Introduction

Welcome to Navigator by Tufts Health Plan™ (“Navigator”). We are pleased you have chosen this Point of Service (POS) health plan. We look forward to working with you to help you meet your health care needs. This Member Handbook describes the Navigator health care plan. Please note that italicized words in this document have special meanings. These meanings are given in the “Definitions” section (see Part 8, pages 90-97).

Navigator is a self-funded plan, which means that the Group Insurance Commission (the “GIC” or “Commission”) is responsible for the cost of the Covered Services you receive. The GIC has contracted with Tufts Health Plan to offer you access to a network of health care professionals known as Tufts Health Plan (“Tufts HP”) Providers. Tufts Health Plan also performs certain services, such as claims processing, but it does not insure plan benefits or determine your eligibility for benefits under the Navigator Plan.

This Member Handbook will help you find answers to your questions about your benefits. Navigator Members have benefits for Covered Services according to the terms of this Member Handbook.

Tufts HP administers your medical and prescription drug benefits.

Medical and Prescription Drug Plan - Tufts Health Plan administers Navigator, which provides the medical and prescription drug benefits described in this Member Handbook. Details on your coverage and costs for medical services are described in “Benefit Overview” (page 13) and “Plan and Benefit Information” (pages 27-31).

Navigator Members are encouraged to receive medical services and prescription drugs from the Tufts Health Plan network of health care Providers. Using these Tufts HP Providers will minimize your out-of-pocket expenses for Covered Services. To find out which Providers are in the network, you can:

- Visit the online Provider Directory at tuftshealthplan.com/gic
- Call the Member Services Department at 800-870-9488

Behavioral Health – Your Mental Health, Substance Use Disorder, and EAP (behavioral health) benefits are included in this plan but administered by Beacon Health Options (Beacon). Your behavioral health benefits, and any requirements you must follow to obtain these benefits, are described on pages 104-126. For further information about your behavioral health benefits, visit beaconhealthoptions.com/gic or call Beacon at 855-750-8980.

Note: Italicized words are defined in Part 8.
Introduction, Continued

Medical and Prescription Drug Plan (continued) –

This is a POS plan. You must select a Primary Care Provider (PCP) under this plan. Each time you need to receive health care services, you may choose to obtain your health care either:

- From or authorized by your Tufts HP Primary Care Provider (PCP). This is called the Authorized Level of Benefits; or
- From any health care Provider without your PCP’s authorization. This is called the Unauthorized Level of Benefits.

Your choice will determine the level of benefits you receive for Covered Services.

For Outpatient medical care, Covered Services from or authorized by your Tufts HP PCP are covered at the Authorized Level of Benefits. Your PCP will authorize you to receive care from other Tufts HP Providers unless the care you need is not available within Tufts HP’s network of Tufts HP Providers. In that case, your PCP (after obtaining approval from an Authorized Reviewer) will refer you to a Provider not affiliated with Tufts HP.

At the Authorized Level of Benefits, your Office Visit Copayment will vary depending on the type of physician who provides your care. Under this plan, the Provider groups to which PCPs, specialists, and hospitals belong are placed into one of three tiers based on participation in the GIC’s Centered Care Program, the providers’ practice and referral patterns, and efficiency of performance. Providers’ tiers are based on their group’s tiering; Providers are not individually tiered. The lowest cost-sharing is applied to Providers that have the most efficient performance.

- Providers that participate in the Centered Care Program and are the most efficient are placed in Tier 1.
- Providers that participate in the Centered Care Program and are less efficient are placed in Tier 2.
- Providers that do not participate in the Centered Care Program are placed in Tier 3. However, hospitals that do not participate in the Centered Care Program, but to whom Centered Care Providers refer, are placed in the tier of the Provider who made the referral.

The following Copayments apply to the following Providers:

- **Primary care provider (PCP)**
  
  PCPs include general practitioners, family practitioners, internal medicine specialists, pediatric primary care providers, physician assistants, nurse practitioners, primary care physicians who are also specialists, and obstetrician/gynecologists. PCPs in Massachusetts are tiered based upon their participation in the Centered Care Program and their Provider group’s efficiency.

  - **Copayment Tier 1 PCP (Lowest Cost Share):** Participates in Centered Care Program and provides the most efficient care -- $10 Copayment
  
  - **Copayment Tier 2 PCP (Mid-level Cost Share):** Participates in Centered Care Program and provides less efficient care-- $20 Copayment
  
  - **Copayment Tier 3 PCP (Highest Cost Share):** Does not participate in the Centered Care Program -- $40 Copayment.

- **All PCPs outside of Massachusetts -- $20 Copayment**

- **Massachusetts Specialists**

  - **Copayment Tier 1 Specialist (Lowest Cost Share):** Participates in the Centered Care Program and provides the most efficient care -- $30 Copayment
  
  - **Copayment Tier 2 Specialist (Mid-level Cost Share):** Participates in the Centered Care Program and provides less efficient care -- $60 Copayment
  
  - **Copayment Tier 3 Specialist (Highest Cost Share):** Does not participate in the Centered Care Program -- $90 Copayment

- **All specialists outside of Massachusetts -- $60 Copayment**
Introduction, Continued

Medical and Prescription Drug Plan (continued) –

- **Limited Service Medical Clinic** or free-standing **Urgent Care Center** that participates in **Tufts Health Plan** – $20 Copayment

**Note:** Copayments for Urgent Care Services at all other locations vary depending on the type of Provider (PCP vs. Specialist) you see and the location (for example, Provider’s office, Limited Service Medical Clinic, Urgent Care Center, or Emergency room) where you receive services.

For a list of **Tufts HP Providers** (including tiers, if applicable), please refer to the online Provider Directory at tuftshealthplan.com/gic.

At the **Authorized Level of Benefits,** **Inpatient hospital stays** at **Tufts Health Plan Hospitals** are grouped into **Inpatient Hospital Copayment** Levels based on their participation in the Centered Care program and their efficiency of performance (see Part 9, pages 98-103, for more information about the standards used for grouping the hospitals). All hospital admissions are subject to the **Inpatient Care Copayment Limit.**

- Tier 1 (Lowest Cost Share): Participates in the Centered Care program and provides the most efficient care -- **$275 Inpatient Copayment**

- Tier 2 (Mid-level Cost Share): Participates in the Centered Care program and provides less efficient care -- **$500 Inpatient Copayment**

- Tier 3 (Highest Cost Share): Does not participate in the Centered Care program -- **$1500 Inpatient Copayment**

**Note:** Hospitals that do not participate in the Centered Care Program, but that Centered Care Providers refer to, are tiered at the same level as the Provider who made the referral.

Please see “Benefit Overview” (page 13) and “Plan and Benefit Information” (pages 27-31) for further details on your coverage and costs for medical services under this Plan. **Covered Services** that are not provided or authorized by your **Tufts HP PCP** are covered at the **Unauthorized Level of Benefits** (see pages 35-36).

**Prescription drug benefits** that are available and the requirements that each **Member** needs to follow in order to obtain these benefits are described in Part 5 (see pages 67-74).

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

**Note:** Services received in the U.S. territories are considered to be outside of the United States.

The Member Services Department is committed to excellent service. Your satisfaction with Navigator is important to us. If at any time you have questions, please call the Member Services Department which will be happy to help you. Calls to the Member Services Department may be monitored by supervisors to assure quality service.

**Mental Health, Substance Use Disorder, and EAP Plan** (pages 104-126) – This plan is administered by Beacon Health Options (Beacon). You and your covered family **Members** are automatically eligible for a full range of confidential mental health, substance use disorder, and EAP services through Beacon.

Beacon can help you access a conveniently located network **Provider** for mental health or substance use disorder services, or in an emergency. Legal, family mediation, and financial counseling services, grief counseling, and referrals to self-help groups and child or elder care services are among the many services available through the Beacon EAP.
Medical and Prescription Drug Plan (continued) –

### Member Identification Card

*Members* must present their member identification card (member ID card) to *Providers* when they receive *Covered Services* in order for benefits to be administered properly. Each member ID card contains the following information:

- The amounts you must pay for certain *Covered Services* (for example, your *Copayments* for *Emergency room visits* or for *office visits* with your *Tufts HP PCP*)
- The toll-free *Tufts Health Plan* telephone number to call if you have questions about your medical and prescription drug coverage under the *Navigator Plan*
- The toll-free *Beacon Health Options* telephone number to call if you have questions related to the Mental Health, Substance Use Disorder, and EAP coverage under this plan
Tufts Health Plan Address and Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, Massachusetts 02472-1508
Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.T.
Friday 8:00 a.m. to 6:00 p.m. E.T.

IMPORTANT PHONE NUMBERS:

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

If you have an urgent medical need and cannot reach your physician, you should seek care at the nearest emergency room or Urgent Care facility.

Member Services Department and Tufts HP Website
For more information about Tufts Health Plan and the self-service options available to you, please visit tuftshealthplan.com/gic. For general questions, benefit questions, and information about eligibility for enrollment and billing, call the Member Services Department at 800-870-9488 or visit the Tufts HP website.

Behavioral Health Services
Beacon Health Options ("Beacon") administers behavioral health benefits (mental health, substance use disorder, and EAP Program services) for the Navigator plan. For questions about your behavioral health benefits, or for assistance finding mental health or substance use disorder professionals in your area, call Beacon at 855-750-8980 or visit beaconhealthoptions.com/gic.

Services for Hearing Impaired Members
If you are hearing impaired, Tufts HP provides the following services:

- Massachusetts Relay (MassRelay): 800-720-3480 or 711
- Telecommunications Device for the Deaf (TDD): 711

Coordination of Benefits (COB) and Workers' Compensation
For questions about coordination of benefits (how Tufts HP coordinates its coverage with other health care coverage you may have) and workers' compensation, call the Liability and Recovery Department at 888-880-8699, ext. 21098. The Liability and Recovery Department is available from 8:30 a.m. – 5:00 p.m. Monday through Thursday and from 10:00 – 5:00 p.m. on Friday (ET).

Subrogation
Subrogation may occur if your illness or injury (such as injuries from an auto accident) was caused by someone else. For questions about subrogation, call the Member Services Department at 800-870-9488.

IMPORTANT ADDRESSES

Appeals and Grievances Department
If you need to call Tufts HP about a concern or appeal, contact the Member Services Department at 800-870-9488. To submit your appeal or grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
Fax: 617-972-9509

Note: Italicized words are defined in Part 8.
Translating Services

Translating services for over 200 languages
Interpreter and translator services related to administrative procedures are available to assist Members upon request.

Arabic 若需免费的中文版本，请拨打ID卡上的电话号码。

Chinese 若需免费的中文版本，请拨打ID卡上的电话号码。

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) សម្រាប់មានការដោះស្រាយការនឹងប្រភេទនេះអាចដោះស្រាយបញ្ចូលគ្នា។

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

Laotian ສັ່ງປະຕິບັດການພັດທະນາສີນ້ຳເພີ່ມກັບການປະຕິບັດການພັດທະນາສີນ້ຳດີເພີ່ມກັບການປະຕິບັດການພັດທະນາສີນ້ຳດີນ້ຳນ້ຳຄົງ.

Navajo Doó biلج ilíní da Diné kʼełįįį ąlneéhgo, hecíilínih béésh bee hani’é bee néé ho’dílizingo nantinii gi békáá’.

Persian دینزب گنز نات یاساچنش شراک رد چردنام نفلت هرامش هب یسراف اگ ناره هچرت یارب.

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.
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  - Bone marrow transplants for breast cancer, hematopoietic stem cell
    transplants, and human solid organ transplants
  - Gender reassignment surgery and related services
  - Maternity care
  - Patient care services provided as part of a clinical trial studying potential treatment(s)
    for cancer or other life-threatening diseases or conditions
  - Reconstructive surgery and procedures

• Other Health Services
  - Ambulance services
  - Cleft lip or cleft palate treatment and services for Children
  - Extended care
  - Home health care
  - Hospice and end-of-life care services
  - Injectable, infused or inhaled medications
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Do not rely on this chart alone. It merely summarizes certain important benefits available to Navigator Members. Be sure to read the benefit explanations in Part 5 (see pages 47-78). They describe Covered Services in more detail and contain some important restrictions. Remember, in order to receive Covered Services at the Authorized Level of Benefits, you must receive care from or authorized by your Tufts HP PCP.

