a hospital or <i>Skilled Nursing Facility</i>:</p> <ul style="list-style-type: none"> • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration. | <p>All <i>Covered Services</i>, except for the annual blood <i>Deductible</i>. This deductible is for the first 3 pints of unreplaced blood during a calendar year.</p> | <p>The cost of the annual blood <i>Deductible</i>.</p> | <p>Nothing.</p> | <p>The cost of the annual blood <i>Deductible</i>.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

Part A Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|---|--|--------------------------------------|---------------------------------------|---|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <p>Skilled Nursing Facility (SNF) care <i>Skilled</i> nursing and rehabilitation services performed by or provided under the supervision of licensed nursing personnel:</p> <ul style="list-style-type: none"> • Semi-private room; • Nursing services; • Meals, including special diets; • Physical, occupational, and speech therapy; • Drugs and medications furnished by the skilled nursing facility during your stay; • Medical supplies, such as casts, surgical dressings, and splints; • Diagnostic services, such as x-rays and laboratory services. <p><u>Note:</u> <i>Custodial care</i> is not covered by either Medicare or <i>Tufts HP</i>.</p> | Days 1 to 20 in a <i>Benefit Period</i> : All <i>Covered Services</i> . | Nothing. | Nothing. | Nothing. |
| | Days 21 to 100 in a <i>Benefit Period</i> : All <i>Covered Services</i> , except for the SNF <i>Coinsurance</i> | The SNF <i>Coinsurance</i> . | Nothing. | The designated SNF for <i>Coinsurance</i> each day. |
| | Days 100+ in a <i>Benefit Period</i> : Nothing. | Nothing. | All charges after a 100-day SNF stay. | All charges after a 100-day SNF stay. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part A Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|--|--|------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| Home Health Care Services <ul style="list-style-type: none"> Services provided to a homebound <i>Member</i> in his/her home by a home health agency: <ul style="list-style-type: none"> Part-time or intermittent <i>Skilled</i> nursing care; Nutritional counseling; Physical therapy; and Speech therapy. If you need intermittent <i>Skilled</i> nursing care, physical therapy, or speech therapy, Medicare may also pay for: <ul style="list-style-type: none"> Occupational therapy; Part-time or intermittent services of a home health aide; Medical social services; and Medical supplies and <i>Durable Medical Equipment</i> provided by the Home Health Agency. <p>Note: <i>Custodial Care</i> is not covered by either <i>Tufts HP</i> or Medicare.</p> | For nutritional counseling, <i>Provider</i> home visits, and inhalation therapy: Nothing. | All <i>Medically Necessary</i> charges. | Nothing. | All Charges. |
| | For <i>Durable Medical Equipment</i> : 80% of the Medicare-approved amount. | 20% of the Medicare-approved amount. | Nothing. | All Charges. |
| | For All other Covered Home Health Care Services: All Charges. | Nothing. | Nothing. | Nothing. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part A Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|--|--|--|------------|--|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <p>Inpatient Services at a chronic care or Rehabilitation Facility</p> <p>Acute <i>Inpatient</i> rehabilitation services provided in an <i>Inpatient</i> Rehabilitation Facility.</p> <p>(continued on next page)</p> | Days 1-60 in a Benefit Period: All <i>Covered Services</i> , except Part A <i>Deductible</i> . | The Part A <i>Deductible</i> | Nothing. | The Part A <i>Deductible</i> . |
| | Days 61-90 in a <i>Benefit Period</i> : All <i>Covered Services</i> , except hospital <i>Coinsurance</i> . | The hospital <i>Coinsurance</i> . | Nothing. | The hospital <i>Coinsurance</i> . |
| | <i>Reserve Days</i> : All <i>Covered Services</i> , except <i>Reserve Day Coinsurance</i> for 60 extra lifetime <i>Reserve Days</i> . | The <i>Reserve Day Coinsurance</i> , for 60 extra lifetime <i>Reserve Days</i> . | Nothing. | The <i>Reserve Day Coinsurance</i> , for 60 extra lifetime <i>Reserve Days</i> . |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part A Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|--|--|---|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p><i>Inpatient Services at a chronic care or Rehabilitation Facility</i></p> <p align="center">(continued from previous page)</p> | <p><u>Additional Days:</u> Nothing.</p> | <p>You could incur <i>Inpatient</i> days that Medicare pays for either during a covered <i>Benefit Period</i> or as <i>Reserve Days</i> or excludes because they occur (1) outside of covered <i>Benefit Period(s)</i> or (2) after you have exhausted your 60 lifetime <i>Reserve Days</i>. If the total number of these days (covered & excluded combined) is less than 100 in a calendar year, <i>Tufts HP</i> will cover any additional days in that year to bring the total to 100 days.</p> <p><i>Tufts HP</i> will pay all charges for these additional days.</p> | <p>As described in the "<i>Tufts HP Pays</i>" column on this page, you pay for any of the Additional Days that <i>Tufts HP</i> covers in a calendar year.</p> <p>You pay all charges for any Additional Days not covered by <i>Tufts HP</i>.</p> | <p>As described in the "<i>Tufts HP Pays</i>" column on this page, you pay all charges for any of the Additional Days that <i>Tufts HP</i> would normally cover in a calendar year.</p> <p>In addition, you pay all charges for any Additional Days that <i>Tufts HP</i> would not cover.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part A Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|--|--|------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Hospice Care Services <u>Hospice care for terminally ill <i>Members</i> with a life expectancy of 6 months or less:</u></p> <ul style="list-style-type: none"> • Home care provided by a hospice program, either a private organization or a public agency, with an emphasis on providing comfort and relief from pain, including: <i>Provider</i> services, nursing care, medical appliances and supplies, and physical therapy, occupational therapy and speech therapy services; • Services not ordinarily covered by Medicare, including homemaker services, counseling, and certain prescription drugs# provided for pain or symptom relief; and • <i>Inpatient</i> respite care intended to give temporary relief to the person or persons who regularly assist with home care. Covered up to a maximum of 5 consecutive days. <p>#Medicare patients can be charged: a <i>Copayment</i> for these prescription drugs; and <i>Coinsurance</i> for <i>Inpatient</i> respite care.</p> | <p>For each day of Medicare-approved <i>Inpatient</i> respite care (maximum of 5 consecutive days) allowed by Medicare: All <i>Covered Services</i>, except the <i>Coinsurance</i>.</p> | The Medicare <i>Coinsurance</i> . | Nothing. | The Medicare <i>Coinsurance</i> . |
| | <p>For each covered prescription <u>drug</u>: All <i>Covered Services</i>, except the <i>Copayment</i>.</p> | The Medicare <i>Copayment</i> . | Nothing. | The Medicare <i>Copayment</i> . |
| | <p>For all other <u><i>Covered Services</i></u>: All <i>Covered Services</i>.</p> | Nothing. | Nothing. | Nothing. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

**Part B Benefits
(Outpatient)
Medicare Benefits**

The following table describes the *Covered Services* available to you under Medicare Part B of Original Medicare and the *Tufts HP* Medicare Complement Plan.

Note: Certain Part B preventive care services are listed in the table below with Medicare paying 100% of the Medicare-approved amount. Please note that Medicare may charge you the Part B *Deductible* or *Coinsurance* when these services are provided in conjunction with an office visit.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|--|--|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Acupuncture Once Medicare provides coverage, <i>Tufts Health Plan</i> provides coverage up to the Allowed Charge for acupuncture for chronic low back pain (lasting 12 weeks or longer) for up to 12 visits in 90 days.</p> <ul style="list-style-type: none"> • Coverage is available for up to 20 acupuncture treatments annually. • An additional 8 sessions will be available to patients showing improvement. • Treatment will be discontinued if no improvement or regression occurs. • The cause of low back pain must be: <ul style="list-style-type: none"> • A non-specific, no identifiable systemic cause (for example, not associated with metastatic, inflammatory or infectious disease), or • Not associated with surgery, or • Not associated with pregnancy. | <p>Medicare benefits in full for Acupuncture Treatment, except: The Part B <i>Deductible</i> The Part B <i>Coinsurance</i></p> | <p>The following charges, minus a \$10.00 <i>Copayment</i> per visit: The Part B <i>Deductible</i> The Part B <i>Coinsurance</i></p> | <p>A \$10.00 <i>Copayment</i> per visit.</p> | <p>All charges after the Medicare payment.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part B Benefits, continued

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|--|--|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Preventive care services</p> <ul style="list-style-type: none"> A baseline mammogram (for women between the ages of 35 and 40). Annual mammography screenings (for women age 40 and over). <ul style="list-style-type: none"> Pap smear, including pelvic exam (once every 3 years), or annual coverage for women: <ul style="list-style-type: none"> at high risk for cervical or vaginal cancer, or of child bearing age who have had a pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality. | <p><u>For baseline and annual mammography screenings:</u> 100% of the Medicare-approved amount</p> <p><u>For Pap Smears (clinical laboratory charge):</u> 100% of the Medicare-approved amount.</p> <p>80% of the Medicare-approved amount for doctor services and all other exams.</p> | <p>Nothing.</p> <p>All charges for annual PAP smear not otherwise covered by Medicare.</p> <p>20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit.</p> | <p>Nothing.</p> <p>Nothing.</p> <p>A \$10.00 <i>Copayment</i> per visit.</p> | <p>All charges after the Medicare payment.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i>* |
|--|--|--|-------------------|---|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <u>Preventive care services (continued), Colorectal cancer screening exam, including:</u> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) or Fecal immunochemical test (FIT), flexible sigmoidoscopy, colonoscopy, and DNA based colorectal screening; • flexible sigmoidoscopy once every four years for persons age 50 and over, • colonoscopy once every two years for persons at high risk for colorectal cancer. • Colonoscopy: one test every ten years for Members determined by Medicare not to be at high risk of colorectal cancer, but not within four years of a screening sigmoidoscopy; and • DNA based colorectal screening every three years. | <u>For the fecal occult blood test:</u> 100% of the Medicare- approved amount. | Nothing. | Nothing. | All charges after the Medicare payment. |
| | <u>For all other tests:</u> 100% of the Medicare- approved amount. | Nothing. | Nothing. | All Charges after the Medicare payment. |

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Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|---|---|---|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| Preventive care services (continued)#, Barium enema - Doctor can substitute for sigmoidoscopy or colonoscopy. | 80% of the Medicare- approved amount, except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|--|---------------------------------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <u>Preventive care services (continued)#.</u> Prostate cancer screening (for men age 50 and over) <ul style="list-style-type: none"> digital rectal exam, and PSA test. | <u>For digital rectal exam:</u> 80% of the Medicare-approved amount, except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |
| | <u>For PSA test:</u> 100% of the Medicare-approved amount. | Nothing. | Nothing. | All charges after the Medicare payment. |
| Alcohol Screening and counseling to reduce alcohol misuse: If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified Primary Care doctor or practitioner in a Primary Care setting. | Medicare benefits in full: Once Medicare provides coverage, <i>Tufts' Plan</i> provides coverage up to the Allowed Charge for one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but are not alcohol dependent. | Nothing. | Nothing. | Nothing. |

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

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the "Other Covered Services" benefit later in this "Covered Services" section of Chapter 3.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> * |
|---|---|--|------------|---|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p><u>Preventive care services (continued)#.</u></p> <p>Abdominal aortic aneurysm screening:</p> <p>The <i>Plan</i> only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> | <p>Medicare benefits in full:</p> <p>Once Medicare provides coverage, the Plan provides coverage up to the Allowed Charge for a one-time screening ultrasound for people at risk.</p> | Nothing. | Nothing. | Nothing. |
| <p>Vaccinations:</p> <ul style="list-style-type: none"> • flu shot (1 per year); • pneumonia shot; and <p>Hepatitis B shot for <i>Members</i> at medium to high risk for hepatitis.</p> | <p>100% of all covered Medicare-approved amount.</p> | Nothing. | Nothing. | All charges after the Medicare payment. |

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the “Other Covered Services” benefit later in this “Covered Services” section of Chapter 3.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|---|---|--|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p><u>Preventive care services (continued)#,</u> Bone mass measurement for <i>Members</i> at risk for losing bone mass. <u>Note:</u> Covered once every 24 months.</p> | <p>For bone mass measurement: 100% of the Medicare-approved amount.</p> | Nothing. | Nothing. | All charges after the Medicare payment. |
| <p>Depression Screening Once Medicare provides coverage, the <i>Plan</i> provides coverage up to the Allowed Charge for a Depression screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p> | <p>Medicare benefits for Depression screening in full for annual Depression screening.</p> | Nothing. | Nothing. | Nothing. |
| <p>Diabetes self-management training.</p> | <p>80% of the Medicare-approved amount, except for the annual Part B <i>Deductible</i>.</p> | <p>The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit.</p> | <p>A \$10.00 <i>Copayment</i> per visit.</p> | All charges after the Medicare payment. |

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the “Other Covered Services” benefit later in this “Covered Services” section of Chapter 3.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|--|--|------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <u>Preventive care services (continued)#.</u> HIV screenings Once Medicare provides coverage, the <i>Plan</i> provides coverage up to the Allowed Charge for HIV screening. <ul style="list-style-type: none"> • For people who ask for an HIV screening test or who are at increased risk for HIV infection, one screening exam every 12 months • For women who are pregnant, up to three screening exams during a pregnancy. | Medicare benefits in full for HIV screening. | Nothing. | Nothing. | Nothing. |
| Smoking and tobacco use cessation counseling | 100% of the Medicare-approved amount. | Nothing. | Nothing. | All charges after the Medicare payment. |

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Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|---|--|------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <u>Preventive care services (continued)#.</u> <ul style="list-style-type: none"> One-time physical exam within 12 months after Part B coverage begins. Annual wellness exam (applies in years following initial one-time Part B physical exam). | 100% of the Medicare-approved <i>Covered Services</i> . | Nothing. | Nothing. | All charges after the Medicare payment. |

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the “Other *Covered Services*” benefit later in this “*Covered Services*” section of Chapter 3.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|--|--|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Emergency room care <i>Medically Necessary Emergency</i> services obtained in a hospital emergency room in the United States.</p> <p>(no <i>PCP</i> referral required)</p> <p>Note: See “Other <i>Covered Services</i>” below for information about obtaining Emergency room care outside of the United States.</p> | <p>80% of Medicare- approved <i>Covered Services</i>, except for the annual Part B <i>Deductible</i>.</p> | <p>The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$50.00 <i>Copayment</i> per visit.</p> | <p>A \$50.00 <i>Copayment</i> per visit.</p> | <p>All charges after the Medicare payment.</p> |
| | | <p><u>Notes:</u></p> <ul style="list-style-type: none"> • Emergency Room <i>Copayment</i> is waived if you are admitted as an <i>Inpatient</i>. • An Emergency Room <i>Copayment</i> may apply if you register in an Emergency Room but leave that facility without receiving care. • A <i>Day Surgery Copayment</i> may apply if <i>Day Surgery</i> services are received. • Observation services will not take an Emergency Room <i>Copayment</i>. | | |

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Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|--|---|--|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Outpatient services</p> <ul style="list-style-type: none"> • Office visits; • Consultation by specialists, including obstetrical and gynecological services; • Allergy testing and treatment; • <i>Outpatient</i> physical, occupational, and speech therapy (for diagnosis and treatment of speech, hearing, and language disorders); • Medical services and surgery; <p>(continued on next page)</p> | <p>80% of Medicare-approved <i>Covered Services</i>, except for the annual Part B <i>Deductible</i>.</p> | <p><u>For <i>Day Surgery</i>:</u> The annual Part B <i>Deductible</i> and 20% <i>Coinsurance</i></p> | <p><u>For <i>Day Surgery</i>:</u> Nothing.</p> | <p>All charges after the Medicare payment.</p> |
| | | <p><u>Allergy injections:</u> The annual Part B <i>Deductible</i> and 20% <i>Coinsurance</i>, minus a \$5 <i>Copayment</i> per admission.</p> | <p><u>Allergy injections:</u> A \$5 <i>Copayment</i> per injection.</p> | |
| | | <p><u>For all other <i>Outpatient services</i> listed on this page:</u> The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit.</p> | <p><u>For all other <i>Outpatient services</i> listed on this page:</u> A \$10.00 <i>Copayment</i> per visit.</p> | |

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Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|--|--|---------------------------------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <u>Outpatient services- continued :</u> <ul style="list-style-type: none"> • Immunizations; • Diagnostic imaging services, including general imaging (such as x-rays and ultrasounds) and MRI/ MRA, CT/CTA, PET and nuclear medicine; • Diagnostic laboratory services including, but not limited to, glycosylated hemoglobin (HbA1c) and urinary protein/microalbumin and lipid profiles; • Inhalation and other home health therapies; • Radiation therapy; • Manipulation of the spine to correct a dislocation that can be shown by an x-ray. (continued on next page) | <u>Diagnostic laboratory services:</u> All <i>Covered Services</i> . | Nothing. | Nothing. | All charges after the Medicare payment. |
| | <u>All other Outpatient services listed on this page:</u> 80% of Medicare-approved <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | |

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Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|--|---------------------------------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p><u><i>Outpatient services - continued:</i></u> Podiatric services, when Medicare-approved and provided by a doctor of podiatry or surgical chiropody.# #Note: Routine foot care is <u>not</u> covered.</p> | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |
| <p>Dental Services The following dental services:</p> <ul style="list-style-type: none"> • Trauma care, reduction of swelling, and pain relief, for damage to sound and natural teeth; • Reduction of dislocations or fractures of the jaw; <p><i>Inpatient or ambulatory surgical services</i> for a non-dental medical condition that requires you to be in a hospital when you receive dental care.</p> | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |
| | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |

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Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|--|--|---------------------------------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Physical therapy, occupational therapy, and speech pathology services, when provided</p> <ul style="list-style-type: none"> • in the following facilities: <ul style="list-style-type: none"> • clinic, • hospital, • rehabilitation facility, or • SNF; • by a home health agency; or • by an independent practicing therapist. | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |
| <p>Outpatient blood services</p> <ul style="list-style-type: none"> • Whole blood; • Packed red blood cells; • Blood components; and • The cost of blood processing and administration. | 80% of <i>Covered Services</i> , except for the annual Blood <i>Deductible</i> and the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount, minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |

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Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|---|---|------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| Ambulance services Transportation between: <ul style="list-style-type: none"> • your home and a hospital; • your home and a SNF; or • a hospital and a SNF; if: <ul style="list-style-type: none"> • the ambulance and personnel meet Medicare requirements; and • transportation in any other vehicle could endanger your health. | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> , and 20% <i>Coinsurance</i> | Nothing. | All charges after the Medicare payment. |
| | | 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. | | |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|---|------------|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p><i>Durable Medical Equipment (DME)</i> Includes coverage for devices or instruments of a durable nature that:</p> <ul style="list-style-type: none"> • 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. <p><u>Note:</u> Includes breast prostheses (including surgical brassiere after a mastectomy).</p> | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> , and 20% <i>Coinsurance</i> . | Nothing. | All charges after the Medicare payment. |
| | | <p>In order to be eligible for coverage, the equipment must also be the most appropriate available supply or level of service for the <i>Member</i> in question considering potential benefits and harms to that individual.</p> <p>Equipment that <i>Tufts Health Plan</i> determines to be non-medical in nature and used primarily for non-medical purposes (even though that equipment may have some limited medical use) will not be considered <i>Durable Medical Equipment</i> and will not be covered under this benefit.</p> | | |

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Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> * |
|---|---|--|------------|---|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| Medical supplies Examples of <i>Covered Services</i> are dressings, splints, and casts. | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | The annual Part B <i>Deductible</i> , and 20% <i>Coinsurance</i> . | Nothing. | All charges after the Medicare payment. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|---|---|---|-----------------|--|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <p>Diabetes Monitoring Equipment <u>The following equipment for use in diabetes monitoring by Medicare beneficiaries with diabetes:</u> Blood glucose monitors and continuous glucose monitors, including related supplies like test strips; lancets; sensors; voice synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids; therapeutic/ molded shoes and shoe inserts for a <i>Member</i> with severe diabetic foot disorder; and self-management.</p> | <p>80% of Medicare-approved <i>Covered Services</i>, except for the annual Part B <i>Deductible</i>..</p> | <p>The annual Part B <i>Deductible</i> and 20% of the Medicare-approved amount.</p> | <p>Nothing.</p> | <p>All charges after the Medicare payment.</p> |
| <p>Note: <i>Tufts HP</i> also pays for the following <i>Covered Services</i> to the extent such services and supplies are not otherwise covered by Medicare:</p> <ul style="list-style-type: none"> • Diabetes self-management. See "Diabetes self-management and educational training services" for more information. | | | | |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|--|---|---|---|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Comprehensive <i>Outpatient</i> Rehabilitation Facility (CORF)</p> <p><i>Outpatient</i> rehabilitation services provided at a Comprehensive <i>Outpatient</i> Rehabilitation Facility (CORF)</p> | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> (subject to the CORF calendar year maximum benefit limit for combined physical and occupational therapy). | The annual Part B <i>Deductible</i> , and 20% <i>Coinsurance</i> , subject to the CORF calendar year maximum benefit limit. | All charges after the calendar year CORF maximum benefit limit. | All charges after the Medicare payment. |
| <p>Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP is a structured health behavioral change intervention that provides practical training in long term dietary change, increased physical activity, and problem solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p> | 100% of <i>Covered Services</i> | Nothing. | Nothing. | All charges after the Medicare payment. |
| <p>Medical nutrition therapy</p> | 100% of the Medicare-approved amount. | Nothing. | Nothing. | All charges after the Medicare payment. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i>* |
|--|---|--|-------------------|---|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Opioid treatment program services Opioid use disorder treatment services are covered. Covered Services include:</p> <ul style="list-style-type: none"> • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable. • Substance use counseling. • Individual and group therapy • Toxicology testing. | Medicare Part B benefits for Opioid treatment program services covered in full. | Nothing. | Nothing. | Nothing. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|---|--|--|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Pulmonary Rehabilitation Services (COPD)</p> <p>Once Medicare provides coverage, the <i>Plan</i> provides coverage up to the Allowed Charge for comprehensive programs of pulmonary rehabilitation. These programs are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> | <p>Medicare benefits in full, except:</p> <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i>. | <p>The following charges, minus a \$10.00 <i>Copayment</i> per visit:</p> <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i>. | <p>A \$10.00 <i>Copayment</i> per visit.</p> | <p>A \$10.00 <i>Copayment</i> per visit.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP*</i> |
|---|--|--|--|--|
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <p>Telehealth</p> <p>The <i>Plan</i> provides coverage up to the Allowed Charge for services like office visits, psychotherapy, consultations, and certain other medical or health services provided by an eligible provider who isn't at your location using an interactive, two-way telecommunications system (like real-time audio and video). For most of these services, you'll pay the same amount that you would if you got the services in person.</p> | <p>Medicare benefits in full, except:</p> <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i> | <p>The following charges, minus a \$10.00 <i>Copayment</i> per visit:</p> <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i>. | <p>A \$10.00 <i>Copayment</i> per visit.</p> | <p>All charges.</p> |
| | | <p>Note: Additional services may be provided (outside of Part B) under this plan. For more information, see "Telemedicine services" in the "Other Covered Services Table" later in this chapter.</p> | | |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|--|--|---|------------|---|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <p>Urgently needed care Once Medicare provides coverage, the <i>Plan</i> provides coverage up to the Allowed Charge for urgently needed care services. These services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.</p> | <p>Medicare benefits in full, except:</p> <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i> | <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i> | Nothing. | Nothing. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|---|--|--|---|---|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <p>Vision Care The <i>Plan</i> provides coverage up to the Allowed Charge for the following services covered under this benefit:</p> <ul style="list-style-type: none"> • <i>Outpatient</i> physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. <p>(continued on next page)</p> | <p>Medicare benefits in full for Vision Care services, except:</p> <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i> <p align="center">Covered in full.</p> | <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i> <p align="center">Nothing.</p> | <ul style="list-style-type: none"> • Part B <i>Deductible</i> • The Part B <i>Coinsurance</i> <p>A \$10.00 <i>Copayment</i> per visit.</p> <p align="center">Nothing.</p> | <ul style="list-style-type: none"> • The Part B <i>Deductible</i> • The Part B <i>Coinsurance</i> <p>A \$10.00 <i>Copayment</i> per visit.</p> <p align="center">Nothing.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Part B Benefits (continued)

| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
|--|--|--------------------------------------|-------------------------|---|
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| Vision Care - continued: <ul style="list-style-type: none"> • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Annual routine glasses, contacts, \$150 allowance. | Covered in full. Covered in full. | Nothing. Nothing | Nothing. Nothing | Nothing. Nothing |