### Deductibles and Limits

<table>
<thead>
<tr>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day Surgery Copayment Limit (Authorized Level of Benefits only)</strong></td>
<td><strong>Member's Cost</strong></td>
</tr>
<tr>
<td>Limit four $250 Day Surgery Copayments per individual Member per Contract Year. Once the Day Surgery Copayment Limit is reached in a Contract Year, the Member is not responsible for any additional Day Surgery Copayments for the remainder of that Contract Year.</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Inpatient Care Copayment Limit (Authorized Level of Benefits only)</strong></td>
<td><strong>Member's Cost</strong></td>
</tr>
<tr>
<td>Limit one Inpatient Copayment per individual Member per quarter Waived for readmissions within 30 days of discharge, within the same Contract Year</td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>Deductible</strong></td>
</tr>
<tr>
<td>$500 per Member or $1,000 per family per Contract Year. (No family Member will pay more than his or her individual Deductible.) The Authorized Deductible accumulates separately from the Unauthorized Deductible. Please note that this Authorized Deductible applies only to Authorized medical benefits; it does not apply to your pharmacy benefit or your In-Network mental health/substance use disorder benefits.</td>
<td>$500 per Member or $1,000 per family each Contract Year. (No family Member will pay more than his or her individual Deductible.) The Unauthorized Deductible accumulates separately from the Authorized Deductible. Please note that this Unauthorized Deductible applies to your Unauthorized medical and out-of-network mental health/substance use disorder benefits.</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit:</strong></td>
<td><strong>Out-of-Pocket Limit:</strong></td>
</tr>
<tr>
<td>$5,000 per Member or $10,000 per family per Contract Year. (No family member will pay more than his or her individual Out-of-Pocket Limit.) The Authorized Out-of-Pocket Limit accumulates separately from the Unauthorized Out-of-Pocket Limit. The Authorized Out-of-Pocket Limit includes your Copayments for Authorized medical services, prescription drugs and in-network mental health and substance use disorder services. It also includes the Authorized Deductible and Coinsurance for services obtained at the Authorized Level of Benefits.</td>
<td>$5,000 per Member or $10,000 per family per Contract Year. (No family member will pay more than his or her individual Out-of-Pocket Limit.) The Unauthorized Out-of-Pocket Limit accumulates separately from the Authorized Out-of-Pocket Limit. The Unauthorized Out-of-Pocket Limit includes your Copayments for Unauthorized medical services and out-of-network mental health and substance use disorder services. It also includes the Unauthorized Deductible and Coinsurance for services obtained at the Unauthorized Level of Benefits.</td>
</tr>
<tr>
<td><strong>Prescription Drug Deductible</strong></td>
<td><strong>Prescription Drug Deductible</strong></td>
</tr>
<tr>
<td>$100 per Member or $200 per family per Contract Year.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Italicized words are defined in Part 8.
### Important Note about your coverage under the Affordable Care Act (“ACA”): Under the ACA, preventive care services -- including women’s preventive health services, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription – received at the Authorized Level of Benefits are covered in full. These services are noted in general in this Benefit Overview. For more information on what services are now covered in full, please visit [https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/](https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/).

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member’s Cost</td>
<td>Member’s Cost</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment in an Emergency</td>
<td>$100 Copayment (waived if admitted as an Inpatient), then Authorized Deductible.</td>
<td>$100 Copayment (waived if admitted as an Inpatient), then Authorized Deductible (plus any balance).</td>
</tr>
<tr>
<td>emergency room</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Emergency care is covered up to the Reasonable Charge regardless of whether care is provided by a Tufts Health Plan Provider.

Observation services received in an Emergency Room will be subject to the Emergency Room Copayment, then the Authorized Deductible.

**Note:** If you are admitted as an Inpatient after Emergency care, you must call Tufts Health Plan at 800-970-9488 within 48 hours to be covered.

Care provided by a specialist will be covered at the Authorized Level of Benefits only if the Member’s Tufts HP PCP authorizes that care.
### Outpatient Care – Office Visit Copayments

If you receive **Outpatient care** at an office visit, your Office Visit **Copayment** will vary depending on the type of **Tufts HP Provider** you see. Massachusetts **Tufts HP PCPs** and Specialists have been rated based on their participation in the Centered Care Program and their **Provider** group’s efficiency of performance, and then placed into three tiers.

- **Massachusetts Primary care providers (PCPs)** -
  - PCPs include general practitioners, family practitioners, internal medicine specialists, pediatric primary care providers, physician assistants, nurse practitioners, primary care physicians who are also specialists, and obstetrician/gynecologists.
  - Tier 1 (Lowest Cost Share): Participates in the Centered Care Program and provides the most efficient care -- **$10 Copayment**
  - Tier 2 (Mid-level Cost Share): Participates in the Centered Care Program and provides less efficient care -- **$20 Copayment**
  - Tier 3 (Highest Cost Share): Does not participate in the Centered Care Program -- **$40 Copayment**
  - **All PCPs outside of Massachusetts** -- **$20 Copayment**

- **Massachusetts Specialists**
  - Tier 1 (Lowest Cost Share): Participates in the Centered Care Program and provides the most efficient care -- **$30 Copayment**
  - Tier 2 (Mid-level Cost Share): Participates in the Centered Care Program and provides less efficient care -- **$60 Copayment**
  - Tier 3 (Highest Cost Share): Does not participate in the Centered Care Program -- **$90 Copayment**
  - **All Specialists outside of Massachusetts** -- **$60 Copayment**

- **Limited Service Medical Clinic** or free-standing **Urgent Care Center** that participates in **Tufts Health Plan** -- **$20 Copayment**

**Note:** Copayments for **Urgent Care Services** at all other locations vary depending on the type of **Provider** (PCP vs. Specialist) you see and the location (for example, **Provider**’s office, **Limited Service Medical Clinic**, **Urgent Care Center**, or **Emergency room**) in which you receive services.

For a list of **Tufts HP Providers** (including their tiers, if applicable), please visit the online **Provider Directory** at tuftshealthplan.com/gic.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism spectrum disorders – diagnosis and treatment (AR)</td>
<td>Habilitative or rehabilitative care (including applied behavioral analysis), and psychiatric and psychological care: For services provided by a licensed physical, occupational or speech therapist, see “Treatment of speech, hearing and language disorders” (page 53) and “Rehabilitative and Habilitative physical and occupational therapy services” (page 55). For services provided by a paraprofessional or Board-Certified Behavior Analyst (BCBA), or for psychiatric and psychological care, see “Mental Health, Substance Use Disorder, and Enrollee Assistance Program” section (page 104). <strong>Prescription medications</strong>: Subject to Prescription Drug Copayment. See “Prescription Drug Benefit” section (page 67). <strong>Note</strong>: Benefit limits for physical and occupational therapy services do not apply to the treatment of autism spectrum disorders.</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>$20 Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>Chiropractic services (spinal manipulation)</td>
<td>$20 Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited to a total of one spinal manipulation evaluation and 20 visits per Contract Year (Authorized and Unauthorized Levels combined).</td>
</tr>
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</tr>
<tr>
<td>Clinical trials for studying potential treatment(s) for cancer or other life-threatening diseases or conditions</td>
<td>$10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Disease Program</td>
<td>10% of the Reasonable Charge</td>
<td>Full cost. This is not covered at the Unauthorized Level of Benefits.</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Diabetes self-management training and educational services</td>
<td>$10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Authorized Deductible then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
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<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member’s Cost</td>
<td>Member’s Cost</td>
</tr>
</tbody>
</table>

**Outpatient Care, continued:**

<table>
<thead>
<tr>
<th>Early intervention services for a Dependent Child</th>
<th>Covered in full (not subject to the Authorized Deductible)</th>
<th>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</th>
</tr>
</thead>
</table>

**Family planning procedures, services, and contraceptives**

<table>
<thead>
<tr>
<th><strong>Office Visit:</strong></th>
<th>Covered in full (not subject to the Authorized Deductible)</th>
<th>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day Surgery:</strong></td>
<td>$250 Copayment per person per Day Surgery admission (applies to all covered Day Surgery services, including those performed at freestanding surgical centers), up to the Day Surgery Copayment Limit; then Authorized Deductible.</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
</tbody>
</table>

**Note:** Women’s preventive health services, including contraceptives and female sterilization procedures, are covered in full at the Authorized Level of Benefits and are not subject to the Authorized Deductible. For more information about which services are considered preventive, see https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.  

<table>
<thead>
<tr>
<th>Infertility services (including up to five attempted ART procedures) (AR)</th>
<th>Office Visit: $10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</th>
<th>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All other services: Authorized Deductible, then covered in full</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity care office visits (includes prenatal &amp; postpartum care)</th>
<th>Maternity care office visits:</th>
<th>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Routine maternity care: Covered in full</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Non-routine maternity care: $10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</td>
<td></td>
</tr>
<tr>
<td>Routine maternity-related laboratory tests: Covered in full (not subject to the Authorized Deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity-related diagnostic tests (i.e., ultrasounds and non-routine lab tests): Authorized Deductible, then covered in full</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**(AR)** – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
### Covered Services

**Outpatient Care, continued:**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient medical care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections</td>
<td>Covered in full (not subject to the Authorized Deductible)</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Page 52</td>
<td>$10/$20/$40 PCP Copayment; $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>$10/$20/$40 PCP Copayment; $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Page 52</td>
<td>$10/$20/$40 PCP Copayment; $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Authorized Deductible, then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Page 52</td>
<td>$10/$20/$40 PCP Copayment; $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Diagnostic or preventive screening procedures</td>
<td><strong>Colon or colorectal cancer screening:</strong> Covered in full (not subject to the Authorized Deductible)</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Page 52</td>
<td><strong>Diagnostic procedure only (i.e., colonoscopies associated with symptoms):</strong> Authorized Deductible, then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Diagnostic procedures with treatment/surgery (i.e. polyp removal):</td>
<td>Covered as Day Surgery admissions - $250 Copayment (applies to all covered Day Surgery services, including those performed at free-standing surgical centers), up to the Day Surgery Copayment Limit; then Authorized Deductible.</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td><strong>General imaging:</strong> Authorized Deductible, then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Page 52</td>
<td>MRI/MRA, CT/CTA, PET and nuclear cardiology (AR): $100 Copayment per day, then subject to Authorized Deductible</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Diagnostic testing (AR)</td>
<td>Authorized Deductible, then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Page 52</td>
<td>Authorized Deductible, then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
### Outpatient Care, continued:

#### EKG testing
- **Authorized Level of Benefits:** Covered in full (not subject to the Authorized Deductible)
- **Unauthorized Level of Benefits:** Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
- **Member’s Cost:**
  - Page 52

#### Human leukocyte antigen testing
- **Authorized Level of Benefits:** Authorized Deductible, then covered in full
- **Unauthorized Level of Benefits:** Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
- **Member’s Cost:**
  - Page 52

#### Laboratory tests (AR)
- **Authorized Level of Benefits:** Authorized Deductible, then covered in full.
- **Unauthorized Level of Benefits:** Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
- **Member’s Cost:**
  - Page 52

#### Mammograms
- **Authorized Level of Benefits:** Covered in full (not subject to the Authorized Deductible)
- **Unauthorized Level of Benefits:** Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
- **Member’s Cost:**
  - Page 53

#### Neuropsychological testing for a medical condition (AR)
- **Authorized Level of Benefits:** Authorized Deductible, then covered in full
- **Unauthorized Level of Benefits:** Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
- **Member’s Cost:**
  - Page 53

#### Nutritional counseling
- **Authorized Level of Benefits:**
  - $10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment
- **Unauthorized Level of Benefits:** Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
- **Member’s Cost:**
  - Page 53

**Note:** Nutritional counseling is covered in full and not subject to the Deductible at the Authorized Level of Benefits when it is provided as preventive care services, as defined by the U.S. Preventive Services Task Force. Please see “Nutritional counseling” in Part 5 for more information.

**Limit of one initial evaluation and 3 treatment visits per Contract Year (Authorized and Unauthorized Levels combined)**

#### Office visits to diagnose and treat illness or injury, including consultations
- **Authorized Level of Benefits:**
  - $10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment
- **Unauthorized Level of Benefits:** Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
- **Member’s Cost:**
  - Page 53

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(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
### Part 1 - Benefit Overview, Continued

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member’s Cost</strong></td>
<td><strong>Member’s Cost</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Outpatient Care, continued:

**Outpatient medical care, continued**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery in a physician’s office</td>
<td>$10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Pap smears (cytology examinations)</td>
<td>Routine annual Pap smears (cytology examinations): Covered in full (not subject to the Authorized Deductible)</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Radiation therapy and x-ray therapy</td>
<td>Authorized Deductible, then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Smoking cessation counseling services</td>
<td>Covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Treatment of speech, hearing and language disorders</td>
<td>$20 Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Voluntary second or third surgical opinions</td>
<td>$10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Preventive health care - Adults (age 18 and over)</td>
<td>Covered in full (not subject to the Authorized Deductible)</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
</tbody>
</table>

**Note:** Copayments for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).

**Note:** Preventive care services for adults are covered in full at the Authorized Level of Benefits and are not subject to the Authorized Deductible. For more information about which services are considered preventive, see [https://www.uspreventiveservicestaskforce.org/Page/Name/uspssf-a-and-b-recommendations/](https://www.uspreventiveservicestaskforce.org/Page/Name/uspssf-a-and-b-recommendations/). Member cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.
### Outpatient Care, continued:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive health care - Children (under age 18)</strong></td>
<td>Covered in full (not subject to the Authorized Deductible)</td>
<td><strong>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> Preventive care services for children are covered in full at the Authorized Level of Benefits and are not subject to the Authorized Deductible. For more information about which services are considered preventive, see <a href="https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/">https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</a>. Member cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine annual gynecological exam</strong></td>
<td>Covered in full (not subject to the Authorized Deductible)</td>
<td><strong>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> Preventive gynecological services are covered in full and are not subject to the Authorized Deductible. For more information about which services are considered preventive, see <a href="https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/">https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</a>. Member cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitative and Habilitative physical therapy (PT) &amp; occupational therapy (OT) services (AR)</strong></td>
<td>$20 Copayment</td>
<td><strong>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</strong></td>
</tr>
<tr>
<td><strong>Limit of 30 visits per Contract Year for each type of therapy.</strong></td>
<td><strong>Note:</strong> Limit does not apply to the treatment of autism spectrum disorders.</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care in a free-standing Urgent Care Center</strong></td>
<td>$20 Copayment for care in a free-standing Urgent Care Center</td>
<td><strong>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance).</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> Copayments for Urgent Care services in all other locations vary depending upon type of Provider (PCP vs. Specialist) and the location (i.e., Provider’s office, Limited Service Medical Clinic, Urgent Care Center, or Emergency room) in which you receive services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision care services, including:</strong></td>
<td><strong>Routine eye exam:</strong> $20 Copayment. <strong>Limit of one routine eye exam in each 24-month period.</strong></td>
<td><strong>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance).</strong></td>
</tr>
<tr>
<td>- Routine eye exam</td>
<td><strong>Note:</strong> Services must be received from an EyeMed network provider.</td>
<td></td>
</tr>
<tr>
<td>- Eye examinations and necessary treatment of a medical condition</td>
<td><strong>Eye examinations and necessary treatment of a medical condition:</strong> $10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</td>
<td></td>
</tr>
</tbody>
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(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
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</thead>
<tbody>
<tr>
<td></td>
<td>Member’s Cost</td>
<td>Member’s Cost</td>
</tr>
<tr>
<td><strong>Oral health services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency dental care</td>
<td>Treatment in an <em>Emergency room:</em> $100 Copayment (waived if admitted as an Inpatient), then Authorized Deductible applies.</td>
<td>Treatment in an <em>Emergency room:</em> $100 Copayment (waived if admitted as an Inpatient), then Authorized Deductible applies (plus any balance).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral surgery for dental treatment (AR)</td>
<td><em>Day Surgery:</em> $250 Copayment (applies to all covered <em>Day Surgery</em> services, including those performed at free-standing surgical centers) per person per <em>Day Surgery</em> admission up to the <em>Day Surgery</em> Copayment Limit; then Authorized Deductible applies.</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td><em>Inpatient care:</em> $275/$500/$1,500 <em>Inpatient Copayment</em> (see “<em>Inpatient Care</em>” below), then Authorized Deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Oral surgery for non-dental medical treatment (AR)</td>
<td><em>Office visit:</em> $10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td><em>Day Surgery:</em> $250 Copayment (applies to all covered <em>Day Surgery</em> services, including those performed at free-standing surgical centers) per person per <em>Day Surgery</em> admission, up to the <em>Day Surgery</em> Copayment Limit; then Authorized Deductible applies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Inpatient care:</em> $275/$500/$1,500 <em>Inpatient Copayment</em> (see “<em>Inpatient Care</em>” below), then Authorized Deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Day Surgery</strong></td>
<td>$250 Copayment (applies to all covered <em>Day Surgery</em> services, including those performed at free-standing surgical centers) per person per <em>Day Surgery</em> admission up to the <em>Day Surgery</em> Copayment Limit; then Authorized Deductible applies.</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
</tbody>
</table>

Members are required to notify Tufts Health Plan of any admissions to non-Tufts HP Hospitals, or that are not authorized by their Tufts HP PCP. Failure to do so may result in a $500 Notification Penalty.

(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
### Part 1 – Benefit Overview, Continued

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member’s Cost</td>
<td>Member’s Cost</td>
</tr>
<tr>
<td><strong>Inpatient Care:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute hospital services (including room and board, physician and surgeon services, surgery, and related services) <strong>(AR)</strong></td>
<td>$275/$500/$1,500, (up to the Inpatient Care Copayment Limit), then Authorized Deductible applies**</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: See Part 9 (pages 98-103) for a list of the Navigator Inpatient Hospital Tiers and their Copayments.</td>
</tr>
<tr>
<td>Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants <strong>(AR)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleft lip or cleft palate treatment and services for Children <strong>(AR)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender reassignment surgery <strong>(AR)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconstructive surgery and procedures <strong>(AR)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services for enrolled newborn Children who stay in the hospital beyond the mother’s discharge <strong>(AR)</strong></td>
<td>Authorized Deductible, then covered in full.</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
</tbody>
</table>

Members are required to notify Tufts Health Plan of any admissions to non-Tufts HP Hospitals, or that are not authorized by their Tufts HP PCP. Failure to do so may result in a $500 Notification Penalty.

**(AR)** – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
### Part 1 - Benefit Overview, Continued

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Health Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance services (AR)</td>
<td>Authorized Deductible, then covered in full.</td>
<td>Authorized Deductible and then covered in full up to the Reasonable Charge.</td>
</tr>
</tbody>
</table>
| Cleft lip or cleft palate treatment and services for Children | Medical or facial surgery:  
- Inpatient services: $275/$500/$1,500  
  Inpatient Copayment (up to the Inpatient Care Copayment Limit (page 28), then Authorized Deductible applies  
- Day Surgery: $250 Copayment (applies to all covered Day Surgery services, including those performed at free-standing surgical centers) per person per Day Surgery admission, up to the Day Surgery Copayment Limit; then Authorized Deductible  
  Note: See Part 9 on pages 98-103 for the Navigator Inpatient Hospital Copayment Tiers and for information on Inpatient Copayments for newborn Children.  
Oral surgery: Covered to the same extent as other covered surgical procedures.  
Dental surgery or orthodontic treatment and management: Covered in full (not subject to the Authorized Deductible).  
Preventive and restorative dentistry: Covered in full (not subject to the Authorized Deductible).  
Speech therapy and audiology services: $20 Copayment  
Nutrition services: $10/$20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment | Dental surgery, orthodontic treatment and management, or preventive and restorative dentistry: Covered in full.  
All other services: Unauthorized Deductible and 20% of the Reasonable Charge (plus any balance). |

(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining his prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.
### Other Health Services, continued:

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1 - Benefit Overview, Continued</strong></td>
<td><strong>Member’s Cost</strong></td>
<td><strong>Member’s Cost</strong></td>
</tr>
<tr>
<td><strong>Authorized Level of Benefits</strong></td>
<td><strong>Skilled nursing facility</strong>: Authorized Deductible, then 20% of the Reasonable Charge</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation hospital or chronic hospital</strong>: Authorized Deductible, then covered in full</td>
<td><strong>Note</strong>: The cost of services provided in a skilled nursing facility at the Unauthorized Level of Benefits cannot be used to satisfy the Unauthorized Out-of-Pocket Limit.</td>
</tr>
<tr>
<td></td>
<td><strong>Limit of 45 days per Member per Contract Year in a skilled nursing facility (Authorized and Unauthorized Levels combined).</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note</strong>: Members are required to notify Tufts Health Plan prior to any admission to non-Tufts HP facilities, or the Member must pay a $500 Notification Penalty (see page 31).</td>
<td></td>
</tr>
<tr>
<td><strong>Unauthorized Level of Benefits</strong></td>
<td><strong>Deductible, then covered in full</strong></td>
<td><strong>Deductible, then covered in full</strong></td>
</tr>
<tr>
<td>Extended care facility services (AR) in:</td>
<td><strong>Deductible, then covered in full</strong></td>
<td><strong>Deductible, then covered in full</strong></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing facility</td>
<td><strong>Deductible, then covered in full</strong></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation hospital</td>
<td><strong>Deductible, then covered in full</strong></td>
</tr>
<tr>
<td></td>
<td>Chronic hospital</td>
<td><strong>Deductible, then covered in full</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Deductible, then covered in full</strong></td>
</tr>
<tr>
<td><strong>Home health care (AR)</strong></td>
<td><strong>Page 62</strong></td>
<td><strong>Page 62</strong></td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td><strong>Page 62</strong></td>
<td><strong>Page 62</strong></td>
</tr>
<tr>
<td><strong>Injectable, infused or inhaled medications (AR)</strong></td>
<td><strong>Page 63</strong></td>
<td><strong>Page 63</strong></td>
</tr>
<tr>
<td><strong>Medical appliances and Equipment, including:</strong></td>
<td><strong>Page 64</strong></td>
<td><strong>Page 65</strong></td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment (including Prosthetic Devices) (AR): Authorized Deductible, then covered in full</td>
<td>Durable Medical Equipment (including Prosthetic Devices) (AR): Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td></td>
<td>Eyeglasses/contact lenses: Authorized Deductible, then covered in full. <strong>Limited to the first pair of lenses after cataract surgery.</strong></td>
<td>Eyeglasses/contact lenses: 20% of the Reasonable Charge (not subject to the Unauthorized Deductible). <strong>Limited to the first pair of lenses after cataract surgery.</strong></td>
</tr>
<tr>
<td></td>
<td>Hearing aids:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Members 21 and under: One hearing aid per ear per prescription change covered in full (not subject to the Authorized Deductible). <strong>Limit of $2,000 per ear per Member every 36 months (Authorized and Unauthorized Levels combined).</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Members 22 and over: First $500 covered in full (not subject to the Authorized Deductible), then 20% of the next $1,500 (plus any balance). <strong>Limit of $1,700 per Member every 24 months (Authorized and Unauthorized combined).</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Note**: These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining his prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

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### Covered Services

<table>
<thead>
<tr>
<th>Other Health Services, continued:</th>
<th>Authorized Level of Benefits</th>
<th>Unauthorized Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Member’s Cost</td>
<td>Member’s Cost</td>
</tr>
<tr>
<td>Personal Emergency Response System (hospital-based)</td>
<td>20% of charges</td>
<td>Limit of $50 for installation and $40 per month for rental charges for hospital-based systems</td>
</tr>
<tr>
<td><a href="#">Page 66</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private duty nursing care (Inpatient and Outpatient) (AR)</td>
<td>Authorized Deductible, then covered in full</td>
<td>Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td><a href="#">Page 66</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scalp hair protheses or wigs for cancer or leukemia patients</td>
<td>Covered in full (not subject to the Authorized Deductible)</td>
<td></td>
</tr>
<tr>
<td><a href="#">Page 66</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special medical formulas, including:</td>
<td>Authorized Deductible, then covered in full</td>
<td>Low protein foods: Unauthorized Deductible &amp; 20% of the Reasonable Charge (plus any balance)</td>
</tr>
<tr>
<td>Low protein foods</td>
<td><a href="#">Page 66</a></td>
<td></td>
</tr>
<tr>
<td>Nonprescription enteral formulas (AR)</td>
<td><a href="#">Page 66</a></td>
<td>Nonprescription enteral formulas (AR) and special medical formulas (AR): Unauthorized Deductible, then covered in full</td>
</tr>
<tr>
<td>Special medical formulas (AR)</td>
<td><a href="#">Page 66</a></td>
<td></td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

### Prescription Drug Benefit (see pages 67-74)

For information about your Copayments and Prescription Drug Deductible for covered prescription drugs, see the “Prescription Drug Benefit” section in Part 5.

### Mental Health, Substance Use Disorder, & EAP Benefits (see pages 104-126)

Benefits administered by Beacon Health Options. For information, see the “Mental Health, Substance Use Disorder, and Enrollee Assistance Programs” section, visit beaconhealthoptions.com/gic or call 855-750-8980.
Part 2 – Plan and Benefit Information

Your Cost for Medical Services

You are responsible for paying the costs described below for Covered Services you receive at the Authorized and Unauthorized Levels of Benefits. For more information about the Covered Services subject to these costs, please see Part 5.

Authorized Level of Benefits

Covered Services are covered at the Authorized Level of Benefits only when the Covered Services are provided or authorized by your Tufts HP PCP.

If Tufts HP determines that a Covered Service is not available from a Tufts HP Provider, you may receive Covered Services at the Authorized Level of Benefits from a non-Tufts HP Provider (with the approval of an Authorized Reviewer), up to the Reasonable Charge. You will be responsible for any charges in excess of the Reasonable Charge.

Copayments

• Emergency Care: Emergency room (waived if admitted) ............................................. $100 per visit

Notes:

• If you register in an Emergency room, but leave without receiving care, an Emergency Room Copayment (and then the Authorized Deductible) may apply.
• A Day Surgery Copayment may apply if Day Surgery services are received.
• If you are admitted to an Inpatient mental health facility after being seen at the Emergency Room, please call the Tufts Health Plan Member Services Department to request that your Emergency Room Copayment be waived, or to request an adjustment of the claim.

• Authorized Level of Benefits:
  • Office Visit......$10/20/$40 PCP Copayment, $30/$60/$90 Specialist Copayment; see page 15

Note: You may be charged an Office Visit Copayment for certain Outpatient services listed as “covered in full” in the Benefit Overview table (see pages 13-26) if these services are provided in conjunction with an office visit.

  • Inpatient Services .................................................................Varies by hospital tier; see Part 9
  • Day Surgery................................................................. $250 per admission

Day Surgery Copayment Limit (Authorized Level of Benefits only)

Each individual Member is responsible for paying a limit of four Day Surgery Copayments per Contract Year. (The Contract Year runs from July 1 to the following June 30.) When you have paid four Day Surgery Copayments, no more Day Surgery Copayments will be charged in that Contract Year.

The Day Surgery Copayment Limit consists of Authorized Day Surgery Copayments only. It does not include Deductibles, Coinsurance, other Copayments, or payments you make for non-Covered Services or care received at the Unauthorized Level of Benefits.

Note: Italicized words are defined in Part 8.
Inpatient Care Copayment Limit (Authorized Level of Benefits only)
Each individual Member is responsible for paying a limit of one Inpatient Copayment per Contract Year quarter. (The Contract Year quarters are: July/August/September, October/November/December, January/February/March, and April/May/June.) The Inpatient Care Copayment is waived if you are readmitted within 30 days of discharge, if both admissions are in the same Contract Year. Contact the Tufts Health Plan Member Services Department if you are billed so that we can adjust your claim.

The quarterly Inpatient Care Copayment includes only Inpatient care Copayments at the Authorized Level of Benefits. It does not include Deductibles, Coinsurance, other Copayments, or payments you make for non-Covered Services.

Authorized Deductible
A $500 individual Authorized Deductible and a $1,000 family Authorized Deductible apply each Contract Year. Your family Authorized Deductible is met once any combination of family Members reaches $1,000; no family Member will pay more than his or her individual Authorized Deductible per Contract Year.

The Authorized Deductible is the amount that you must first pay for for Covered Services before the Navigator Plan will pay for certain Covered Services at the Authorized Level of Benefits. It accumulates separately from the Unauthorized Deductible under this Medical and Prescription Drug Plan. It also does not apply to prescription drugs or care from in-network behavioral health Providers. (For more information, see “Mental Health, Substance Use Disorder, and EAP Plan” later in this Member Handbook.)

Note: The Authorized Deductible applies to: Day Surgery, Emergency room, Inpatient hospital, and many Outpatient services, when they are received at the Authorized Level of Benefits. It also applies to all services and supplies categorized as “Other Health Services”, except for hearing aids, Personal Emergency Response Systems, scalp hair prostheses or wigs for cancer and leukemia patients, and chiropractic services (spinal manipulation). See the “Benefit Overview” in Part 1 for more information.