#Additional *Outpatient* preventive care services may be provided (outside of Part B) under this plan. For more information, see the “Other Covered Services” benefit later in this “Covered Services” section of Chapter 3.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

| | |
|---|--|
| Mental health and substance abuse services (Parts A and B) | The following table describes the mental health and substance abuse services available to you under Medicare Parts A and B of Original Medicare and the <i>Tufts HP</i> Medicare Complement Plan |
|---|--|

| <i>Mental health and substance abuse services (Parts A and B)</i> | | | | |
|--|--|--|-------------------|---|
| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i>* |
| | | <i>TUFTS HP PAYS...</i> | YOU PAY... | YOU PAY... |
| <i>Inpatient</i> mental health and substance abuse services# (Part A): <i>Inpatient</i> hospital and <i>Provider</i> services for the treatment of a mental condition or substance abuse. Note: When provided in a psychiatric facility, Medicare limits these services to 190 lifetime days. This limit does not apply to inpatient services in a general hospital. | Days 1 - 190 (lifetime) in a psychiatric hospital OR care in general hospital: All Covered Services, except annual Part A Deductible. | The Part A <i>Deductible</i> per admission. | Nothing | All charges after the Medicare payment. |

#Coverage provided the same as for “Hospital *Inpatient* Services” at a general hospital for: *Inpatient* mental health services for *Biologically-based Mental Disorders* (as defined by Massachusetts law) and *Rape-related Mental or Emotional Disorders*.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

| <i>Mental health and substance abuse services (Parts A and B)</i> | | | | |
|--|---|--|---|--|
| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <u><i>Inpatient mental health and substance abuse services# (Part A) (continued)</i></u> | After 190-day Medicare lifetime maximum (in psychiatric hospital only) exhausted: Nothing. | All Covered Services for Mental health and substance abuse services for <i>Mental Disorders</i> : <ul style="list-style-type: none"> Up to 60 days per calendar year in a general hospital, mental health hospital, or substance abuse facility charges. | For mental health and substance abuse services in a general hospital, mental health hospital, or substance abuse facility: <ul style="list-style-type: none"> Before calendar year maximum exhausted, you pay Nothing. After calendar year maximum exhausted, you pay all charges. | All charges. |

The 60-day calendar year limit listed on this page only applies to non-*Biologically-based Mental Disorders*. For *Inpatient* mental health services for *Biologically-based Mental Disorders* (as defined by Massachusetts law) and *Rape-related Mental or Emotional Disorders*, coverage provided is the same as for “Hospital *Inpatient Services*” at a general hospital.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

| Mental health and substance abuse services (Parts A and B) (continued) | | | |
|---|-------------------------|--|--|
| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
| | | | YOU PAY... |
| <u>Inpatient mental health and substance abuse service# (Part A)</u> (continued) | | <p>Note: To the extent that these services are not otherwise covered by Medicare, <i>Tufts HP</i> pays for the following <i>Covered Services</i> for intermediate mental health and substance abuse services for <i>Mental Disorders</i></p> <p>Intermediate mental health care services for <i>Mental Disorders</i> (including diagnosis, detoxification, and treatment of substance abuse disorders)</p> <p>(These services must be provided by <i>Tufts Health Plan</i>.)</p> <p>These services are more intensive than traditional <i>Outpatient</i> mental health care and substance abuse disorder services, but less intensive than 24-hour hospitalization. Some examples of <i>Covered</i> intermediate mental health care and substance abuse disorder services are: level III community-based detoxification; intensive <i>Outpatient</i> programs; crisis stabilization; acute residential treatment (longer term residential treatment is not covered); and day treatment/partial hospital programs**.</p> <p>**Two mental health day treatment/partial hospital days count as one of the 60 <i>Inpatient</i> days you get per calendar year.</p> | All charges. |

#Coverage provided the same as for "Hospital *Inpatient* Services" at a general hospital for *Inpatient* mental health and substance abuse services for *Biologically-based Mental Disorders* (as defined by Massachusetts law) and Rape-related Mental or *Emotional Disorders*.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

| Mental health and substance abuse services (Parts A and B) (continued) | | | | |
|---|---|---|---------------------------------------|--|
| BENEFIT | MEDICARE PAYS... | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP* |
| | | TUFTS HP PAYS... | YOU PAY... | YOU PAY... |
| <p>Outpatient mental health services for Mental Disorders (Part B): Outpatient mental health and substance abuse services for the diagnosis and treatment of a <i>Mental Disorder</i>.</p> <p><u>Note:</u> Psychopharmacological services and neuropsychological services are covered as "Outpatient Services" under Part B.</p> | 80% of <i>Covered Services</i> , except for the annual Part B <i>Deductible</i> . | <p>The annual Part B <i>Deductible</i>, and 20% <i>Coinsurance</i>, minus a \$10.00 <i>Copayment</i> per visit, for <i>Covered Services</i> for:</p> <p>Mental health and substance abuse services for <i>Mental Disorders</i> provided in a general hospital, a mental health hospital, or a substance abuse facility.</p> | A \$10.00 <i>Copayment</i> per visit. | All charges after the Medicare payment. |

Coverage is provided the same as for "Outpatient Services" under Part B for *outpatient* mental health and substance abuse services for: *Biologically-based Mental Disorders* (as defined by Massachusetts law) and Rape-related Mental or *Emotional Disorders* see Appendix A for definitions of these terms). Please note that coverage of other, non-mental health treatment of autism and autism spectrum disorders is described under "Autism spectrum disorders – diagnosis and treatment." Mental health services for autism and autism spectrum disorders are covered as described above.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

| | |
|---|--|
| Other Covered Services (outside of Medicare Parts A and B) | The following table describes the services which <i>Tufts HP</i> covers, but Original Medicare may not cover. If Medicare coverage is available for any service listed below, the coverage provided by the TMC Plan is reduced by the Subscriber's Medicare benefits. <i>Tufts HP</i> is required under Massachusetts law to cover some of these services. |
|---|--|

Other Covered Services (outside of Medicare Parts A and B)

| BENEFIT | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> |
|---|---|---|---|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Preventive Care Services</p> <ul style="list-style-type: none"> • Routine physical exams, including appropriate immunizations and lab tests as recommended by the <i>Provider</i>; • Routine eye exams (no <i>PCP</i> referral required); • Hearing exams and screenings; and • Hormone replacement therapy services. | <p>All <i>Covered Services</i>, minus a \$10.00 <i>Copayment</i> per visit, for one routine eye exam every 12 months.</p> | <p>A \$10.00 <i>Copayment</i> per visit for one routine eye exam every 12 months.</p> | <p>All charges.</p> |
| <p><u>Notes:</u></p> <ul style="list-style-type: none"> • Routine annual physical exams are covered under your Medicare Part B benefits at 100% of the Medicare-approved amount. For more information about these Medicare-covered services, see "Part B Benefits" earlier in this chapter. • <i>Tufts Health Plan</i> will cover one routine eye exam once every 12 months. You must receive routine eye examinations from a <i>Provider</i> in the EyeMed Vision Care network in order to obtain coverage for these services. Please go to www.tuftshealthplan.com or contact Member Services for more information. In order to be covered for services to treat a medical condition of the eye, you must obtain services from a <i>Tufts HP Provider</i>. | | | |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Other Covered Services (outside of Medicare Parts A and B)

| BENEFIT | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP |
|---|--|---------------------------------------|--|
| | Tufts HP Pays... | You Pay... | You Pay... |
| Emergency Room Care <i>Medically Necessary Emergency services obtained in a hospital Emergency room outside of the United States (no PCP referral required).</i> | All <i>Covered Services</i> , minus a \$50.00 <i>Copayment</i> per visit. | A \$50.00 <i>Copayment</i> per visit. | A \$50.00 <i>Copayment</i> per visit. (<i>Tufts HP</i> will pay for all <i>Covered Services</i> , except for the \$50.00 <i>Copayment</i> per visit). |
| | <u>Notes:</u> <ul style="list-style-type: none"> • The <i>Emergency Room Copayment</i> is waived if you are admitted as an <i>Inpatient</i>. • An <i>Emergency Room Copayment</i> may apply if you register in an <i>Emergency Room</i> but leave that facility without receiving care. • <i>Observation services</i> will not take an <i>Emergency Room Copayment</i>. | | |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> |
|---|---|--|--|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Family Planning</p> <p>Coverage is provided as described in this section for <i>Outpatient</i> 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).</p> <p>Services:</p> <ul style="list-style-type: none"> • medical examinations; • consultations; • birth control counseling; and • genetic counseling. | <p>All <i>Covered Services</i>, minus a \$10.00 <i>Copayment</i> per visit.</p> | <p>A \$10.00 <i>Copayment</i> per visit.</p> | <p>All charges.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> |
|--|--|--|---|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Family planning, continued</p> <p>Procedures:</p> <ul style="list-style-type: none"> sterilization, and pregnancy termination. <p>Note: Please note that pregnancy terminations and related care are covered in full. The term “pregnancy termination” shall not include providing care related to a pregnancy or miscarriage. The following services are covered when provided in conjunction with a pregnancy termination:</p> <ul style="list-style-type: none"> Pre-pregnancy termination evaluations and examinations; Pre-operative counseling; Ultrasounds; Laboratory services, including pregnancy testing, blood type, and Rh factor; Rh (D) immune globulin (human); Anesthesia (general or local); Post-pregnancy termination care; Follow-up; and Advice on contraception or referral to family planning services. | <p><u>Office Visit:</u> All Covered Services, minus a \$10.00 Copayment per visit.</p> <p><u>Day Surgery:</u> All Covered Services</p> | <p><u>Office Visit:</u> A \$10.00 Copayment per visit.</p> <p><u>Day Surgery:</u> Nothing.</p> | <p>All charges.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP |
|---|--|--|---|
| | Tufts HP Pays... | You Pay... | You Pay... |
| <p>Family planning, continued</p> <p>Contraceptives:</p> <ul style="list-style-type: none"> • cervical caps; • Intrauterine Devices (IUDs); • Implantable contraceptives (e.g., Implanon (etonorgestrel), (levonorgestrel implants); • Depo-Provera or its generic equivalent; • any other Medically Necessary contraceptive device that has been approved by the United States Food and Drug Administration. <p>*Note: Please note that Tufts HP covers certain contraceptives, such as oral contraceptives, over the counter female contraceptives and diaphragms, under your Prescription Drug Benefit. If those contraceptives are covered under that Benefit; they are not covered here. For more information, see that benefit later in this Chapter.</p> | <p><u>Office Visit:</u> All Covered Services, minus a \$10.00 Copayment per visit.</p> <p><u>Day Surgery:</u> All Covered Services</p> | <p><u>Office Visit:</u> A \$10.00 Copayment per visit.</p> <p><u>Day Surgery:</u> Nothing.</p> | <p>All charges.</p> |