Prescription Drug Deductible
A $100 individual Prescription Drug Deductible and a $200 family Prescription Drug Deductible apply each Contract Year. Your family Prescription Drug Deductible is met once any combination of family members reaches $200; no family Member will pay more than his or her individual Prescription Drug Deductible per Contract Year.

The Prescription Drug Deductible is the amount you must first pay for covered prescription drugs before the Navigator Plan will pay for any covered prescription drugs. The amount you accrue towards your deductible when filling a prescription is calculated based upon Tufts Health Plan’s contracted rate at the time the prescription is filled and does not reflect any rebates that we may receive at a later date.

Note: This Prescription Drug Deductible does not apply to smoking cessation agents or to generic buprenorphine-naloxone, naloxone, and naltrexone products.

Coinsurance
There is no Coinsurance for most Covered Services provided by a Tufts HP Provider. Except as shown in Part 1 (see “Benefit Overview” on pages 13-26), the Member pays the applicable Deductible and/or Copayment for all Covered Services provided by a Tufts HP Provider. The Plan will cover the remaining charges for Covered Services.
Your Cost for Medical Services, continued

(Authorized Level of Benefits, continued)

**Authorized Out-of-Pocket Limit**
A $5,000 individual Authorized Out-of-Pocket Limit and a $10,000 family Authorized Out-of-Pocket Limit apply each Contract Year for Covered Services received at the Authorized Level of Benefits. The Family Out-of-Pocket Limit includes all amounts any enrolled family Members pay toward their individual Authorized Out-of-Pocket Limits, including the Authorized Deductible, Coinsurance, and Copayments.

Once the family Authorized Out-of-Pocket Limit has been met, all enrolled family Members will thereafter have satisfied their individual Authorized Out-of-Pocket Limits for the remainder of that Contract Year. Once you satisfy the Authorized Out-of-Pocket Limit, all Covered Services you receive at the Authorized Level of Benefits are covered in full up to the Reasonable Charge for the rest of that Contract Year.

The Authorized Out-of-Pocket Limit accumulates separately from the Unauthorized Out-of-Pocket Limit. Your Copayments for prescription drugs and for in-network mental health and substance use disorder services (described in the "Mental Health, Substance Use Disorder, and EAP Plan" later in this Member Handbook) also count towards this Out-of-Pocket Limit.

<table>
<thead>
<tr>
<th>Note: You cannot use the following services and supplies to satisfy this Out-of-Pocket Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any service or supply that does not qualify as a Covered Service. This includes any services that require the approval of an Authorized Reviewer prior to treatment for which you do not obtain such approval.</td>
</tr>
<tr>
<td>• Any amount you pay for Covered Services received at the Unauthorized Level of Benefits.</td>
</tr>
</tbody>
</table>
Your Cost for Medical Services, continued

Unauthorized Level of Benefits
Covered Services are covered at the Unauthorized Level of Benefits when you receive them from a Tufts HP Provider without your PCP’s authorization, or from a non-Tufts HP Provider. These Covered Services are subject to a Deductible and Coinsurance, and are covered at a lower level than Covered Services provided at the Authorized Level of Benefits.

Notes: Each time you receive care at the Unauthorized Level of Benefits from a non-Tufts HP Provider, you must submit a claim form to Tufts Health Plan. (You are not required to submit claim forms for care you receive from Tufts HP Providers.) You may be required to notify Tufts Health Plan and/or obtain prior authorization for certain Covered Services. If you do not notify Tufts Health Plan and/or obtain prior authorization for these certain Covered Services, you will incur additional costs. Please see “Inpatient Notification” on pages 40-42 and the “Important Notes” on page 48 for more information.

For more information, contact the Member Services Department at 800-870-9488.

Coinsurance
Except as shown in Part 1 (see “Benefit Overview” on pages 13-26), the Member pays 20% Coinsurance for all Covered Services provided by a Tufts HP Provider without the authorization of his or her Tufts HP PCP, or for all Covered Services provided by a Non-Tufts HP Provider. The Plan will cover the remaining charges for Covered Services, up to the Reasonable Charge. (The Member is responsible for any charges in excess of the Reasonable Charge.)

Unauthorized Deductible
A $500 individual Unauthorized Deductible and a $1,000 family Unauthorized Deductible apply each Contract Year. Your family Unauthorized Deductible is met once any combination of family Members reaches $1,000; no family Member will pay more than his or her individual Unauthorized Deductible per Contract Year.

The Unauthorized Deductible is the amount you must first pay for Covered Services before the Navigator Plan will pay for any Covered Services at the Unauthorized Level of Benefits. It applies to all Covered Services received at the Unauthorized Level of Benefits, including out-of-network mental health and substance use disorder services. (For more information, see “Mental Health, Substance Use Disorder, and EAP Plan” later in this Member Handbook.) Costs in excess of the Reasonable Charge do not count towards the Individual Deductible.

The Unauthorized Deductible accumulates separately from the Authorized Deductible under this Medical and Prescription Drug Plan.

Note: The Deductible does not apply to Outpatient Emergency care and Urgent Care you receive in a hospital Emergency room or physician’s office; Personal Emergency Response Systems (PERS); hearing aids, scalp hair prostheses or wigs for cancer or leukemia patients; and the first pair of eyeglass lenses and/or contact lenses needed after cataract surgery. See the “Benefit Overview” in Part 1 for more information.
Your Cost for Medical Services, continued

(Unauthorized Level of Benefits, continued)

Unauthorized Out-of-Pocket Limit
A $5,000 individual Unauthorized Out-of-Pocket Limit and a $10,000 family Unauthorized Out-of-Pocket Limit apply each Contract Year for Covered Services received at the Unauthorized Level of Benefits. The Unauthorized Out-of-Pocket Limit accumulates separately from the Authorized Out-of-Pocket Limit. The Family Unauthorized Out-of-Pocket Limit includes all amounts any enrolled family Members pay towards their individual Unauthorized Out-of-Pocket Limits, including the Unauthorized Deductible, Coinsurance, and costs for out-of-network mental health and substance use disorder services.

Once the family Unauthorized Out-of-Pocket Limit has been met, all enrolled family Members will thereafter have satisfied their individual Unauthorized Out-of-Pocket Limits for the remainder of that Contract Year. Once you satisfy the Unauthorized Out-of-Pocket Limit, all Covered Services received at the Unauthorized Level of Benefits are covered in full up to the Reasonable Charge for the rest of that Contract Year. (You continue to pay for any costs in excess of the Reasonable Charge.)

The Unauthorized Out-of-Pocket Limit accumulates separately from the Authorized Out-of-Pocket Limit.

<table>
<thead>
<tr>
<th>Note: You cannot use the following services and supplies to satisfy the Unauthorized Out-of-Pocket Limit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any service or supply that does not qualify as a Covered Service, including any services that require approval from an Authorized Reviewer prior to treatment.</td>
</tr>
<tr>
<td>• Charges that exceed the Reasonable Charge for services received at the Unauthorized Level of Benefits</td>
</tr>
<tr>
<td>• Any amount paid for prescription drugs</td>
</tr>
<tr>
<td>• Any amount paid as a Notification Penalty or any other reduction or denial of benefits due to failure to notify Tufts Health Plan as required under the Navigator Plan (see pages 40-42 for more information)</td>
</tr>
<tr>
<td>• Any Copayment or other amount paid for Covered Services received at the Authorized Level of Benefits.</td>
</tr>
</tbody>
</table>

Notification Penalty
You must pay the Notification Penalty listed below for failure to notify Tufts Health Plan of a hospitalization or hospital transfer in accordance with Part 3.

• Authorized Level of Benefits:
  There is no Notification Penalty for a hospitalization at a Tufts HP Hospital or a hospital transfer to a Tufts HP Hospital. Your Tufts HP Provider will notify Tufts Health Plan of the procedure for you.

• Unauthorized Level of Benefits:
  You must pay a $500 Notification Penalty for failure to notify Tufts Health Plan of a hospitalization or hospital transfer when (1) the hospitalization or transfer is not authorized by your Tufts HP PCP, or (2) the hospitalization is at or the transfer is to a hospital that is not a Tufts HP Hospital, in accordance with Part 3. For more information, please see “Inpatient Notification” in Part 3 (pages 40-42).

Note: This Notification Penalty cannot be used to meet the Deductibles or Out-of-Pocket Limits described earlier in this section.
Part 3 – How Your Health Plan Works

How the Plan Works

Eligibility for Benefits
When you need health care services, you may choose to obtain these services either from or authorized by your Tufts HP PCP (Authorized Level of Benefits) or from any health care Provider without your PCP’s authorization (Unauthorized Level of Benefits). Your choice will determine the level of benefits you receive for your health care services.

The Plan covers only the services and supplies described as Covered Services in Part 5. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your Effective Date.

In accordance with federal law (45 CFR § 148.180), Tufts Health Plan does not:
- Adjust premiums based on genetic information;
- Request or require genetic testing; or
- Collect genetic information from individuals prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

Medically Necessary services and supplies
The Plan will pay for Covered Services and supplies when they are Medically Necessary, as determined by Tufts Health Plan. Covered Services must be provided or authorized by your Tufts HP PCP to be covered at the Authorized Level of Benefits. Covered Services obtained from any other health care Provider without your PCP’s authorization will be covered at the Unauthorized Level of Benefits.

Important: The Navigator Plan will not pay for services or supplies which are not Covered Services, even if they are provided by your Tufts HP PCP, a Tufts HP Provider or any other Provider.

Authorized Level of Benefits

Outpatient Care
Each Member must choose a Primary Care Provider (PCP) in order to receive care at the Authorized Level of Benefits. The PCP is responsible for providing or authorizing all of your health care services at the Authorized Level of Benefits. Except for Emergency care, if you do not choose a PCP, or if you receive care from any Provider without the authorization of your PCP, this care will be covered at the Unauthorized Level of Benefits.

If your care is provided or authorized by your Tufts HP PCP, or if you seek care at a Limited Service Medical Clinic or Urgent Care Center that participates with Tufts Health Plan, you are entitled to coverage for Covered Services at the Authorized Level of Benefits.

When a Tufts HP Provider provides your care, you do not have to submit any claim forms. The claim forms are submitted to Tufts Health Plan by the Tufts HP Provider.

You will be required to pay a Copayment for certain Covered Services you receive at the Authorized Level of Benefits. For more information about your Copayments, please see “Benefit Overview” and “Plan and Benefit Information” earlier in this Member Handbook. In order to obtain coverage at the Authorized Level of Benefits, you must live in or near the Service Area so that you can access Tufts HP Providers. Otherwise, your coverage will be at the Unauthorized Level of Benefits.

Note: Italicized words are defined in Part 8.
Authorized Level of Benefits, continued

Outpatient care, continued
If your PCP cannot provide the services you need, he or she will refer you to another Tufts HP Provider. If the services you need are not available from any Tufts HP Providers, your PCP, after obtaining approval from an Authorized Reviewer, will refer you to a Provider not affiliated with Tufts HP. You will be covered at the Authorized Level of Benefits for these services. The Plan will pay up to the Reasonable Charge for these services. You will be responsible for any charges in excess of the Reasonable Charge (as well as any applicable Cost Sharing Amount). You may receive a bill for these services. If you do receive a bill, please call Member Services or see “Bills from Providers” in Part 6 for more information on what to do if you receive a bill.

Your PCP is responsible for completing a referral form and sending it to the specialist prior to your visit for specialty care. In order to expedite matters, sometimes your PCP will give you the referral form to deliver to the specialist. Your PCP must authorize, in advance, any referral that a specialist may make to another Provider. A PCP may authorize a standing referral for specialty health care provided by a Tufts HP Provider.

**Note:** 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, the services will be covered at the Unauthorized Level of Benefits.

Selecting a PCP
In order to receive coverage at the Authorized Level of Benefits, you must select a PCP. Tufts HP must receive notice of your selection. PCPs provide routine health care (including routine physical examinations), coordinate your care with other Tufts HP Providers and authorize referrals for other Covered Services. PCPs are doctors of internal medicine, family/general practice or pediatrics, physician assistants, or nurse practitioners.

At the time you enroll, you can select a PCP from among those listed in the Directory of Health Care Providers. Each family member may choose a different PCP to manage his or her care. You should choose a PCP who is at a location convenient to you. Once you have chosen a PCP who is part of the Tufts HP network, you must inform Tufts HP of your choice in order to be eligible for all Covered Services. If you need assistance in choosing a PCP, call the Tufts HP Member Services Department.

If you do not select a PCP at the time you fill out the member application form, you can do so at any time by finding one in the Directory of Health Care Providers and reporting your choice to the Tufts HP Member Services Department.

You do not need to select a PCP in order to receive in-network coverage for Inpatient mental health and Inpatient substance use disorder services. You will receive coverage for these services as long as the services are provided or authorized in accordance with the rules described under “Mental Health, Substance Use Disorder, and Enrollee Assistance Programs”, beginning on page 104.

**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 that Provider. A Member Specialist can give you more information. Please see “Continuity of Care” later in this chapter for more information.
- For additional information about a PCP or specialist, contact the Massachusetts Board of Registration in Medicine at 800-377-0550 or mass.gov/massmedboard. The Board of Registration provides information about physicians licensed to practice in Massachusetts.

Changing Your PCP
In order to change your PCP, select a new PCP from the Directory of Health Care Providers and report your selection to the Tufts HP Member Services Department. Your new PCP is not considered your PCP until you have reported your selection to the Tufts HP Member Services Department.