*Note: Tufts HP does not pay for any services or supplies when care is not provided or authorized by your Tufts Health Plan PCP. **Italicized words are defined in Appendix A.**

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> |
|---|--|------------|---|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Cardiac Rehabilitation Services</p> <p>Services for <i>Outpatient</i> treatment of documented cardiovascular disease that: (1) meet the standards promulgated by the Massachusetts Commissioner of Public Health; and (2) are initiated within 26 weeks after diagnosis of cardiovascular disease.</p> <p><i>Tufts HP</i> covers only the following services:</p> <ul style="list-style-type: none"> • the <i>Outpatient</i> convalescent phase of the rehabilitation program following hospital discharge; and • the <i>Outpatient</i> phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise. <p><u>Note:</u> <i>Tufts HP</i> does not cover the program phase that maintains rehabilitated cardiovascular health.</p> | All Covered Services. | Nothing. | All charges. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP |
|---|---|--|---|
| | <i>Tufts HP Pays...</i> | <i>You Pay...</i> | <i>You Pay...</i> |
| <p>Hospice Care Services</p> <p>We will cover the following services for <i>Members</i> who are terminally ill (having a life expectancy of 6 months or less):</p> <ul style="list-style-type: none"> • 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 <i>Member's</i> family for up to one year following the <i>Member's</i> death). <p>"Hospice care services" are defined as a coordinated licensed program of services provided, during the life of the <i>Member</i>, to a terminally ill <i>Member</i>. Such services can be provided:</p> <ul style="list-style-type: none"> • in a home setting; • on an <i>Outpatient</i> basis; and • on a short-term <i>Inpatient</i> 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. | <p>All <i>Covered Services</i>, minus a \$10.00 <i>Copayment</i> per visit.</p> | <p>A \$10.00 <i>Copayment</i> per visit.</p> | <p>All charges.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. **Italicized words are defined in Appendix A.**

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> |
|---|--|------------|---|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Bone marrow transplants for breast cancer Bone marrow transplants for <i>Members</i> diagnosed with breast cancer that has progressed to metastatic disease who meet the criteria established by the Massachusetts Department of Public Health.</p> | All <i>Covered Services</i> | Nothing | All charges. |
| <p>Nonprescription enteral formulas Coverage is provided:</p> <ul style="list-style-type: none"> • For home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, and chronic intestinal pseudo-obstruction. • When <i>Medically Necessary</i>: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure. | All <i>Covered Services</i> . | Nothing. | All charges. |

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Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP |
|--|---|--|--|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Human Leukocyte Antigen Testing Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a <i>Member's</i> bone marrow transplant donor suitability. Includes: costs of testing for A, B or DR antigens; or any combination consistent with the rules and criteria established by the Department of Public Health.</p> | All <i>Covered Services</i> , minus a \$10.00 <i>Copayment</i> per visit. | A \$10.00 <i>Copayment</i> per visit. | All charges. |
| <p>Low Protein Foods When given to treat inherited diseases of amino acids and organic acids.</p> | All <i>Covered Services</i> , up to a maximum benefit of \$5,000 per calendar year. | Nothing, up to a maximum benefit of \$5,000 per calendar year. | All charges, after the benefit of \$5,000 has been reached in a calendar year. |
| <p>Special Medical Formulas When <i>Medically Necessary</i> to protect the unborn fetuses of women with PKU.</p> | All <i>Covered Services</i> . | Nothing. | All charges. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> |
|---|--|--|--|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Medical Supplies <i>Tufts Health Plan</i> covers the cost of certain types of medical supplies from an authorized vendor, including: ostomy, tracheostomy, catheter, and oxygen supplies; and insulin pumps and related supplies. These supplies must be obtained from a vendor that has an agreement with <i>Tufts HP</i> to provide such supplies.</p> | All Covered Services. | Nothing. | All charges. |
| <p>Diabetes self-management and educational training services <i>Outpatient</i> 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: <i>Tufts HP</i> will only cover these services when provided by a <i>Tufts HP Provider</i> who is a certified diabetes health care provider.</p> | <p>All Covered Services , minus a \$10.00 Copayment per visit.</p> <p><u>Note:</u> These services are also covered under your Medicare Part B benefits. For more information, see "Diabetes self-management training" under the "Part B Benefits" section earlier in this chapter.</p> | A \$10.00 Copayment per visit. | All charges. |
| <p>Scalp hair prostheses or wigs for cancer or leukemia patients Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia.</p> | All Covered Services up to a maximum benefit of \$350 per calendar year. | For all services after the \$350 calendar year maximum benefit has been reached. | All charges. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> | | CARE NOT AUTHORIZED BY YOUR <i>TUFTS HP PCP</i> |
|--|---|--|---|
| | <i>Tufts HP Pays...</i> | You Pay... | You Pay... |
| <p>Patient care services provided pursuant to a qualified clinical trial</p> <p>As required by Massachusetts law, patient care services provided pursuant to a qualified clinical trial for the treatment of cancer to the same extent as those Inpatient or <i>Outpatient</i> services would be covered if the <i>Member</i> did not receive care in a qualified clinical trial.</p> | <p><u><i>Inpatient care:</i></u> All <i>Covered Services</i></p> <p><u><i>Outpatient care:</i></u> All <i>Covered Services</i>, minus a \$10.00 <i>Copayment</i> per visit.</p> | <p><u><i>Inpatient care:</i></u> Nothing</p> <p><u><i>Outpatient care:</i></u> A \$10.00 <i>Copayment</i> per visit.</p> | <p>All charges.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

| BENEFIT | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP |
|--|--|---|---|
| | Tufts HP Pays... | You Pay... | You Pay... |
| <p>Autism spectrum disorders – diagnosis and treatment</p> <p>Coverage is provided, in accordance with Massachusetts law, for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive developmental disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, and include:</p> <ul style="list-style-type: none"> • autistic disorder; • Asperger’s disorder; and • pervasive developmental disorders not otherwise specified. <p>Coverage is provided for the following <i>Covered Services</i>:</p> <ul style="list-style-type: none"> • Habilitative or rehabilitative care, which are professional, counseling and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA)** supervised by a <i>Board-Certified Behavior Analyst</i>. <p align="center">(continued on next page)</p> | <ul style="list-style-type: none"> • For habilitative or rehabilitative care: <ul style="list-style-type: none"> • When provided by a <i>Paraprofessional</i>: All <i>Covered Services</i>. • When provided by a <i>Board-Certified Behavior Analyst (BCBA)</i>: All <i>Covered Services</i>, minus a \$10.00 <i>Copayment</i> per visit. • For prescription medications: See the “Coverage for Other Prescription Drugs” section, below. • For psychiatric and psychological care: All <i>Covered Services</i>, minus a \$10.00 <i>Copayment</i> per visit. • For therapeutic care: All <i>Covered Services</i>, minus a \$10.00 <i>Copayment</i> per visit. | <ul style="list-style-type: none"> • For habilitative or rehabilitative care: <ul style="list-style-type: none"> • When provided by a <i>Paraprofessional</i>: Nothing. • When provided by a <i>Board-Certified Behavior Analyst (BCBA)</i>: A \$10.00 <i>Copayment</i> per visit. • For prescription medications: See the “Coverage for Other Prescription Drugs” section, below. • For psychiatric and psychological care: A \$10.00 <i>Copayment</i> per visit. • For therapeutic care: A \$10.00 <i>Copayment</i> per visit. | <p align="center">All charges.</p> |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

Benefit

Autism spectrum disorders – diagnosis and treatment (continued)

For more information about these programs, call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565;

- services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers. **Note:** Visit limits for services described under the “Physical therapy, occupational therapy, and speech therapy services” benefit do not apply to coverage for autism spectrum disorders.
- prescription medications, covered under the *Tufts Health Plan* “Coverage for Other Prescription Drugs” section;
- psychiatric and psychological care, covered under the “Mental Health and Substance Abuse Services” benefit; and
- therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your “Physical therapy, occupational therapy, and speech pathology services “ benefit.

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

Other Covered Services (outside of Medicare Parts A and B)- continued

Benefit

Cleft lip and cleft palate treatment and services for children

In accordance with Massachusetts law, the following services are covered for children under the age of 18 who are covered under this plan:

- **Medical and facial surgery:** Coverage is provided for *Day Surgery* and Inpatient hospital admissions. This includes surgical management and follow-up care by plastic surgeons;
- **Oral surgery:** No referral is required from the child's *PCP*. This includes surgical management and follow-up care by oral surgeons;
- **Dental surgery or orthodontic treatment and management:** No referral from the child's *PCP* is required for these services;
- **Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy:** No referral from the child's *PCP* is required for these services;
- **Speech therapy and audiology services;**
- **Nutrition services.**

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.

NOTE: The next two pages in this *Evidence of Coverage* list the *Cost-Sharing Amounts* that apply to these *Covered Services* under this plan.

Other Covered Services (outside of Medicare Parts A and B)- continued

| | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP |
|---|--|--|---|
| BENEFIT | <i>Tufts HP Pays...</i> | <i>You Pay...</i> | <i>You Pay...</i> |
| Cleft lip and cleft palate treatment and services for children - continued | <u>Medical or facial surgery:</u> <ul style="list-style-type: none"> • <i>Inpatient services:</i> All Covered Services • <i>Day Surgery:</i> All Covered Services | <u>Medical or facial surgery:</u> <ul style="list-style-type: none"> • <i>Inpatient services:</i> Nothing • <i>Day Surgery:</i> Nothing. | <u>Medical or facial surgery:</u> All charges. |
| | <u>Nutrition services:</u> All Covered Services, minus a \$10.00 Copayment per visit. | <u>Nutrition services:</u> \$10.00 Copayment per visit. | <u>Nutrition services:</u> All charges. |
| | <u>Oral surgery:</u> <ul style="list-style-type: none"> • <u>Office Visit:</u> All Covered Services, minus a \$10.00 Copayment per visit. • <u>Emergency Room:</u> All Covered Services, minus an Emergency Room Copayment per visit. • <u>Inpatient services:</u> All Covered Services • <u>Day Surgery:</u> All Covered Services | <u>Oral surgery:</u> <ul style="list-style-type: none"> • <u>Office Visit:</u> \$10.00 Copayment per visit. • <u>Emergency Room:</u> An Emergency Room Copayment per visit. • <u>Inpatient services:</u> Nothing • <u>Day Surgery:</u> Nothing | <u>Oral surgery:</u> <ul style="list-style-type: none"> • <u>Office Visit:</u> All charges • <u>Emergency Room:</u> An Emergency Room Copayment per visit. • <u>Inpatient services:</u> All charges • <u>Day Surgery:</u> All charges |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

| | CARE AUTHORIZED BY YOUR TUFTS HP PCP | | CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP |
|---|--|---|---|
| BENEFIT | Tufts HP Pays... | You Pay... | You Pay... |
| Cleft lip and cleft palate treatment and services for children - continued | <u>Dental surgery or orthodontic treatment and management:</u> Covered in full. | <u>Dental surgery or orthodontic treatment and management:</u> Nothing. | <u>Dental surgery or orthodontic treatment and management:</u> All charges. |
| | See "Cleft lip and cleft palate treatment and services for children" earlier in Chapter 3 for more information about what is covered under this benefit. | | |
| | <u>Preventive and restorative dentistry:</u> Covered in full. | <u>Preventive and restorative dentistry:</u> Nothing. | <u>Preventive and restorative dentistry:</u> Nothing. |
| | See "Cleft lip and cleft palate treatment and services for children" earlier in Chapter 3 for more information about what is covered under this benefit. | | |
| | <u>Speech therapy and audiology services:</u> All <i>Covered Services</i> , minus a \$10.00 <i>Copayment</i> per visit. | <u>Speech therapy and audiology services:</u> \$10.00 <i>Copayment</i> per visit. | <u>Speech therapy and audiology services:</u> All charges. |
| Outpatient substance services for medication assisted treatment, including methadone maintenance | All <i>Covered Services</i> , minus a \$5 <i>Copayment</i> per visit. | \$5 <i>Copayment</i> per visit. | All charges. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

Other Covered Services (outside of Medicare Parts A and B)- continued

Inpatient and intermediate services for child-adolescent Behavioral Health Disorders

In addition to the Outpatient, *Inpatient*, and intermediate mental health and substance abuse 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 mental 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 are able to 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 an ICBAT directly from the community as an alternative to Inpatient hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour hospital setting.

The following services are covered intermediate mental health services. 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 providing 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.

Other Covered Services (outside of Medicare Parts A and B)- continued

Benefit

Intermediate services for child-adolescent Behavioral Health Disorders - continued

- **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 mental 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 mental 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.

- **In-home behavioral services** - A combination of Medically Necessary behavior management therapy and behavior 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 child'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.

Other Covered Services (outside of Medicare Parts A and B)- continued

Benefit

Intermediate services for child-adolescent Behavioral Health Disorders - continued

- **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. Covered Services include:
 - 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 involve 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.

Other Covered Services (outside of Medicare Parts A and B)- continued

Benefit

Intermediate services for child-adolescent Behavioral Health Disorders - continued

- **Intensive care coordination** -A collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, mental 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 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 mental health needs and resiliency factors;
- teaching parent(s)/caregiver(s) how to navigate services on behalf of the child; and
- identifying formal and informal services and supports in their communities, including parent support and self-help groups.

Other Covered Services (outside of Medicare Parts A and B) - continued

Benefit

Intermediate services for child-adolescent *Behavioral Health Disorders* - continued

- **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
- 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.

For more information about the services available under this benefit, please call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565.

(continued on next page)

Other Covered Services (outside of Medicare Parts A and B)- continued

| <u>Benefit</u> | <u>Tufts HP Pays...</u> | <u>You Pay....</u> |
|---|--|--|
| <i>Inpatient services for child-adolescent Mental Health Disorders</i> | <p>If your Plan includes an <i>Inpatient Copayment</i>, we pay All charges, minus your <i>Inpatient Copayment</i>. If your Plan does not include an <i>Inpatient Copayment</i>, we pay: All charges.</p> | <p>If your Plan includes an <i>Inpatient Copayment</i>, you pay: Your <i>Inpatient Copayment</i>. If your Plan does not include an <i>Inpatient Copayment</i>, you pay: Nothing.</p> |
| Intermediate services for child-adolescent Mental Health Disorders | All charges | Nothing. |

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.
Italicized words are defined in Appendix A.

Other Covered Services (outside of Medicare Parts A and B)- continued

| <u>Benefit</u> | <u>CARE AUTHORIZED BY YOUR TUFTS HP PCP</u> | | <u>CARE NOT AUTHORIZED BY YOUR TUFTS HP PCP</u> |
|---|--|--------------------------|--|
| | <u>Tufts HP Pays...</u> | <u>You Pay...</u> | <u>You Pay...</u> |
| Telemedicine Services | | | |
| Office visit | All charges. | Nothing. | All charges. |
| Remote Patient Monitoring | All charges. | Nothing. | All charges. |
| Remote medical data transfer/evaluation | All charges. | Nothing. | All charges. |

Coverage is provided for Medically Necessary telemedicine services for the purpose of diagnosis, consultation, or treatment in the same manner as an in-person consultation between you and your Tufts HP Provider. Telemedicine visits are provided through audio, video, or other electronic media communications. They substitute for in-person consultations with Tufts HP Providers when determined to be medically appropriate. These visits are available for both medical services and behavioral health services. This includes audio only consultations.

In addition, coverage is provided for additional telemedicine services that are not considered telemedicine visits, including:

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

Telemedicine services with Tufts HP Providers follow the same rules about referrals that apply for in-person services with those Providers. Please see Chapter 1 for more information about referral requirements.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*. ***Italicized words are defined in Appendix A.***

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>.

Other Covered Services (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUGS COVERED BY MEDICARE

Prescription Drugs Covered By Medicare

Medicare provides coverage for certain prescription drugs used to treat certain medical conditions, including certain injectable medications, when those drugs are obtained and administered by a *Provider*. The *Provider* will bill Medicare, and if the drug meets Medicare's coverage guideline, Medicare will pay for 80% of the Medicare approved charge for that drug. Then, this TMC plan will pay the remainder of the Medicare approved amount for the drug. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered under this section of the Prescription Drug Benefit.

Note: Infused medications and their administration are not covered in the home setting (home infusion) under this TMC plan, unless Medicare covers the infused medication and/or its administration as the primary payor. *Tufts HP* will cover any remainder of the cost up to the Medicare allowed amount.

For more information about coverage under this TMC plan, call Member Services at 1-800-462-0224.

Exclusions from Benefits

| | |
|----------------------------------|--|
| <p>List of exclusions</p> | <p><i>Tufts HP</i> will not pay for the following services, supplies, or medications:</p> <ul style="list-style-type: none"> • A service, supply or medication which is not <i>Medically Necessary</i>. • A service, supply or medication which is not a <i>Covered Service</i>. • A service, supply or medication received outside the <i>Tufts HP Service Area</i>, except as described under "How the Plan Works" in Chapter 1. • A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services. • A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting. • A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience. • Custodial Care. • Services related to non-covered services. • A drug, device, medical treatment or procedure (collectively "treatment") that is Experimental or Investigative. This exclusion does not apply to: <ul style="list-style-type: none"> • long-term antibiotic treatment of chronic Lyme disease; • bone marrow transplants for breast cancer; • patient care services provided pursuant to a qualified clinical trial; or • off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS, if you have a Prescription Drug Benefit. which meet the requirements of Massachusetts law. If the treatment is Experimental or Investigative, <i>Tufts HP</i> will not pay for any related treatments which are provided to the <i>Member</i> for the purpose of furnishing the Experimental or Investigative treatment. • Drugs, medicines, materials or supplies for use outside the hospital or any other facility , except as described in a Prescription Drug Benefit earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered under a Prescription Drug Benefit. Laboratory tests ordered by a <i>Member</i> (online or through the mail), even if performed in a licensed laboratory. |
|----------------------------------|--|

List of exclusions
(continued)

- Injectable medications, except for (i) Intravenous Immunoglobulin (IVIg) therapy is covered for the treatment of Pediatric Autoimmune Neuropsychiatric Disorders and Pediatric Acute-Onset Neuropsychiatric Syndromes, as required under Massachusetts law; or as described earlier in this chapter.
- Infused medications and their administration are not covered in the home setting (home infusion) under this TMC plan, unless Medicare covers the infused medication and/or its administration as the primary payor. *Tufts HP* will cover any remainder of the cost up to the Medicare allowed amount.
- The following exclusions apply to services provided by the relative of a *Member*:
 - Services provided by a relative who is not a *Tufts Health Plan Provider*, whether or not the services are authorized by your *PCP*, are not covered.
 - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Tufts Health Plan Provider* and the services are authorized by your *PCP*, are not covered.
 - If you are a *Tufts Health Plan Provider*, you cannot provide or authorize services for yourself, be your own *PCP*, or be the *PCP* of a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated).
- Facility charges or related services if the procedure being performed is not a *Covered Service*.
- Preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under "Dental Services" earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea), including those for TMJ disorders. This exclusion does not apply to the treatment of cleft lip or cleft palate for children under the age of 18, as described under "Cleft lip or cleft palate treatment and services for children" earlier in this chapter.

List of exclusions
(continued)

- Surgical removal or extraction of teeth, except as provided under "dental services" earlier in this chapter.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances. Breast reconstruction is covered when following a *Medically Necessary* mastectomy, as described in "Hospital *Inpatient* Services (Part A) earlier in this chapter.
- Rhinoplasty;
- Liposuction for cosmetic reasons; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags.
- Hair removal, (e.g., electrolysis, laser hair removal), except when *Medically Necessary* to treat an underlying skin condition.
- Circumcisions performed in any setting other than a hospital, *Day Surgery*, or *Provider's office*.
- Costs associated with home births.
- Infertility services, infertility medications, and associated reproductive technologies (such as IVF, GIFT, and ZIFT) including, but not limited to, experimental infertility procedures; the costs of surrogacy*; reversal of voluntary sterilization; long-term sperm or embryo cryopreservation; donor recruitment fee for donor egg or donor sperm; donor sperm and associated laboratory services, costs associated with donor recruitment and compensation; and Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
*the costs of surrogacy means: (1) all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*. These costs include, but are not limited to: costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos; (2) use of donor egg and a gestational carrier; 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.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Reversal of voluntary sterilization; or over-the-counter contraceptive agents.

List of exclusions
(continued)

- Human organ transplants if not covered by Medicare.
- the purchase of an electric hospital grade breast pump; donor breast milk.
- Services provided to a non-*Member*, except as described earlier in this chapter:
- Psychoanalysis.
- Inpatient and Outpatient weight-loss programs and clinics, except as described earlier in this chapter.
- Biofeedback, except for the treatment of urinary incontinence; neuromuscular stimulators and related supplies.
- Hypnotherapy; relaxation therapies; massage therapies, except as described under “Physical therapy, occupational therapy, and speech pathology services” earlier in this chapter; services by a personal trainer; exercise classes; cognitive rehabilitation programs or cognitive retraining programs, except as described earlier in this chapter. Also excluded are diagnostic services related to any of these procedures or programs.
- Multi-purpose general electronic devices including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electronic 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.
- Any service, program, supply or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; educational, vocational or recreational settings; Outward Bound; or wilderness, camp or ranch programs, even if performed or provided by a licensed PROVIDER (including, but not limited to, mental health professionals, nutritionists, nurses or physicians.) Examples of services provided in a non-conventional setting that are excluded from coverage include, but are not limited to, psychotherapy, ABA services, and nutritional counseling.
- Blood, blood donor fees, blood storage fees, or blood substitutes; blood banking, cord blood banking and blood products, except as detailed in the "Note" below.
Note: The following blood services and products are covered:
 - blood processing;
 - blood administration;
 - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease;
 - intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders.

List of exclusions

(continued)

- We do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including, but not limited to: therapeutic schools, camps, wilderness or ranch programs; sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound. We will provide coverage for *Medically Necessary Outpatient* or intermediate behavioral health services provided by licensed behavioral health *Providers* while the *Member* is in a tuition-based program, subject to plan rules, including any network requirements or *Cost Sharing*.
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational purposes. This includes physical therapy, speech therapy, and occupational therapy, except as provided earlier in this chapter. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities, and behavioral problems in a school-based setting.
- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described earlier in this chapter, *Tufts HP* will not pay for contact lenses or contact lens fittings.
- Hearing aids.
- 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 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:
 - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
 - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.This exclusion also does not apply to routine foot care for *Members* diagnosed with diabetes.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance Services" in this Chapter;
- Travel expenses, including lodging related to receiving any covered service.
- Intra-articular hyaluronan injections (e.g., viscosupplements, Euflexxa, Syncisc).
- All *Non-Conventional Medicine* services, provided independently or together with conventional medicines, and all related testing, laboratory testing, services, supplies, procedures and supplements associated with this type of medicine.
- Service or therapy animals and related supplies.

*Note: *Tufts HP* does not pay for any services or supplies when care is not provided or authorized by your *Tufts Health Plan PCP*.

Italicized words are defined in Appendix A.

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| List of exclusions (continued) | <ul style="list-style-type: none">• With respect to child-adolescent mental health intermediate care and <i>Outpatient services</i>, <i>Tufts Health Plan</i> will not pay for the following programs:<ul style="list-style-type: none">• Programs in which the patient has a pre-defined duration of care without <i>Tufts Health Plan's</i> 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 mental health disorders. |
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Chapter 4 - When Coverage Ends

Overview

Introduction

This chapter tells you when coverage ends.