Canceling Appointments
The Plan will not pay for missed appointments which you did not cancel in advance (usually at least 24 hours). If the Tufts HP Provider's office policy is to charge for missed appointments that were not canceled in advance, you will have to pay the charges.
**Authorized Level of Benefits, continued**

**Changes to Tufts HP Provider network**

Tufts HP offers Members 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, the Provider’s moving out of the Service Area, or his or her failure to continue to meet Tufts HP’s credentialing standards. 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 Member Services.

**When Referrals are Not Required at the Authorized Level of Benefits**

The following Covered Services do not require a referral or prior authorization from your Primary Care Provider in order for you to obtain coverage at the Authorized Level of Benefits. Except as detailed earlier in this chapter, or for Emergency care, you must receive these services from a Tufts HP Provider in order to obtain coverage at the Authorized Level of Benefits.

- *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 physician satisfies this requirement.)

- Mammograms at the following intervals:
  - One baseline at 35-39 years of age
  - One every year at age 40 and older
  - As otherwise Medically Necessary

- Care in a Limited Service Medical Clinic, if available
- Care in an Urgent Care Center, if available
- Pregnancy terminations
- Routine eye exams
- Medical treatment provided by an optometrist
- Dental surgery, orthodontic treatment and management, or preventive and restorative dentistry, when provided for the treatment of cleft lip or cleft palate for Children under age 18
- Oral surgery
- Chiropractic services (spinal manipulation)
- 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 *Medically Necessary* follow-up obstetric or gynecological care as a result of that exam

**Inpatient Care**

At the Authorized Level of Benefits, the Navigator Plan has three different Copayment Levels for Inpatient hospital stays at Tufts HP Hospitals. Copayments vary based on which hospital you choose. If you are admitted as an Inpatient, you or someone acting on your behalf must notify your PCP or Tufts HP of the admission within 48 hours in order for the services to be covered at the Authorized Level of Benefits.

Part 9 provides a list of the Tufts HP Hospitals and their Copayment tiers.

*Note:* Inpatient hospital Copayments are based on their participation in the Centered Care program and their efficiency of performance.
Authorized Level of Benefits, continued

Non-Tiered Services
Covered transplant services for Members at the Authorized Level of Benefits at Tufts Health Plan’s designated transplant network are not grouped in a Copayment Level. These services are subject to a $275 Copayment per admission. Any additional Inpatient admission to a Tufts HP Hospital for Covered Services related to the transplant procedure(s) is subject to the applicable Inpatient Hospital Copayment in the “Navigator Inpatient Hospital Copayment List.” Please see pages 98-103 of this Navigator Member Handbook for those Copayment amounts in effect as of July 1, 2017.

In addition, there are other services that are not included under these Copayment Levels. These include Day Surgery; certain care for newborn Children; and rehabilitation, extended care, and skilled nursing services at a skilled nursing facility, rehabilitation hospital, or chronic care facility. For information about your costs and limits for these services, please see “Benefit Overview” and Part 9 in this Member Handbook.

Inpatient Notification for services authorized by your PCP
As long as your Inpatient admission or procedure is authorized by your Tufts HP PCP, you are not responsible for notifying Tufts Health Plan about the admission or procedure. Your Tufts HP Provider will notify Tufts Health Plan about the admission or procedure for you. See “Inpatient Notification” on pages 40-42 for more information.

Covered Services Not Available from a Tufts HP Provider
If Tufts Health Plan determines that a Covered Service is not available from a Tufts HP Provider, with Tufts Health Plan’s prior approval, you may go to a non-Tufts HP Provider and receive Covered Services at the Authorized Level of Benefits up to the Reasonable Charge. You are responsible for any charges in excess of the Reasonable Charge.

Unauthorized Level of Benefits

Unauthorized Level of Benefits
If your care is not provided or authorized by your Tufts HP PCP, Covered Services will be covered at the Unauthorized Level of Benefits. If you choose to obtain care at the Unauthorized Level of Benefits, (or if you have not chosen a PCP), you pay a Deductible and Coinsurance for certain Covered Services. The Member is responsible for any charges in excess of the Reasonable Charge. For more information about your Member costs for medical services, see “Plan and Benefit Information” at the front of this Member Handbook.

Please note that you must submit a claim form for each service that is not authorized or provided by your Tufts HP PCP. For information on filing claim forms, see pages 79 and 84.

Inpatient Notification by You
If you receive Inpatient services that were not authorized by your Tufts HP PCP, you must notify Tufts Health Plan of these services within 48 hours of seeking or receiving care. If you do not notify Tufts Health Plan, you will be subject to a Notification Penalty. See “Inpatient Notification” on pages 40-42 for more information.

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

Note: Services provided in U.S. territories are considered to be provided outside of the United States.
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 to obtain Covered Services at the Authorized Level of Benefits in the following circumstances:

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

If your PCP disenrolls, Tufts HP 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 Member Services at 800-870-9488 or visit tuftshealthplan.com/gic. The Member Specialist will help you to select one from the Tufts Health Plan Directory of Health Care Providers. You can also visit the Tufts Health Plan website at tuftshealthplan.com to choose a PCP.

If you are enrolling as a new Member
If your Provider is not included in one of the Group Insurance Commission’s health plans at the time of your enrollment as a new Member, you may continue to see him or her if:

- **Undergoing Treatment.** If you are undergoing a course of treatment, you may continue to see your Provider for Covered Services for up to 30 days from your Effective Date and receive the Covered Services at the Authorized Level of Benefits.
- **Pregnancy.** If you are in your second or third trimester of pregnancy, you may continue to see your Provider to obtain Covered Services at the Authorized Level of Benefits through your first postpartum visit.
- **Terminal Illness.** If you are terminally ill, you may continue to see your Provider to obtain Covered Services at the Authorized Level of Benefits as long as necessary.

Conditions for coverage of continued treatment
As a condition for continued coverage of Covered Services at the Authorized Level of Benefits, Tufts Health Plan may require your Provider to agree to:

- Accept reimbursement from Tufts Health Plan at the rates applicable prior to notice of disenrollment as payment in full, and not to impose Member cost sharing in an amount exceeding the cost sharing that could have been imposed prior to the Provider’s disenrollment
- Adhere to the quality assurance standards of Tufts Health Plan and to provide Tufts HP with any necessary medical information
- Adhere to Tufts Health Plan’s policies and procedures, including those regarding referrals, prior authorization, and providing services pursuant to a treatment plan approved by Tufts HP.

Emergency Care

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

Outpatient Emergency Care
If you receive Emergency services but are not admitted as an Inpatient, the services will be covered at the Authorized Level of Benefits. You will be required to pay a Copayment, then the Deductible for each Emergency room visit.

If you receive Emergency Covered Services from a non-Tufts HP Provider, the Plan will pay up to the Reasonable Charge. You pay the applicable Copayment, then the Authorized Deductible, as well as any charges in excess of the Reasonable Charge. You may receive a bill for these services. If you receive a bill, call Member Services or see “Bills from Providers” for more information on what to do if you receive a bill.

**Note:** You or someone acting for you must call your PCP or Tufts HP within 48 hours of receiving care. You are encouraged to contact your PCP so he or she can provide or arrange for any follow-up care that you may need.
Emergency Care, continued

Inpatient Emergency Care
If you receive Emergency services and are admitted as an Inpatient (in either a Tufts HP Hospital or a non-Tufts HP Hospital), you or someone acting for you must notify your Tufts HP PCP within 48 hours of seeking care in order to be covered at the Authorized Level of Benefits. (Notification from the attending physician satisfies this requirement.) Otherwise, coverage for these services will be provided at the Unauthorized Level of Benefits.

Also, if you are admitted as an Inpatient to a hospital that is not a Tufts HP Hospital after receiving Emergency care, that admission will be subject to Inpatient Copayment Tier 1 (a $275 Copayment per admission). In addition, you or someone acting for you must notify your PCP of the admission within 48 hours after you are admitted for Inpatient Emergency care or you will be charged a $500 Notification Penalty. Inpatient notification guidelines are described on pages 40-42.

In addition, if you are admitted to a facility which is not a Tufts HP Hospital, and your PCP determines that transfer is medically appropriate, he/she may transfer you to a Tufts HP Hospital or another appropriate facility. If you choose to remain in the facility to which you were originally admitted after your PCP has determined that transfer is medically appropriate, coverage for your Inpatient stay will revert to the Unauthorized Level of Benefits.

Financial Arrangements between Tufts Health Plan and Tufts HP Providers

Methods of payment to Tufts HP Providers
Tufts Health Plan’s goal in compensating Providers is to encourage preventive care and active management of illnesses. Tufts Health Plan strives to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards Providers for taking the best care of our Members. Tufts Health Plan uses a variety of mutually agreed upon methods to compensate Tufts HP Providers.

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

Tufts Health Plan reviews the quality of care provided to Members through its Quality of Health Care Program. You should feel free to ask your Provider specific questions about how he or she is paid.

Member Identification Card
The Plan gives each Member a Member Identification card (Member ID card). Your Member ID card identifies your health care plan and your individual Member Identification Number.

When you receive your Member ID card, check it carefully. If any information is incorrect, call Member Services at 800-870-9488.

Please remember to carry your card with you at all times and bring it to your medical appointments. When you receive services, you must tell the office staff that you are a Navigator Member.

Note: If you do not identify yourself as a Member, and, as a result, your PCP and/or the Plan does not manage your care, then the Plan may not pay for the services provided. If this occurs, the Covered Services you receive from that Tufts HP Provider may be covered at the Unauthorized Level of Benefits.
Utilization Management
The purpose of the Tufts HP utilization management program is to evaluate whether health care services provided to Members are Medically Necessary and provided in the most appropriate and efficient manner. Under this program, Tufts Health Plan sometimes uses prospective, concurrent, and retrospective review of health care services.

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Timeframe for Determinations*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective (Pre-service)  • Tufts Health Plan determines whether the proposed treatment is Medically Necessary</td>
<td>Within two (2) working days of receiving all necessary information, but no later than 15 days from receipt of the request</td>
</tr>
<tr>
<td>Concurrent             • Tufts Health Plan monitors the course of treatment as it occurs and determines when it is no longer Medically Necessary</td>
<td>Determination is made prior to treatment being reduced or terminated. This allows you to appeal an adverse determination.</td>
</tr>
<tr>
<td>Retrospective (Post-Service)  • Tufts Health Plan evaluates care after it has been provided, and to more accurately determine the appropriateness of health care services provided to Members</td>
<td>30 days</td>
</tr>
<tr>
<td>Urgent care review</td>
<td>72 hours</td>
</tr>
</tbody>
</table>

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

Tufts HP makes coverage determinations. You and your Provider make all treatment decisions.

Notes: Members can call the Member Services Department at 800-870-9488 to determine the status or outcome of utilization review decisions.

Utilization review for behavioral health (mental health and substance use disorder) services is conducted by Beacon Health Options. See the “Mental Health, Substance Use Disorder, and Enrollee Assistance Programs” section later in this Member Handbook or call Beacon at 855-750-8980.
Care Management

Some Members with severe illnesses or injuries may warrant care management intervention under Tufts Health Plan’s case management program.

Severe illness and injuries may include, but are not limited to, the following:

- High-risk pregnancy and newborn Children
- Serious heart or lung disease
- Cancer
- Certain neurological diseases
- AIDS or other immune system diseases
- Severe traumatic injury

Under this program, Tufts Health Plan

- Encourages the use of the most appropriate and cost-effective treatment
- Supports the Member’s treatment and progress

If a Member is identified by Tufts Health Plan as an appropriate candidate for care management or is referred to the program, Tufts HP may contact Members and their Providers to:

- Discuss a treatment plan
- Established prioritized goals
- Explore potential alternative services or supplies.

Members and their Tufts HP Providers will be contacted if Tufts Health Plan identifies alternatives to the Member’s current treatment plan that qualify as Covered Services, are cost effective, and are appropriate for the Member.

Individual case management (ICM)

In certain circumstances, Tufts Health Plan may authorize an individual case management (“ICM”) plan for a Member with severe illnesses or injuries. The goal of the ICM plan is to identify and arrange for the most appropriate type, level, and setting of health care services and supplies for the Member.

Under the ICM plan, Tufts Health Plan may authorize coverage for alternative services and supplies that do not otherwise constitute Covered Services for that Member. This will occur only if Tufts Health Plan, at its sole discretion, determines that all of the following conditions are satisfied:

- The Member’s condition is expected to require medical treatment for an extended duration;
- The alternative services and supplies are:
  - Medically Necessary
  - Provided directly to the Member with the condition
  - In place of more expensive treatment that is a Covered Service.
- The Member and an Authorized Reviewer agree to the alternative treatment program
- The Member continues to show improvement in his or her condition, as determined periodically by an Authorized Reviewer.

When Tufts Health Plan authorizes an ICM plan, the Covered Service that the ICM plan will replace will also be indicated. The benefit available for the ICM plan will be limited to the benefit that the Member otherwise would have received for the Covered Service.

Tufts Health Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the Member. If, at any time, these services and supplies fail to satisfy any of the conditions described above, the Plan may modify or terminate coverage for the services or supplies provided under the ICM plan.
**Authorized Reviewer Approval**

Certain **Covered Services** require prior approval from an **Authorized Reviewer**. These services are identified by (AR) in the “Benefit Overview”.

If you receive these services from or authorized by your **Tufts HP PCP**, your **PCP** is responsible for obtaining approval from an **Authorized Reviewer**.

If your services are not provided or authorized by your **Tufts HP PCP**, you are responsible for obtaining prior approval from an **Authorized Reviewer**. If you fail to obtain prior approval, the Navigator Plan will not cover those services and supplies. In addition, if you receive services that **Tufts HP** determines are not **Covered Services**, you will be responsible for the cost of those services.

For more information about how to obtain this prior approval, please call Member Services at 800-870-9488.