Reasons coverage ends

Coverage ends when any of the following occurs:

- you lose eligibility because you
 - no longer meet your *Group's* or *Tufts HP's* eligibility rules,
 - no longer are eligible for and enrolled in Parts A and B of Medicare (please refer to your Medicare Handbook for events that can change your Medicare coverage), or
 - move out of the *Service Area*,
- you choose to drop coverage,
- 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 HP Member*, or *Tufts Health Plan* or any *Tufts HP* employee,
- misrepresentation or fraud, or
- your *Group's Contract* with *Tufts HP* ends.

Benefits after termination

Tufts HP will not pay for services you receive after your coverage ends even if

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

Continuation and conversion

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

When a *Member* is No Longer Eligible

Loss of eligibility

Your coverage ends on the date you

- no longer meet your *Group's* or *Tufts HP's* eligibility rules, or
- no longer are eligible for and enrolled in Parts A and B of Medicare.

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

If you move out of Tufts HP's Service Area

If you move out of the *Tufts HP Service Area*, coverage ends as of the date you move.

Tell your *Group* or call a Member Representative before you move to notify *Tufts HP* of the date you are moving. If you keep a residence in the *Service Area* but have been out of the *Service Area* for more than 90 days, coverage ends 90 days after the date you left the *Service Area*.

For more information about coverage available to you when you move out of the *Service Area*, contact a Member Representative at 1-800-462-0224.

You choose to drop coverage

Coverage ends if you decide you no longer want coverage and you meet any qualifying event your *Group* requires. To end your coverage, notify your *Group* (or *Tufts Health Plan* if covered under an *Individual Contract*) at least 30 days before the date you want your coverage to end. You must pay *Premiums* up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse *Tufts HP* 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 HP Member*, or
 - *Tufts Health Plan* or any *Tufts HP* employee.

Membership Termination for Misrepresentation or Fraud

Policy

Tufts HP may terminate your coverage for misrepresentation or fraud. If your coverage is terminated for misrepresentation or fraud, *Tufts HP* may not allow you to re-enroll for coverage with *Tufts HP* under any other plan (such as a Nongroup or another employer's plan) or type of coverage (for example, coverage as a *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*;
- submission of any false paperwork, forms, or claims information; or
- allowing someone else to use your Member ID.

Date of termination

If *Tufts HP* terminates your coverage for misrepresentation or fraud, your coverage will end as of your *Effective Date* or a later date chosen by *Tufts HP*.

Payment of claims *Tufts HP* will pay for all *Covered Services* you received between:

- your *Effective Date*; and
- your termination date, as chosen by *Tufts HP*. *Tufts HP* may retroactively terminate your coverage back to a date no earlier than your *Effective Date*. *Tufts HP* will use any *Premium* you paid for a period after your termination date to pay for any *Covered Services* you received after your termination date.

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

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

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

Termination of the Group Contract and Notice

Termination This topic describes the end of the *Group Contract*.

End of *Tufts HP's* and *Group's* relationship Coverage will terminate if the relationship between your *Group* and *Tufts HP* ends for any reason, including:

- your *Group's* contract with *Tufts HP* terminates;
- your *Group* fails to pay *Premiums* on time;
- *Tufts HP* no longer offers this Tufts Medicare Complement plan; or
- *Tufts HP* stops operating.

Notice of termination

The *Group Contract* will terminate if your *Group* fails to pay *Premiums* on time. If this happens, *Tufts HP* 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), as well as how to elect that coverage. If you elect Temporary Continuation of Coverage and pay the required *Premium*, TCC coverage is available to you during the period between:

- the effective date of termination of your *Group* coverage; and
- the date *Tufts HP* sends to you a written notice of termination.

The benefits available under Temporary Continuation of Coverage will be identical to those in your *Group* coverage.

Tufts HP may terminate your coverage back to the date the *Group Contract* terminated, if:

- *Tufts HP* sends to you a written notice of termination;
 - *Tufts HP* offers you the opportunity to elect Temporary Continuation of Coverage; and
 - you do not elect that coverage within the time period specified in the notice.
- If the *Group Contract* terminates for any reason other than your *Group's* failure to pay *Premiums*, *Tufts HP* will send a notice of termination to your *Group* with the effective date of termination. Your *Group* is responsible for notifying you of the termination. *Tufts HP* is not responsible if your *Group* does not notify you.

Plant Closing

Description of continuation

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.

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

Please call your *Group* or the *Tufts HP* Member Services Department for more information about this continuation coverage.

Chapter 5 - Member Satisfaction

Member Satisfaction Process

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

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

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan

Attn: Appeals and Grievances Dept.

P.O. Box 474

Canton, MA 02021

Fax: 617-972-9509

All calls should be directed to *Tufts HP's* Member Services. You may also submit your appeal or grievance electronically via the secure online member portal.

Internal Inquiry Call a *Tufts HP* Member Representative to discuss concerns you may have regarding your healthcare. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be 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 *Tufts HP*, we will send you a letter describing 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 accord with the timelines outlined below.

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

Important Note: In many instances, we will ask you to direct your initial concern to Medicare (since Medicare will make the primary determination on your health care benefits). Information is available by contacting your local Social Security office or via the internet on the official Medicare Web site at www.medicare.gov.

Member Grievance Process

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

It is important that you contact *Tufts HP* as soon as possible to explain your concern. Grievances may be filed verbally, in writing, or through the secure online member portal. If you choose to file a grievance verbally, please call a *Tufts Health Plan* Member Specialist, who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and fax it to us at 617-972-9509 or send it to the address provided at the beginning of this section. You may also submit your grievance electronically via the secure online member portal. Your explanation should include:

- your name and address;
- your *Tufts HP* 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 Grievance Timeline

- If you file your grievance verbally or in writing, within five (5) business days after receiving your letter, we will notify you by mail that your letter has been received and 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 *Tufts HP* that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your *Providers* to release medical information relevant to your grievance to *Tufts HP*. You must sign and return the form before *Tufts HP* can begin the review process. If you do not sign and return the form to *Tufts HP* within thirty (30) calendar days of the date you filed, *Tufts HP* 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 which are in the possession and control of *Tufts HP*.
- *Tufts HP* will review your grievance, and will send you a letter regarding the outcome via certified or registered mail, 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 HP*.

Clinical Grievances

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

If you file your grievance verbally or in writing, we will notify you by mail, within five (5) business days after receiving your grievance, that your grievance has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your grievance.

Tufts HP will review your grievance and will notify you in writing regarding the outcome via certified or registered mail, 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.

"Reconsideration"

If you are not satisfied with the result of the Clinical Grievance review process, you may request a "reconsideration". If you so choose, your concerns will be reviewed by a clinician who was not involved in the initial review process. Upon request for a reconsideration, your concerns will be reviewed within thirty (30) calendar days. You will be notified in writing of the results of the review.

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 HP* 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 *Tufts HP* 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 verbally, in writing, or through the secure online member portal. If you would like to file a verbal appeal, call a *Tufts HP* Member Representative who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing and fax it to us at 617-972-9509 or send it to the address provided at the beginning of this section. You may also submit your appeal electronically via the secure online member portal.

Your explanation should include:

- your name and address;
- your *Tufts HP* 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, within forty-eight (48) hours after receiving your appeal, we will notify you in writing that your appeal has been received and 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) day internal inquiry process or earlier if you notify *Tufts HP* that you are not satisfied with the response you received during the internal inquiry process.
- *Tufts HP* will review your appeal, make a decision, and send you a decision letter via certified or registered mail 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 HP*.

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

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
(800) 272-4232

<http://www.hcfama.org/helpline>

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.

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 which authorizes your *Providers* to release to *Tufts HP* medical information relevant to your Appeal. You must sign and return the form before *Tufts HP* can begin the review process. If you do not sign and return the form to *Tufts HP* within thirty (30) calendar days of the date you filed your appeal, *Tufts HP* 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, which are in the possession and control of *Tufts HP*.

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 HP* departments will review your appeal. A committee within the Appeals and Grievances Department will review appeals involving non-covered services.

Appeal Response Letters

The letter you receive from *Tufts HP* will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on medical necessity) will include: the specific information upon which the adverse determination was based; *Tufts HP's* understanding of your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; notification of the steps for requesting external review by the Office for Patient Protection; 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* (EOC) are not eligible for external review.

An appeal not properly acted on by *Tufts HP* 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 HP*, shall be deemed resolved in your favor.

Expedited Appeals

Tufts HP recognizes that there are circumstances that require a quicker turnaround than the 30 calendar days allotted for the standard Appeals Process. *Tufts HP* will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending *Provider* should contact the Member Services Department. Under these circumstances, you will be notified of *Tufts HP's* decision within 2 business days, but no later than seventy-two (72) hours (whichever is less) after the review is initiated.

If your treating *Provider* (the practitioner responsible for the treatment or proposed treatment) certifies that the service being requested is *Medically Necessary*; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal appeal process, you will be notified of *Tufts HP's* decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for *Durable Medical Equipment* (DME) that *Tufts HP* determined was not *Medically Necessary*, you will be notified of *Tufts HP's* decision within less than forty-eight (48) hours of the receipt of certification. If you are an *Inpatient* in a hospital, *Tufts HP* will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at *Tufts HP's* expense through the completion of the Internal Appeals Process. Only those services which were originally authorized by *Tufts Health Plan* and which were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

We will notify you of *Tufts HP's* decision in writing via certified or registered mail within two (2) business days of the decision. If *Tufts HP's* decision is to deny coverage, you may request a conference.

We will schedule the conference within 10 days (or within 5 business days if your *Provider* determines, after talking with a *Tufts Health Plan* Medical Affairs Department Physician or Psychological Testing Reviewer, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date). You may bring another person with you to the conference. At the conference, you and/or your authorized representative, if any, and a representative of *Tufts HP* 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.

**Conference
(Walk-in)
Appeals**

If the case involves an adverse determination (*Medical Necessity* determination), you or your representative may also appear in person or by conference call to present your appeal. This is an opportunity for you to present additional information to the Committee that may be better communicated in person. If you would like to present your appeal in person, you must request this option. A Member Appeals Specialist will contact you to schedule a date and time to appear. You will have approximately twenty minutes to address the Committee. The Committee will not make a decision while you are present, but the Member Appeals Specialist will notify you of a decision after it has been made.

If You are Not Satisfied with the Appeals Decision

**"Recon-
sideration"**

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 HP* 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 Office of Patient Protection, which is not connected in any way with *Tufts HP*, 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 EOC and payment disputes are not eligible for external review.

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

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

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.

**External
Review by The
Office
of Patient
Protection,
continued**

You, or your authorized representative, will have access to any medical information and records relating to your appeal, in the possession of the *Tufts HP* or under its control.

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

The decision of the review panel will be binding on *Tufts HP*. If the external review agency overturns a *Tufts HP* decision in whole or in part, *Tufts HP* 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 HP*; and
- include the name and phone number of the person at *Tufts HP* who will assist you with final resolution of the appeal.

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

**Health Policy Commission, Office of Patient Protection
50 Milk Street
Boston, MA 02109**

Phone: 1-800-436-7757 / Fax: 1-617-624-5046/

Internet: www.mass.gov/hpc/opp

E-mail: HPC-OPP@state.ma.us

Bills from Providers

Bills from Providers

Medical Expenses

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

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

- a completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the *Tufts HP* Web site or by contacting the *Tufts HP* Member Services Department; and
- the documents listed on the Member Reimbursement Medical Claim Form that 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 HP* regarding your bill(s) or send your bill(s) to *Tufts HP* 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 4-6 weeks. 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.

If you receive *Covered Services* from a non-*Tufts HP* *Provider*, *Tufts HP* will pay you up to the *Reasonable Charge* for the services.

Tufts HP reserves the right to be reimbursed by the *Member* for payments made due to *Tufts HP's* error.

Pharmacy Expenses

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

Limitation on Actions

Limitation on Actions

You cannot file a lawsuit against *Tufts HP* for failing to pay or arrange for *Covered Services* unless you have completed the *Tufts HP* Member Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under this *Group Contract*, you must first complete our Member Satisfaction Process, and then file your lawsuit within the next two years after the date you were first sent a notice of the denial. Going through the Member Satisfaction Process does not extend the time limit for filing a lawsuit beyond the 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 6 - 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 homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you for Third Party injuries.

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

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

Workers' compensation

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

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. *Tufts HP* will not provide coverage for any injury or illness for which it determines that benefits are available under any workers' compensation coverage or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If *Tufts HP* pays for the costs of health care services or medications for any work-related illness or injury, *Tufts HP* has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider*. If your *Provider* bills services or medications to *Tufts HP* for any work-related illness or injury, please contact the *Tufts HP* Member Services Department.

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 *Tufts HP* for the cost of health care services, supplies, medications, and expenses for which *Tufts HP* paid or will pay.

This right of reimbursement attaches when we have provided health care benefits for expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- no-fault PIP, or MedPay under any automobile policy to the extent permissible by law;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you where a Third Party is responsible.

Tufts HP has the right to be reimbursed up to the amount of any payment received by you to the extent permissible by law. This is regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to compensate you fully for the illness or injury.

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 written representative fails to cooperate with Tufts Health Plan, you shall be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by Tufts Health Plan in obtaining repayment.

Subrogation Agent

Tufts HP may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as *Tufts HP's* 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

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| Benefits under other plans | <p>You may have benefits under other plans for hospital, medical, dental or other health care expenses.</p> <p><i>Tufts HP</i> has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for <i>Covered Services</i> with benefits payable by other plans, consistent with Massachusetts law, 211 CMR 38.00 <i>et seq.</i></p> <p>Note: We coordinate benefits with Medicare according to federal law, rather than state law.</p> |
| Primary and secondary plans | <p><i>Tufts HP</i> will coordinate benefits by determining</p> <ul style="list-style-type: none">• which plan has to pay first; and• which plan has to pay second. <p><i>Tufts HP</i> determines 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.</p> |
| Right to receive and release necessary information | <p>When you enroll, you must include information on your membership application about other health coverage you have.</p> <p>After you enroll, you must notify <i>Tufts HP</i> of new coverage or termination of other coverage. <i>Tufts HP</i> may ask for and give out information needed to coordinate benefits.</p> <p>You agree to provide information about other coverage and cooperate with <i>Tufts HP's</i> COB program.</p> |
| Right to recover overpayment | <p><i>Tufts HP</i> 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. <i>Tufts HP</i> will recover only overpayments actually made.</p> |
| For more information | <p>For more information about COB, contact the <i>Tufts HP</i> Liability Recovery (COB) Department at 1-888-880-8699, x21098. You can also call a Member Representative at 1-800-462-0224 and have your call transferred to the <i>Tufts HP</i> Liability Recovery Department.</p> |

Use and Disclosure of Medical Information

The "Notice of Privacy Practices" explains how *Tufts HP* uses and discloses your medical information. If you have questions or would like a paper copy of our "Notice of Privacy Practices", please call a Member Representative at 1-800-462-0224. You can also obtain a copy from our Website.

Relationships between *Tufts HP* and *Providers*

Tufts HP* and *Providers *Tufts HP* arranges health care services. *Tufts HP* does not provide health care services. *Tufts HP* has agreements with *Providers* practicing in their private offices throughout the *Tufts HP Service Area*. These *Providers* are independent. They are not *Tufts HP* employees, agents or representatives. *Providers* are not authorized to:

- change this *Evidence of Coverage*; or
- assume or create any obligation for *Tufts HP*.

Tufts HP is not liable for acts, omissions, representations or other conduct of any *Provider*.

Circumstances Beyond *Tufts Health Plan's* Reasonable Control

Circumstances beyond *Tufts HP'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 HP*. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services. In doing so, *Tufts HP* will take into account the impact of the event and the availability of *Tufts HP Providers*.

Group Contract

Acceptance of the terms of the Group Contract

By signing and returning the membership application form, you apply for *Group* coverage and agree to all the terms and conditions of the *Group Contract*, including this *Evidence of Coverage*.

Payments for coverage

Tufts HP will bill your *Group* and your *Group* will pay *Premiums* to *Tufts HP* for you. *Tufts HP* is not responsible if your *Group* fails to pay the *Premium*.

Note: If your *Group* fails to pay the *Premium* on time, *Tufts HP* may cancel your coverage in accordance with the *Group Contract* and applicable state law.

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

Group Contract, continued

Changes to this Evidence of Coverage

Tufts HP 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 changes in clinical review criteria; and
- detail the effect of such changes on a *Member's* personal liability for the cost of such changes.

Changes will apply to all benefits for services received on or after the effective date with one exception.

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

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

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

Notice to Members: When *Tufts HP* sends a notice to you, it will be sent to your last address on file with *Tufts HP*.

Notice to Tufts HP: *Members* should address all correspondence to:

Tufts Health Plan
P.O. Box 308
Canton, MA 02021

Enforcement of terms

Tufts HP may choose to waive certain terms of the *Group Contract*, if applicable, including the *Evidence of Coverage*. This does not mean that *Tufts HP* gives up its 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 January 1, 2023, and supersedes all previous *Evidences of Coverage*.

Appendix A -Glossary of Terms

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| Terms and Definition table | The table below defines the terms used in this <i>Evidence of Coverage</i> . |
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| Term | Definition |
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| Annual Coverage Limitations | Annual dollar or time limitations on <i>Covered Services</i> . |
| Authorized Reviewer | <p><i>Authorized Reviewers</i> review and approve certain services and supplies to <i>Members</i>. They are:</p> <ul style="list-style-type: none"> • <i>Tufts HP's</i> Chief Medical Officer (or equivalent); or • someone he or she names. |
| Benefit Period | The way that Medicare measures your use of hospital and <i>Skilled</i> nursing facility services. A <i>Benefit Period</i> begins the day you go to a hospital or <i>Skilled</i> nursing facility. The <i>Benefit Period</i> ends when you have not received hospital or <i>Skilled</i> nursing care for 60 days in a row. If you go into the hospital after one <i>Benefit Period</i> has ended, a new <i>Benefit Period</i> begins. You must pay the <i>Inpatient</i> hospital deductible for each <i>Benefit Period</i> . There is no limit to the number of <i>Benefit Periods</i> you can have. |
| Biologically-based Mental Disorders | <p>The following <i>Mental Disorders</i>:</p> <ul style="list-style-type: none"> • schizophrenia; • schizoaffective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders; • obsessive-compulsive disorder; • panic disorder; • delirium and dementia; • affective disorders; and • any other mental disorders added by the Commissioners of the Department of Mental Health and the Division of Insurance. <p>Note: See Chapter 3 for information regarding coverage for biologically-based mental disorders</p> |
| Board-Certified Behavior Analyst (BCBA) | A <i>Board-Certified Behavior Analyst (BCBA)</i> meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A <i>BCBA</i> professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for <i>Members</i> with diagnoses of autism spectrum disorders. <i>BCBAs</i> may supervise the work of Board-Certified Assistant Behavior Analysts and other <i>Paraprofessionals</i> who implement behavior analytic interventions. |

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| Coinsurance | <p>The percentage of costs you must pay for certain <i>Covered Services</i>. For services provided by a <i>Non-Tufts HP Provider</i>, your share is a percentage of the <i>Reasonable Charge</i> for those services. For services provided by a <i>Tufts HP Provider</i>, your share is a percentage of:</p> <ul style="list-style-type: none"> • the applicable <i>Tufts HP</i> fee schedule amount for those services; and • the <i>Tufts HP Provider's</i> actual charges for those services, whichever is less. <p>Costs in excess of the <i>Reasonable Charge</i> are not subject to <i>Coinsurance</i>. The <i>Member</i> may be responsible for paying for costs in excess of the <i>Reasonable Charge</i>.</p> <p>Note: The <i>Member's</i> share percentage is based on the <i>Tufts Health Plan Provider</i> 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.</p> |
| Copayment | <p>Fees you pay for <i>Covered Services</i>. <i>Copayments</i> are paid to the <i>Provider</i> when you receive care unless the <i>Provider</i> arranges otherwise.</p> |
| Cost Sharing Amount | <p>The cost you pay for certain <i>Covered Services</i>. This amount may consist of <i>Copayments</i> and/or <i>Coinsurance</i>.</p> |
| Covered Services | <p>The services and supplies for which <i>Tufts HP</i> will pay. They must be</p> <ul style="list-style-type: none"> • described in Chapter 3; • <i>Medically Necessary</i>; and • given or authorized by your <i>PCP</i> and in some cases approved by an <i>Authorized Reviewer</i>. <p>Note: <i>Covered Services</i> do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any <i>Provider, Member, service, supply, or medication</i>.</p> |
| Covering Provider | <p>The <i>Provider</i> named by your <i>PCP</i> to give or authorize services in your <i>PCP's</i> absence.</p> |
| Custodial Care | <ul style="list-style-type: none"> • Care given primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety; • care given primarily for maintaining the <i>Member's</i> or anyone else's safety, when no other aspects of treatment require an acute hospital level of care; • services that could be given by people without professional skills or training; or • routine maintenance of colostomies, ileostomies, and urinary catheters; or • adult and pediatric day care. <p>Note: <i>Custodial Care</i> is not covered by <i>Tufts HP</i>.</p> |
| Day Surgery | <p>Any surgical procedure(s) provided to a <i>Member</i> at a facility licensed by the state to perform surgery, and with an expected departure the same day, or in some instances, within twenty-four hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care."</p> |
| Deductible | <p>The amount you must pay for health care, before Medicare begins to pay for Medicare <i>Covered Services</i>. There is a <i>Deductible</i> for each <i>Benefit Period</i> for Part A, and each year for Part B. These amounts can change every year.</p> |

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| Dependent | The <i>Subscriber's Spouse</i> , child, or disabled dependents. |
| 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 | <p>A searchable list of:</p> <ul style="list-style-type: none"> • <i>Tufts HP PCPs</i> and their affiliated <i>Tufts HP Hospital</i>; and • certain other <i>Tufts HP Providers</i>. <p>Note: This list is updated from time to time to show changes in <i>Providers</i> affiliated with <i>Tufts HP</i>. For information about the <i>Providers</i> listed in the <i>Directory of Health Care Providers</i>, you can call <i>Tufts HP Member Services</i> at 1-800-462-0224 or check our Website.</p> |
| Durable Medical Equipment | <p>Devices or instruments of a durable nature that</p> <ul style="list-style-type: none"> • 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 <i>Tufts HP's</i> records, when you become a <i>Member</i> and are first eligible for <i>Covered Services</i> . |
| Emergency | <p>An illness or medical condition, whether physical, behavioral, related to substance abuse or mental, that manifests itself by symptoms of sufficient severity including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:</p> <ul style="list-style-type: none"> • serious jeopardy to the physical and / or mental health of a <i>Member</i> or another person (or with respect to a pregnant <i>Member</i>, the <i>Member's</i> or her unborn child's physical and / or mental health); • 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 <i>Member</i> or her unborn child in the event of transfer to another hospital before delivery. <p>Some examples of illnesses or medical conditions requiring <i>Emergency</i> 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.</p> |
| Evidence of Coverage | This document and any future amendments. |