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

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**Services that you receive in an Emergency do not require prior approval from an Authorized Reviewer.**

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**Inpatient Notification** (formerly known as pre-registration)

**Inpatient Notification**

**Inpatient** notification is a process that makes **Tufts Health Plan** aware of all **Inpatient** hospital admissions and transfers to another hospital. We will evaluate the anticipated hospital stay, and, in certain cases, will also:

- Evaluate your proposed medical care
- Verify whether that care is **Medically Necessary**
- Assess the need for a care management program after discharge
- Recommend an alternative treatment setting.

**Important note about Inpatient notification**

The **Inpatient** notification to **Tufts Health Plan** by your **Provider** does not guarantee that the **Plan** will cover the health care services you receive. Even if **Tufts Health Plan** is notified of an **Inpatient** admission or hospital transfer, the **Plan** is not obligated to cover any services or supplies for any person who:

- Fails to meet eligibility rules
- Receives services or supplies that are not **Covered Services**
- Receives care that is not **Medically Necessary**, as determined by **Tufts Health Plan**

**When Covered Services are Authorized by your Tufts HP PCP**

When your **Tufts HP PCP** is directing your care, he or she is responsible for notifying **Tufts Health Plan** of your **Inpatient** admission or transfer. In this case, you do not need to notify us of the admission or transfer.
Inpatient Notification, continued

When Covered Services are not Authorized by your Tufts HP PCP
When your care is not authorized by your Tufts HP PCP, you, the Member, are responsible to notify Tufts Health Plan of any Inpatient admission or transfer.

Important: If you do not notify Tufts Health Plan, you will be required to pay a $500 Notification Penalty for the care you receive in addition to the Deductible and Coinsurance. Please carefully read the following description of the Inpatient notification process that you must complete when your Tufts HP PCP is not directing your care.

How to Notify Tufts Health Plan of a Hospital Admission or Transfer
You must call the Member Services Department at 800-870-9488 to report your hospital admission or transfer.

You, or someone acting on your behalf, will need to provide the following information:

- The patient name, address, and phone numbers (work and home)
- The Member’s identification number (from your member ID)
- The admitting physician’s name, address, and phone number
- The admitting hospital’s name, address, and phone number
- The Member’s diagnosis and proposed procedure;
- The proposed admission and discharge dates

When to notify Tufts Health Plan
You must notify Tufts Health Plan of the following services within the following time limits:

- For elective hospital admissions or transfers - You must notify Tufts Health Plan at least seven (7) days prior to hospitalization or transfer. After you notify us, we will consult with your physician and then:
  - Notify you or your physician of the determination of the admission, including the anticipated hospital stay; or
  - Recommend alternative treatment settings.

- For urgent or emergent admissions – For an urgent admission, you must notify Tufts Health Plan as soon as possible, but no later than one business day after the admission. An urgent admission is one which requires prompt medical intervention but one in which there is a reasonable opportunity to notify Tufts Health Plan prior to, or at the time of, admission. Notification for an Emergency admission should be completed within one business day following the admission. For a definition of Emergency, see Appendix A.

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

- For Inpatient hospital care for a newborn Child - You must immediately notify Tufts Health Plan of the hospital stay of your newborn Child, if the newborn Child remains a hospital Inpatient for more than 48 hours after birth (following a vaginal delivery) or 96 hours after birth (following a cesarean delivery), and his or her care is not provided or authorized by his or her Tufts HP PCP.

Note: If your newborn Child is a hospital Inpatient for less than 48 hours after birth, you do not need to pre-register Inpatient hospital care for that Child.
Inpatient Notification, continued

When Covered Services are not Authorized by your Tufts HP PCP, continued

Notification Penalty
You must notify Tufts Health Plan of your Inpatient hospital admission or a transfer for care that is not authorized by your Tufts HP PCP, as described above. If you fail to meet any of the Inpatient notification requirements described in this Part 3, you must pay a $500 Notification Penalty. This Notification Penalty is in addition to any Deductible and Coinsurance that you are required to pay for that care.

After you notify Tufts Health Plan of a hospital admission
After you call with the required information, your physician or the hospital will be notified of the decision made by Tufts Health Plan.

Changes to hospital admission information
Notification of your hospital admission is valid only for the diagnosis, procedure, admission date, and medical facility specified at the time of the notification. You must notify Tufts Health Plan about any delays, changes, or cancellations of your proposed hospital admission.

A separate notification to Tufts Health Plan must be obtained for:
- A new date for your hospital admission
- Readmission or a new admission as a hospital Inpatient
- Transfer to another facility

Important Note: You must notify Tufts Health Plan about these changes before your hospital admission begins. If you fail to do this, you will be required to pay a $500 Notification Penalty for that admission.

Extending Inpatient Hospital Care
You or someone acting for you (for example, your physician) may contact Tufts Health Plan to request an extension of your Inpatient hospital care beyond the originally determined stay. This is true whether or not your Tufts HP PCP authorized this care.

Tufts Health Plan will review your request to extend your Inpatient hospital care. As a part of this review, your physician or hospital may be asked to provide additional information about your medical condition. If Tufts Health Plan determines that an extension of your Inpatient hospital care is Medically Necessary, additional hospital days may be authorized for you.

Important Note: Tufts Health Plan may determine that your Inpatient hospital care is no longer Medically Necessary. In this case, Tufts Health Plan will notify you that the Plan will not pay for any additional hospital days. You will be responsible for paying all hospital and physician charges, if you choose to remain as a hospital Inpatient beyond the length of stay initially authorized by Tufts Health Plan.
Part 4 - Enrollment and Termination Provisions

Enrollment

When to enroll
As a Subscriber, you may enroll yourself and your eligible Dependents, if any, for this coverage. You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC.

You and your eligible Dependents, if any, may enroll for this coverage only:
- Within 10 days of your hire date as an eligible new employee
- During the Annual Enrollment Period
- Within 60 days of the date your Dependent is first eligible for this coverage.

You must complete an enrollment form to enroll or add Dependents in a Family Plan. Additional documentation may be required, as follows:
- Newborns and Dependent Children (including stepchildren) under age 26: copy of hospital announcement letter (for a newborn) or the Child’s certified birth certificate
- Adopted Children: photocopy of proof of placement letter or adoption
- Foster Children ages 19-26: photocopy of proof of placement letter or court order
- Spouses: copy of certified marriage certificate

Enrollment is subject to the provisions of Massachusetts General Laws, Chapter 32A, the GIC Rules and Regulations, and applicable federal law.

Special Enrollment Condition
If you declined to enroll your spouse or Dependents when first eligible, you and your eligible Dependents may be enrolled within 60 days of a qualifying status change event (“qualifying events”) or during the GIC’s Annual Enrollment Period. Qualifying events include the following:
- Your coverage under the other health coverage ends involuntarily
- Your marriage or divorce
- The birth, adoption, or placement for adoption of your Dependent Child
- The employee or Dependent is eligible under a state Medicaid plan or state children’s health insurance program (CHIP), and the Medicaid or CHIP coverage is terminated
- The employee or Dependent becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP.

To obtain GIC enrollment and change forms, active employees should contact the GIC Coordinator at their workplace, and retirees should contact the GIC. Enrollment and change forms are also available on the GIC’s website at mass.gov/gic.

Additional Information about Newborn Children
The Plan will cover your newborn Child from birth under a Family Plan, provided the Subscriber enrolls the newborn Child within 60 days after birth.

If the Subscriber does not enroll the newborn Child within 31 days after birth, the Navigator Plan will only cover that newborn Child at birth for an initial 31-day period. During this period, the Navigator Plan will only cover Routine Nursery Care for up to 48 hours (in the case of a vaginal delivery) or up to 96 hours (in the case of a caesarean delivery).

To continue coverage for the newborn Child after this 31-day period, the Subscriber must apply to enroll the Child within 60 days after birth.

Note: Italicized words are defined in Part 8.
Enrollment, continued

**Handicapped Child**
Coverage is available under a *Family Plan* for a *Handicapped Child* over the age of 25, provided that the *Child* was either mentally or physically handicapped so as not to be capable of earning his or her own living before age 19. Contact the GIC at 617-727-3210, ext. 5, for an application to continue coverage for a *Handicapped Child*.

Coverage may also be available under age 26 for *Children* who become handicapped at age 19 or older. Contact the GIC for information.

**Effective Date**

**New employees**
Coverage begins on the first day of the month following 60 days or two (2) calendar months of employment, whichever comes first.

**Persons applying during an Annual Enrollment Period**
Coverage begins each year on July 1.

**Spouses and Dependents**
Coverage begins on the later of:
- The date your own coverage begins, or
- The date that the GIC has determined your *Spouse* or *Dependent* is eligible.

**Surviving Spouses**
Upon application, you will be notified by the GIC of the date your coverage begins.

**Residence in Service Area Requirement**
Every individual covered by a *Family Plan* must reside in the *Service Area* for at least 9 months of the year, **except for full-time students**. Please contact the GIC at 617-727-2310, ext. 1 if your *Dependent(s)* do not reside in the *Plan’s Service Area*.

**Termination**

**Subscribers**
Your coverage ends on the earliest of:
- The end of the month in which you cease to be eligible for coverage
- The date of death
- The date the surviving *Spouse* (or covered former *Spouse*) remarries
- The end of the month covered by your last contribution toward the cost of coverage
- The date the *Plan* terminates
- The date a *Subscriber* becomes eligible for Medicare and retires (or is already retired). Contact the GIC for more information about the options to continue health care coverage in one of the GIC’s Medicare health plans.
- The date the *Subscriber* moves out of the *Service Area*. In order to remain enrolled in the Navigator *Plan*, the *Subscriber* must remain in the *Service Area* for 9 months in each calendar year.

**Dependents**
A *Dependent’s* coverage ends on the earliest of:
- The date the *Subscriber’s* coverage under the *Plan* ends
- The end of the month covered by your last contribution toward the cost of coverage
- The date you become ineligible to have a *Spouse* or *Dependent* covered
- The end of the month in which the *Dependent* ceases to qualify as a *Dependent*
- The date the *Handicapped Child* marries
- The date the covered divorced *Spouse* remarries (or the date the *Subscriber* marries)
- The date of the *Spouse* or *Dependent*’s death
- The date the *Plan* terminates
- The date the *Spouse* of a retired *Subscriber* becomes eligible for Medicare. Contact the GIC for more information about the options to continue health care coverage in one of the GIC’s Medicare health plans.
Continuation of Coverage

Option to Continue Coverage for Dependents Age 26 and Over
Dependent Children age 26 and over are no longer eligible for coverage under this Plan. Dependents age 26 and over who are full-time students at accredited educational institutions may continue to be covered. However, you must pay 100% of the individual premium. The student must also submit an application to the GIC no later than 30 days after his or her 26th birthday. If this application is submitted late, your Dependent Child may apply during the GIC’s annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their GIC coverage.

Continuing Coverage for Surviving Spouses and Dependent Children
In the event of the death of the Subscriber, the surviving Spouse and/or eligible Dependent Children may be able to continue coverage. For more information on eligibility for survivors and orphans, contact the GIC.

To continue coverage, you must submit an enrollment form to the GIC within 30 days of the covered employee or retiree’s death. You must also make the required contribution toward the cost of the coverage. Coverage will end on the earliest of:

- The end of the month in which the survivor dies
- The end of the month covered by your last contribution payment for coverage
- The date the coverage ends
- The date the Plan terminates
- For Dependents: the end of the month in which the Dependent would otherwise cease to qualify as a dependent
- The date the surviving Spouse remarries

Option to Continue Coverage after a Change in Marital Status
Your former Spouse will not cease to qualify as a Dependent under the Plan solely because a judgment of divorce or separate support is granted. Massachusetts law presumes that he or she continues to qualify as a Dependent, unless the divorce judgment states otherwise.

If you get divorced, you must notify the GIC within 60 days and send the GIC a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions. If you or your former Spouse remarries, you must also notify the GIC. If you fail to report a divorce or remarriage, Tufts Health Plan and the GIC have the right to seek recovery of health claims paid or premiums owed for your former Spouse.

Under M.G.L. Ch. 32A as amended and the GIC’s regulations, your former Spouse will no longer qualify as a dependent after the earliest of these dates:

- The end of the period in which the judgment states he or she must remain eligible for coverage
- The end of the month covered by the last contribution toward the cost of coverage
- The date he or she remarries
- The date you remarry. If your former Spouse is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the GIC) under a divorced Spouse rider. Alternatively, your former Spouse may enroll in COBRA coverage.

Family Members of Subscribers Enrolled in Medicare
When a retired Subscriber turns 65 years of age and becomes eligible to enroll in the Medicare Program (Parts A and B), the Subscriber’s family Members who are under age 65 may stay on the Plan provided that the Subscriber enrolls in one of the GIC’s Tufts Health Plan Medicare plans.

COBRA Coverage
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called ‘Qualifying Events.’ If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC’s plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

For more information about COBRA coverage, please see “Group Insurance Commission Notices” beginning on page 127.
Coverage under an *Individual Contract*
Under certain circumstances, a person whose *Group Insurance Commission* coverage is ending has the option to convert to an *Individual Contract*. Please note that conversion to non-group health coverage may offer less comprehensive benefits and higher member cost-sharing than either COBRA coverage or plans offered under the Health Insurance Marketplaces in many states.

**If you live in Massachusetts**
If your *Group Insurance Commission* coverage ends, you may be eligible to enroll in coverage under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority (“the Connector”). For more information, call Member Services or contact the Connector by phone at 877-MA-ENROLL or on its website at [mahealthconnector.org](http://mahealthconnector.org).

**If you live outside Massachusetts**
If your *Group Insurance Commission* coverage ends, you are not eligible to enroll in coverage under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority. Please contact your state insurance department for information about coverage options that are available to you in your state.

**For more information**
Please call *Tufts Health Plan* Member Services at 800-870-9488.
Part 5 - Covered Services

Covered Services

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

- Listed as Covered Services in this Part 5
- Medically Necessary, as determined by Tufts Health Plan
- Consistent with applicable law
- Consistent with Tufts Health Plan’s Medical Necessity Guidelines in effect at the time the services or supplies are provided. This information is available to you at tuftshealthplan.com or by calling Member Services at 800-870-9488.
- Obtained within the 50 United States (U.S. territories are excluded), except for Emergency or Urgent Care services while traveling
- Provided to treat an injury, illness or pregnancy, or are preventive care services
- With respect to care at the Authorized Level of Benefits: provided or authorized in advance by your PCP, except in an Emergency or for care at a Limited Service Medical Clinic or Urgent Care Center that participates with Tufts Health Plan
- Approved by an Authorized Reviewer (if applicable)

Important Notes:

- Certain Covered Services at both the Authorized and Unauthorized Levels of Benefits require prior approval from an Authorized Reviewer. (See “Benefit Overview” for the services that require prior approval.)
  - If these services are from or authorized by your Tufts HP PCP, your PCP is responsible for obtaining approval from an Authorized Reviewer.
  - If your services are not provided or authorized by your Tufts HP PCP, you are responsible for obtaining prior approval from an Authorized Reviewer. If you fail to obtain prior approval, the Navigator Plan will not cover those services and supplies. For more information about obtaining this prior approval, please call Member Services at 800-870-9488.
- All claims are subject to retrospective review from an Authorized Reviewer to ensure that they are for the Covered Services described in Part 5. The Plan will only pay claims that are for Covered Services.
- Inpatient notification: You must notify Tufts Health Plan of any Inpatient services you receive at the Unauthorized Level of Benefits. Please see “Inpatient Notification” in Part 3 (pages 40-42) for more information.
- At the Authorized Level of Benefits: you may be charged an Office Visit Copayment for certain Outpatient services listed as “covered in full” in the “Benefit Overview”, if these services are provided in conjunction with an office visit.

YOUR COSTS FOR COVERED SERVICES: For information about your costs (i.e., Copayments, Coinsurance, and Deductibles) for the Covered Services listed below, see the “Benefit Overview” starting on page 12. Information about the day, dollar, and visit limits under this plan can be found in the “Benefit Overview” and in certain Covered Services listed below.

Note: Italicized words are defined in Part 8.
Covered Services, Continued

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

No PCP referral is required for receiving Emergency care. However, you or someone acting for you should call your PCP or Tufts HP within 48 hours after receiving care so your PCP can provide or arrange for any follow-up care that you may need.

If you receive Emergency services but are not admitted as an Inpatient, the services will be covered up to the Reasonable Charge. You will be required to pay a Copayment, then the Deductible for each Emergency room visit. Emergency Covered Services from a non-Plan Provider are subject to the applicable Copayment and Authorized Deductible (up to the Reasonable Charge). If you receive a bill for these services from a non-Plan Provider, please contact Member Services at 800-870-9488.

Notes:
- The Emergency Room Copayment is waived if you are admitted as an Inpatient, or if the Emergency room visit results in an immediate Day Surgery. It may apply if you register in an Emergency room but leave without receiving care. The Emergency Room Copayment applies to Observation services. Call Member Services at 800-870-9488 for more information.
- If you are admitted as an Inpatient after receiving Emergency care, you or someone acting for you must notify Tufts Health Plan within 48 hours of seeking care to be covered. (Notification from the attending physician satisfies this requirement.)
- If you are admitted to an Inpatient mental health facility after being seen at the Emergency Room, the Emergency Room Copayment will be waived. Members must call the Tufts Health Plan Member Services Department to request this waiver or to have the claim adjusted.
- If you receive Emergency Covered Services from a non-Tufts HP Provider, the Plan will pay the Provider up to the Reasonable Charge. You will be responsible for any charges in excess of the Reasonable Charge (as well as any applicable Cost Sharing Amount). You may receive a bill for these services. If you receive a bill, please call Member Services or see “Bills from Providers” for more information on what to do if you receive a bill.
Covered Services, Continued

Outpatient care

Autism spectrum disorders – diagnosis and treatment (requires prior approval at both the Authorized and Unauthorized Levels of Benefits)

Autism spectrum disorders include any of the pervasive Developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include autistic disorder, Asperger’s disorder, and pervasive Developmental disorders not otherwise specified.

Coverage is provided, in accordance with Massachusetts law, for the diagnosis and treatment of autism spectrum disorders.

Covered Services include:

- Habilitative or rehabilitative care: 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 behavior analysis (ABA) supervised by a Board-Certified Behavior Analyst. For 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. Services provided by a paraprofessional or a Board-Certified Behavior Analyst are covered as described under the “Mental Health, Substance Use Disorder, and Enrollee Assistance Programs” benefit (pages 104-126), administered by Beacon Health Options. Services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers (see “Outpatient medical care” and “Rehabilitative and Habilitative physical and occupational therapy services” on pages 53 and 55). Please note that benefit limits for physical and occupational therapy do not apply when these services are provided for the treatment of autism spectrum disorders.

- Prescription medications (see “Prescription Drug Benefit” on pages 67-74)

- Psychiatric and psychological care (see “Mental Health, Substance Use Disorder, and Enrollee Assistance Programs” benefit on 104-126)

Cardiac rehabilitation

The Plan covers services for the Outpatient 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.

The Plan covers only the following services:

- Outpatient convalescent phase of the rehabilitation program following hospital discharge

- Outpatient phase of the program that addresses multiple risk reduction, adjustment to illness and therapeutic exercise.

Notes:

- Once treatment has been initiated, the Member can receive covered cardiac rehabilitation services for up to 6 months from the date of the first visit.

- For Members with angina pectoris, only one course of cardiac rehabilitation services will qualify as Covered Services.

- The Plan does not cover the program phase that maintains rehabilitated cardiovascular health.

Chiropractic services

Spinal manipulation, when provided by a chiropractor.

Limited to one spinal manipulation evaluation and a total of 20 visits per Member in a Contract Year (Authorized and Unauthorized Levels combined).

Note: Spinal manipulation services for Members age 12 and under are not covered.
Covered Services, Continued

Outpatient Care - continued

Clinical trials studying potential treatment(s) for cancer or other life-threatening diseases or conditions
As required by applicable law, patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions are covered to the same extent as those Outpatient services would be covered if the Member did not receive care in a qualified clinical trial.

Please see page 50 or call Member Services at 800-870-9488 for more information about the criteria for a qualified clinical trial.

Contraceptives – See “Family Planning Procedures, Services, and Contraceptives” on page 50.

Coronary Artery Disease Program
A Coronary Artery Disease secondary prevention program assists Members with documented coronary artery disease in making necessary lifestyle changes to reduce your cardiac risk factors. This benefit is available, when Medically Necessary, at designated programs to Members who meet the clinical criteria established for this program.
For more information about this program, call Member Services at 800-870-9488.

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

Notes:
- Tufts Health Plan will only cover these services at the Authorized Level of Benefits when they are provided by a Tufts HP Provider who is a certified diabetes health care provider.
- Medical nutritional therapy provided under this benefit is not subject to any visit limit described in the “Nutritional counseling” benefit on page 53.

Dialysis
Outpatient dialysis treatment, including hemodialysis and peritoneal dialysis, is covered. Home peritoneal dialysis is a Covered Service. Home hemodialysis is covered only when provided under the direction of a general or chronic disease hospital or free-standing dialysis facility.

Early intervention services for a Dependent Child
Early intervention services include occupational, physical and speech therapy, nursing care and psychological counseling. These services must be provided by early intervention programs that meet the standards established by the Massachusetts Department of Public Health.
These services are available to Members from birth until their third birthday.

Family planning procedures, services, and contraceptives
Covered family planning procedures include tubal ligation, sterilization, and pregnancy termination. Family planning services include medical examinations, birth control counseling, and genetic counseling.

The following contraceptives are available, when provided by a physician and administered in that physician’s office:
- Cervical caps
- Implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants)
- IUDs
- Depo-Provera or its generic equivalent.

Note: Tufts HP covers certain contraceptives, such as oral contraceptives, over-the-counter female contraceptives, and diaphragms, under your Prescription Drug Benefit.
Covered Services, Continued

Outpatient Care - continued

Infertility services (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)

Infertility occurs when a female Member has been unable to conceive or produce conception, during a period of: (1) one year if age 35 or younger, or (2) during a period of six months if over the age of 35. If a woman conceives but is unable to carry the pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one-year or six-month period, as applicable.

Covered infertility services, which may require prior approval from an Authorized Reviewer (as noted by (AR) below), include:

- Diagnostic procedures and tests
- Procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment
- Artificial insemination (intrauterine or intracervical) (AR)
- Cryopreservation of eggs (less than 90 days) (AR)
- Procurement and processing of eggs or inseminated eggs or banking of inseminated eggs when associated with active infertility treatment (AR)
- Assisted Reproductive Technology ("ART") procedures, including:
  - I.V.F. (in-vitro fertilization and embryo transfer) (AR)
  - D.O. (donor oocyte) (AR)
  - F.E.T. (frozen embryo transfer) (AR)
  - Z.I.F.T. (zygote intra-fallopian transfer) (AR)
  - Assisted hatching (AR)
  - G.I.F.T. (gamete intra-fallopian transfer) (AR)
  - I.C.S.I. (intracytoplasmic sperm injection) (AR)

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

Oral and injectable drug therapies used in the treatment of infertility associated with the Covered Services below are covered only when the Member has been approved for associated infertility services. (See the "Prescription Drug Benefit" section for your Copayment amounts.)

Note: Artificial insemination and the ART procedures described above will only be considered Covered Services for Members with infertility who meet the eligibility criteria of both Tufts HP (based on the Member’s medical history) and the Plan’s contracted Infertility Services providers. Services at both the Authorized and Unauthorized Levels of Benefits must be approved in advance by an Authorized Reviewer. The procurement and processing of donor sperm, eggs, or inseminated eggs, or the banking of sperm or inseminated eggs, will be covered to the extent such costs are not covered by the donor’s health care coverage, if any.
**Covered Services, continued**

**Outpatient Care – continued**

**Maternity care**
Covered Services include prenatal care, exams, and tests, and postpartum care provided in a physician’s office.

**Notes:** You will be reimbursed for up to three visits with a lactation consultant per pregnancy. Please contact the Tufts Health Plan Member Services Department for information on how to be reimbursed for these services.

Maternity related tests (i.e., ultrasounds, diagnostic testing, and non-routine laboratory tests) are subject to the Deductible. However, in accordance with the ACA, routine laboratory tests associated with maternity care at the Authorized Level of Benefits are covered in full and not subject to the Deductible. Please call Member Services at 800-870-9488 for further information.

**Outpatient medical care**

- Allergy testing (including antigens) and treatment, and allergy injections.
  
  **Note:** Allergy treatment provided to you at the Authorized Level of Benefits is subject to an Office Visit Copayment when received as part of an office visit. However, there may not be a Copayment if the sole purpose of your visit is to receive allergy treatment (for example, an allergy shot).

- Chemotherapy. Please see “Injectable, inhaled and infused medications” later in this Part 5 for more information about coverage for medications.

- Diagnostic or preventive screening procedures (including, for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies)
  
  **Note:** Please see page 18 of the “Benefit Overview” for information about your Copayments for these procedures.

- Diagnostic imaging, including:
  
  - General imaging (such as x-rays and ultrasounds)
  - MRI/MRA, CT/CTA, and PET tests and nuclear cardiology (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Level of Benefits)

  **Note:** Please call Member Services at 800-870-9488 with questions about specific imaging services.

- Diagnostic testing, including, but not limited to, sleep studies and diagnostic audiological testing (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits).

  **Note:** Please call Member Services at 800-870-9488 with questions about specific tests.

- EKG testing

- Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a Member’s bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens; or any combination consistent with the rules and criteria established by the Massachusetts Department of Public Health.

- Laboratory tests, including, but not limited to, blood tests, urinalysis, throat cultures, glycosolated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles

  **Note:** Laboratory tests must be ordered by a licensed Provider and be performed at a licensed laboratory. Some lab tests (e.g., genetic testing) may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits. In addition, please note that laboratory tests performed as part of preventive care are covered in full at the Authorized Level of Benefits.
Covered Services, Continued

Outpatient Care – continued

Outpatient medical care (continued)

- Mammograms at the following intervals:
  - One baseline at 35-39 years of age
  - One every year at age 40 and older
  - As otherwise Medically Necessary

- Neuropsychological testing for a medical condition (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits).
  
  **Note:** Neuropsychological testing for a mental health condition is not covered under the Medical and Prescription Drug Benefit section of your Navigator Plan. For information about this testing, please refer to the “Mental Health, Substance Use Disorder, and EAP Services” section (pages 104-126) of this Member Handbook, which describes the benefits administered by Beacon Health Options.

- Nutritional counseling, including nutritional counseling for an eating disorder, when given outside of an approved home health care plan, prescribed by a physician and performed by a registered dietician/nutritionist. Coverage is provided for a total of 3 treatment visits per Contract Year. Nutritional counseling visits are covered:
  - When Medically Necessary, for the purpose of treating an illness. Please see “Nutritional Counseling” in the “Benefit Overview” (Part 1) for the applicable Cost Sharing Amount; or
  - As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, and behavior change counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full at the Authorized Level of Benefits.

  **Notes:** Weight loss programs and clinics are not covered. The visit limit does not apply to Outpatient nutritional counseling provided as part of:
  - An approved home health care plan (see “Home health care” on page 62)
  - Treatment for an eating disorder
  - Diabetes self-management training and educational services (see page 50)

- Office visits to diagnose and treat illness or injury.
  