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| Experimental or Investigative | <p>A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered <i>Experimental or Investigative</i> and therefore not <i>Medically Necessary</i>, if any of the following is true:</p> <ul style="list-style-type: none"> • 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; <ul style="list-style-type: none"> • 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 not 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. <p>This definition is fully explained in the corresponding Medical Necessity Guidelines.</p> |
| Group | <p>An employer or other legal entity with which <i>Tufts HP</i> has an agreement to provide group coverage. An employer <i>Group</i> subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. The <i>Group</i> is your agent and is not <i>Tufts HP's</i> agent.</p> |
| Group Anniversary Date | <p>The date upon which the <i>Group Contract</i> first renews and each successive annual renewal date.</p> |
| Group Contract | <p>The agreement between <i>Tufts HP</i> the <i>Group</i> under which</p> <ul style="list-style-type: none"> • <i>Tufts HP</i> agrees to provide <i>Group Coverage</i>; and • the <i>Group</i> agrees to pay a <i>Premium</i> to <i>Tufts HP</i> on your behalf. <p>The <i>Group Contract</i> includes this <i>Evidence of Coverage</i> and any amendments.</p> |
| Individual Coverage | <p>Coverage for a <i>Subscriber</i> only.</p> |
| Inpatient | <p>A patient who is</p> <ul style="list-style-type: none"> • admitted to a hospital or other facility licensed to provide continuous care; and • classified as an Inpatient for all or a part of the day. |

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| Medically Necessary | <p>A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply:</p> <ul style="list-style-type: none"> • Is the most appropriate available supply or level of services for the <i>Member</i> 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. <p>In determining coverage for <i>Medically Necessary Services</i>, <i>Tufts HP</i> uses <i>Medical Necessity Guidelines</i> which are:</p> <ul style="list-style-type: none"> • developed with input from practicing <i>Providers</i> in the <i>Tufts HP Service Area</i>; • developed in accordance with the standards adopted by national accreditation organizations; • updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and • scientific evidence-based, if practicable. |
| Member | A person enrolled in <i>Tufts HP</i> under the <i>Group Contract</i> , also referred to as "you." |
| Mental Disorders | Psychiatric illnesses or diseases listed as <i>Mental Disorders</i> in the latest edition, at the time treatment is given, of the American Psychiatric Association's Diagnostic and Statistical Manual: <i>Mental Disorders</i> regardless of whether the cause of the illness or disease is organic. |

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| Non-Conventional Medicine | <p>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 <i>Tufts Health Plan</i> definition of <i>Medical Necessity</i> 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 <i>Non-Convention Medicine</i> services often request payment up front because health insurance typically does not cover these services.</p> <p>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 <i>Non-Conventional Medicine</i> and related services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 <i>Non-Conventional Medicine</i> services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises). |
| Observation | <p>The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within twenty-three (23) hours or a verified diagnosis and concurrent treatment plan. At times, an Observation stay may be followed by an Inpatient admission to treat a diagnosis revealed during the period of Observation.</p> |
| Open Enrollment Period | <p>The period each year when <i>Tufts HP</i> and the <i>Group</i> allow eligible persons to apply for <i>Group</i> coverage in accordance with the <i>Group Contract</i>.</p> |
| Outpatient | <p>A patient who receives care other than on an Inpatient basis. This includes services provided in:</p> <ul style="list-style-type: none"> • a <i>Provider's</i> office; • a Day Surgery or ambulatory care unit; and • an <i>Emergency</i> room or <i>Outpatient</i> clinic. |
| Paraprofessional | <p>As it pertains to the treatment of autism and autism spectrum disorders, a <i>Paraprofessional</i> is an individual who performs applied behavioral analysis (ABA) services under the supervision of a <i>Board-Certified Behavior Analyst (BCBA)</i>.</p> |
| Provider Organization | <p>A <i>Provider Organization</i> is comprised of doctors and other health care <i>Providers</i> who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care.</p> |

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| Premium | The total monthly cost of <i>Individual Coverage</i> which the <i>Group</i> pays to <i>Tufts HP</i> . |
| Primary Care Provider (PCP) | The <i>Tufts HP</i> physician or nurse practitioner you have chosen from the <i>Tufts HP Directory of Health Care Providers</i> and who has an agreement with <i>Tufts HP</i> to provide primary care and to coordinate, arrange, and authorize the provision of <i>Covered Services</i> . |
| Provider | <p>A health care professional or facility licensed or certified in accordance with applicable law, including, but not limited to, hospitals, limited service medical clinics, urgent care centers, if available, physicians, physician assistants, nurse midwives, registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, mental health counselors, independent clinical social workers, drug and alcohol counselors I; marriage and family therapists; psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, speech-language pathologists, and audiologists.</p> <p><i>Tufts HP</i> will only cover services of a <i>Provider</i>, if those services are:</p> <ul style="list-style-type: none"> • listed as <i>Covered Services</i>; and • within the scope of the <i>Provider's</i> license or certification, if applicable. <p>Notes:</p> <ul style="list-style-type: none"> • With respect to <i>Outpatient</i> services for the treatment of alcoholism, <i>Provider</i> means an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health or under other applicable state law. • With respect to <i>Inpatient Services</i> for the treatment of alcoholism, <i>Provider</i> 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. |
| Rape-related Mental or Emotional Disorder | <p>A mental or emotional disorder related to a Member who is a victim of rape or assault with intent to commit rape.</p> <p><i>Rape-related Mental or Emotional Disorders</i> are covered when the costs for treatment exceed the maximum amount awarded under applicable Massachusetts law.</p> <p>Note: See Chapter 3 for information regarding coverage for rape-related mental or emotional disorders.</p> |

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| Reasonable Charge | <p>The lesser of the:</p> <ul style="list-style-type: none"> • amount charged; or • amount that <i>Tufts HP</i> determines, based upon nationally accepted means of claims payment and the fees most often charged by similar <i>Providers</i> for the same service in the geographic area in which it is given, to be the reasonable amount for the service. Nationally accepted means of claims payment includes, but is not limited to: CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines. <p>With respect to Out-of-Network Emergency care, reasonable charge is the highest of: (1) the median amount negotiated with Tufts Health Plan Providers for the Emergency services; (2) the amount for the Emergency service calculated using the same method we generally use to determine payments for out-of-network services (such as the usual, customary and reasonable (UCR) amount; or (3) the amount that would be paid under Medicare for the Emergency service.</p> |
| Reserve Days | <p>Sixty days that Medicare will pay for when you are put in a hospital for more than 90 days of Medicare <i>Covered Services</i>. These 60 <i>Reserve Days</i> can be used only once during your lifetime. For each lifetime <i>Reserve Day</i>, Medicare pays all covered costs except for a daily <i>Coinsurance</i> amount.</p> |

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|-------------------------------|--|
| Service Area | <p>The <i>Service Area</i> is the geographical area within which <i>Tufts HP</i> has developed a network of <i>Providers</i> to afford <i>Members</i> with adequate access to <i>Covered Services</i>. The <i>Service Area</i> consists of the Standard <i>Service Area</i> and the Extended <i>Service Area</i>.</p> <p>The Standard <i>Service Area</i> is comprised of:</p> <ul style="list-style-type: none"> • all of Massachusetts; • all of Rhode Island; • all of New Hampshire; • The Extended <i>Service Area</i> includes certain towns in Connecticut, Maine, New York, and Vermont which surround the Standard <i>Service Area</i> and are within a reasonable distance from <i>Tufts Health Plan PCPs</i> and specialists who provide the most-often used services, such as behavioral health practitioners and physicians who are surgeons or OB/GYNs. <p>Notes:</p> <ul style="list-style-type: none"> • There are generally no <i>Tufts HP PCPs</i> located within the Extended <i>Service Area</i>. • For a list of cities and towns in the <i>Service Area</i>, you can call <i>Tufts HP Member Services</i> at 1-800-462-0224 or check our Web site at www.tuftshealthplan.com. |
| Skilled | A type of care which is <i>Medically Necessary</i> and must be provided by, or under the direct supervision of, licensed medical personnel. <i>Skilled</i> care is provided to achieve a medically desired and realistically achievable outcome. |
| Spouse | The <i>Subscriber's</i> legal spouse, according to the law of the state in which you reside. |
| Subscriber | <p>The person who:</p> <ul style="list-style-type: none"> • is an employee of the <i>Group</i>; • enrolls in <i>Tufts Health Plan</i> and signs the membership application form; and • in whose name the <i>Premium</i> is paid by a <i>Group</i>. |
| Tufts Health Plan or Tufts HP | Tufts Associated Health Maintenance Organization, Inc., a Massachusetts corporation d/b/a <i>Tufts Health Plan</i> . <i>Tufts Health Plan</i> is licensed by Massachusetts as a health maintenance organization (HMO). Also referred to as " <i>Tufts HP</i> ". |
| Tufts HP Hospital | A hospital which has an agreement with <i>Tufts Health Plan</i> to provide certain <i>Covered Services</i> to <i>Members</i> . <i>Tufts HP Hospitals</i> are independent. They are not owned by <i>Tufts Health Plan</i> . <i>Tufts HP Hospitals</i> are not <i>Tufts Health Plan's</i> agents or representatives, and their staff are not <i>Tufts Health Plan's</i> employees. |
| Tufts HP Provider | A <i>Provider</i> with which <i>Tufts Health Plan</i> has an agreement to provide <i>Covered Services</i> to <i>Members</i> . <i>Providers</i> are not <i>Tufts Health Plan's</i> employees, agents or representatives. |
| Urgent Care | <p>Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, sudden extreme anxiety, or symptoms of a urinary tract infection.</p> <p>Note: Care that is rendered after the <i>Urgent</i> condition has been treated and stabilized and the <i>Member</i> is safe for transport is not considered <i>Urgent Care</i>.</p> |

Appendix B - ERISA Information and other State and Federal Notices

ERISA RIGHTS

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

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

Receiving Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

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

Continuing Group Health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

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

Prudent Actions by Plan Fiduciaries

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

Enforcing Your Rights

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

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

Assistance with Your Questions

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

PROCESSING OF CLAIMS FOR PLAN BENEFITS

The Department of Labor's (DOL) Employee Benefits Security Administration 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 HP's* procedures for reviewing claims depends upon the type of claim submitted (urgent care claims, pre-service claims, post-service claims, and concurrent care decisions).

Urgent care claim: An "urgent care claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your Provider's determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested. For urgent care claims, *Tufts HP* will respond to you within 72 hours after receipt of the claim. If *Tufts HP* determines that additional information is needed to review your claim, we will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hours after that time to provide the requested information. *Tufts HP* 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 *Tufts HP* has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, *Tufts HP* will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the decision and obtain a determination before the treatment is reduced or terminated. If you request to extend an ongoing course of treatment that involves urgent care, *Tufts HP* will respond to you within 24 hours after receipt of the request (provided that you make the request at least 24 hour prior to the expiration of the ongoing course of treatment). If you reach the end of a pre-approved course of treatment before requesting additional services, the "pre-service" or "post-service" time limits will apply.

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

Post-service claim: A "post-service claim" is a claim for payment for a particular service after the service has been provided. For post-service claims, *Tufts HP* will respond to you within 30 days after receipt of the claim. If *Tufts HP* determines that an extension is necessary due to matters beyond our control, we will notify you within 30 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a post-service claim, but do not submit enough information for *Tufts HP* to make a determination, we will notify you within 30 days and describe the information that you need to provide to *Tufts HP*.

PROCESSING OF CLAIMS FOR PLAN BENEFITS, continued

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.

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:

- to work because of a serious health condition. 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

Military Family Leave

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 to up to 26 weeks of leave in a single 12-month period to care for the servicemember. The employee is entitled to a combined total of 26 weeks for all types of FMLA leave in the single 12-month period. 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/fmla/finalrule/FMLAPoster.pdf>.

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, sex, sexual orientation, or gender identity. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Tufts Health Plan at 800.462.0224.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, 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@point32health.org.

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>.

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.

Appendix C – Schedule II and III Opioid Medications

Effective January 1, 2023, 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 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. 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

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/

- 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
- 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 apply¹. 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>.

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.