  **Note:** This includes consultations, Medically Necessary evaluations and related health care services for acute or Emergency gynecological conditions, and visits to a Limited Service Medical Clinic.

- Outpatient surgery in a physician’s office.

- Pap smears (cytology examinations) - one annual screening for women age 18 and older, or as otherwise Medically Necessary;

- Radiation therapy and x-ray therapy.

- Smoking cessation counseling services. These services may be provided through the QuitWorks program, or by physicians, nurse practitioners, physician assistants, nurse midwives, or Tobacco Cessation Counselors. This benefit includes individual, group, and telephonic smoking cessation counseling services that (1) are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and (2) meet the requirements of the ACA.

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

- Treatment of speech, hearing and language disorders (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits).

  Services include speech therapy, and short-term cognitive retraining or cognitive rehabilitation services, if provided to restore function lost or impaired as the result of an accidental injury or sickness. For these services to be covered, measurable improvement must be anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery.

- Voluntary second or third surgical opinions.

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Covered Services, Continued

Outpatient Care – continued

Preventive health care – Adults (age 18 and over)
Preventive care services for Members age 18 and over include routine physical examinations, including appropriate immunizations and lab tests as recommended by the physician. They also include immunizations and lab tests, when not rendered as part of a routine physical exam.

Please visit https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations for more information about which services are considered preventive.

Note: Any Medically Necessary follow-up care resulting from a routine physical exam is subject to an Office Visit Copayment at the Authorized Level of Benefits, as described under “Office visits to diagnose and treat illness or injury” (page 53).

Preventive health care – Children (under age 18)
Preventive care services for Children from the date of birth until age 18, include:

• Physical examination, including limited developmental testing with interpretation and report
• History
• Measurements
• Sensory screening, including hearing exams and screenings
• Neuropsychiatric evaluation
• Developmental screening and assessment at the following intervals:
  o Birth until age 6 months: 6 visits
  o Age 6 months until age 18 months: 6 visits
  o Age 18 months until age 3: 6 visits
  o Age 3 until age 18: 1 visit per Contract Year
• Hereditary and metabolic screening at birth
• Appropriate immunizations and tuberculin tests
• Hematocrit, hemoglobin, or other appropriate blood tests
• Urinalysis as recommended by the physician
• Newborn auditory screening tests, as required by state law

Please visit https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations for more information about which services are considered preventive.

Note: Any Medically Necessary follow-up care resulting from a routine physical exam is subject to an office visit Copayment at the Authorized Level of Benefits, as described under “Office visits to diagnose and treat illness or injury” (page 53). Diagnostic tests or diagnostic laboratory tests ordered as part of a routine physical exam are subject to the Deductible.


**Covered Services**, Continued

**Outpatient Care – continued**

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

Please visit https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations for more information about which services are considered preventive.

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**Note:** Any *Medically Necessary* follow-up care resulting from a routine annual gynecological exam is subject to an *Office Visit Copayment* at the *Authorized Level of Benefits*, as described under “Office visits to diagnose and treat illness or injury” on page 53. Diagnostic tests or diagnostic laboratory tests ordered as part of a routine physical exam are subject to the *Deductible*.

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**Rehabilitative and Habilitative physical and occupational therapy services (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)**
Rehabilitative and *Habilitative* physical and occupational therapy services, including cognitive rehabilitation or cognitive retraining, are covered for up to 30 visits per *Contract Year* for each type of therapy.

Rehabilitative services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness. For rehabilitative therapy services to be covered, *Tufts Health Plan* must determine that the *Member’s* condition is subject to significant improvement as a direct result of these therapies.

*Habilitative* physical and occupational therapy services are covered only when provided to keep, learn, or improve skills and functioning for daily living never learned or acquired due to a disabling condition.

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**Notes:** Benefit limits do not apply when these services are provided for the treatment of autism spectrum disorders.

Massage therapy may be covered as a treatment modality only when administered as part of a physical therapy visit that is provided by a licensed physical therapist; and in compliance with *Tufts Health Plan’s Medical Necessity* and prior authorization guidelines (if applicable).

**Urgent Care in an Urgent Care Center**
*Urgent Care* refers to services provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. To find an *Urgent Care Center* (a medical facility, clinic, or medical practitioner’s office) in the *Plan’s* network, please visit tuftshealthplan.com and click on “Find a Doctor”.

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

**Vision care services**
Covered vision care services include:

- Routine eye exams (one each 24-month period). Exams must be received from a *Provider* in the EyeMed Vision Care network to be covered at the *Authorized Level of Benefits*. Please go to tuftshealthplan.com or contact Member Services at 800-870-9488 for more information.
- Eye examinations and necessary treatment of a medical condition
**Covered Services, Continued**

**Oral health services** (may require prior approval from an Authorized Reviewer)

**Emergency Dental Care**
Benefits are provided for treatment rendered by a dentist within 72 hours of an accidental external injury to the mouth and sound natural teeth. This treatment is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

**Note:** Repair or restoration of teeth is not a Covered Service.

**Oral Surgery for Dental Treatment in an Inpatient or Day Surgery setting**
Benefits are provided only if the Member is (1) of young age or (2) has a serious medical condition (including, but not limited to, hemophilia and heart disease) that makes it essential that he or she be admitted to a general hospital as an Inpatient or to a Day Surgery unit or ambulatory surgical facility for the dental care to be performed safely. Covered procedures in an Inpatient or Day Surgery setting include:

- Extraction of seven or more permanent, sound natural teeth
- Gingivectomies (including osseous surgery) of two or more gum quadrants
- Excision of radicular cysts involving the roots of three or more teeth
- Removal of one or more bone impacted teeth

**Note:** The above services are not covered when performed in an office setting.

**Oral surgical procedures for non-dental medical treatment**
Oral surgical procedures for non-dental medical treatment (i.e., the reduction of a dislocated or fractured jaw or facial bone, surgical treatment of cleft lip or cleft palate for Children under the age of 18, and removal or excision of benign or malignant tumors) are covered to the same extent as are other covered surgical procedures.

**Day Surgery** (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)
Covered Day Surgery services include Outpatient surgery done under anesthesia in an operating room of a facility licensed to perform surgery, and associated physician and surgeon services. You must be expected to be discharged the same day and be shown on the facility’s census as an Outpatient.

**Note:** If you are admitted to a Tufts HP Hospital immediately following Day Surgery, the Day Surgery Copayment will be waived. You will instead be required to pay the applicable Inpatient Copayment for that hospital admission. Call Member Services at 800-870-9488 for more information.
Covered Services, Continued

Inpatient care

**Important Note:** At the Authorized Level of Benefits, Members will only be responsible for one Inpatient Copayment if readmitted within 30 days of discharge. Please call Member Services to arrange to have the second Copayment waived.

**Acute hospital services**

- Semi-private room (private room when Medically Necessary)
- Physician's and surgeon's services while hospitalized
- Surgery (AR)
- Anesthesia
- Nursing care
  - Intensive care/coronary care
- Diagnostic tests, imaging, and lab services
- Radiation therapy
- Dialysis
- Physical, occupational, speech, and respiratory therapies
- Durable Medical Equipment and appliances
- Drugs

**Bone Marrow Transplants for Breast Cancer, Hematopoietic Stem Cell Transplants, and Human Solid Organ Transplants (requires prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)**

Bone marrow transplants for Members diagnosed with metastatic breast cancer who meet the criteria established by the Massachusetts Department of Public Health.

Covered Services also include hematopoietic stem cell transplants and human solid organ transplants. The Plan pays for charges incurred by the donor in donating the organ to the Member, but only to the extent that charges are not covered by any other health insurer. This includes evaluation and preparation of the donor, surgery, and recovery services when those services relate directly to donating the organ to the Member.

**Notes:**

- The Plan covers a Member's human leukocyte antigen (HLA) testing. See page 52 in “Outpatient care” for more information.
- The Plan does not cover the following services related to bone marrow and human organ transplants:
  - Transportation costs for the donated stem cells or solid organ
  - Donor charges for Members who donate stem cells or solid organs to non-Members
  - Search costs for matching or for laboratory testing, either (1) to identify a donor for a recipient who is a Member, or (2) for a Member being considered as a potential stem cell or solid organ donor (whether or not the recipient is a Member)
Covered Services, continued

Inpatient care, continued

Gender reassignment surgery and related services
Coverage is provided for gender reassignment surgery and related pre- and post-operative services and prescription drugs. Mental health care services for Members undergoing gender reassignment process are covered through Beacon Health Options. (See the “Mental Health, Substance Use Disorder, and Enrollee Assistance Program” section (page 104) for more information.)

Covered Services offered through Tufts HP include:

- **Inpatient** services, including female to male or male to female gender reassignment surgery and related surgical procedures
- **Day Surgery** for surgical procedures related to the female to male or male to female gender reassignment surgery. These services are covered as described under “Day Surgery” earlier in this Part 5.
- **Outpatient** medical care (pre- and post-operative) related to gender reassignment surgery. These services are covered as described under “Office visits to diagnose and treat illness or injury”, earlier in this Part 5.
- Prescription medications required as part of the gender reassignment process. These medications are covered as described under the “Prescription Drug Benefit”, later in this Part 5.

**Note:** Services at both the Authorized and Unauthorized Levels of Benefits must be authorized in advance by an Authorized Reviewer. Members must meet specific Medical Necessity Guidelines in order for these services to be covered. Gender reassignment surgery and related services only qualify as Covered Services when they are obtained within the 50 United States. Please call Member Services at 800-970-9488 for more information.

Maternity care
The following Covered Services are available to a mother and her newborn Child, regardless of whether or not there is an early discharge (less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery):

- Hospital and delivery services
- Newborn hearing screening test
- Well newborn Child care in hospital
- Inpatient care in hospital for mother and newborn Child for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery
- One home visit by a registered nurse, physician, or certified nurse midwife, and additional home visits licensed health care Provider, when Medically Necessary
- Parent education, assistance, and training in breast and bottle feeding
- The performance of any necessary and appropriate clinical tests
**Covered Services**, continued

**Inpatient care**, continued

### Benefits for Newborn Children at Time of Delivery

Massachusetts law requires a newborn Child’s Routine Nursery Care to be covered under the maternity coverage benefits of the mother’s health plan. If the mother is not a Member under the Plan and has no other maternity coverage benefits, the Plan will cover Medically Necessary care that the newborn Child may require (either Routine Nursery Care or other care) if that newborn Child is enrolled in the Plan.

See Part 4 for information about enrolling a newborn Child in the Plan.

The Plan will pay for Medically Necessary care as follows:

| IF the mother is... | AND the newborn Child is... | THEN the Plan covers...
|---------------------|-----------------------------|-------------------------|
| A Member whose delivery was performed or authorized by her Tufts HP PCP | Enrolled | Routine Nursery Care at the Authorized Level of Benefits  
Other Medically Necessary care  
• At the Authorized Level of Benefits if from or authorized by Child’s Tufts HP PCP; and  
• At the Unauthorized Level of Benefits if not provided or authorized by the Child’s Tufts HP PCP. |
| Not enrolled | Routine Nursery Care only |
| Not a Member under the Plan and has no other maternity coverage benefits | Enrolled (e.g., by the other parent, who is a Subscriber) | Routine Nursery Care:  
• At the Authorized Level of Benefits if from or authorized by the Child’s Tufts HP PCP, and at a Tufts HP Hospital; and  
• At the Unauthorized Level of Benefits if not provided at a Tufts HP Hospital  
Other Medically Necessary care:  
• At the Authorized Level of Benefits if form or authorized by the Child’s Tufts HP PCP; and  
• At the Unauthorized Level of Benefits, if not provided or authorized by the Child’s Tufts HP PCP |
| Not enrolled | Not covered |
Covered Services, continued

Inpatient care, continued

Patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions

As required by applicable law, the Plan covers patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions. Patient care services include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol.

Coverage is subject to all pertinent provisions of the Plan, including, but not limited to, use of Tufts HP Providers, utilization review, and provider payment methods.

The following services are covered under this benefit:

1. All medically necessary services for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.

2. The allowed cost, as determined by the Plan, of investigational drugs or devices approved for use in the qualified clinical trial if they are not paid for by its manufacturer, distributor or provider. This is true regardless of whether the Food and Drug Administration has approved the drug or device for use in treating your particular condition.

“Patient care services” do not include any of the following:

- Investigational drugs or devices that do not meet the criteria in (2) above
- Non-health care services that a patient may be required to receive as a result of participation in the clinical trial.
- Costs associated with managing the research of the clinical trial.
- Costs that would not be covered for non-investigational treatments.
- Any items, services or costs that are reimbursed or provided by the sponsor of the clinical trial.
- Services that are inconsistent with widely accepted and established national or regional standards of care.
- Services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration under the clinical trial.
- Services or costs that are not covered under the Plan.
Covered Services, continued

Inpatient care, continued

Reconstructive surgery and procedures (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)

- Services required to repair or restore a bodily function that is impaired as a result of a congenital defect (including treatment of cleft lip or cleft palate for Children under the age of 18), birth abnormality, traumatic injury, or covered surgical procedure (AR)
- The following services in connection with mastectomy:
  - Reconstruction of the breast affected by the mastectomy
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance
  - Prostheses (covered as described under “Medical Appliances and Equipment” on page 62) and treatment of physical complications of all stages of mastectomy.
- Removal of breast implants when there is documented rupture of a silicone implant, auto-immune disease or infection (AR)

Notes: Cosmetic surgery is not covered.
No coverage is provided for the removal of the ruptured or intact saline breast implants or intact silicone breast implants except as specified above.

Other Health Services

Ambulance services (may require prior approval from an Authorized Reviewer)
The following ambulance services are Covered Services.

- Ground, sea, and helicopter ambulance transportation for Emergency care.
- Airplane ambulance services (e.g., Medflight) (AR)
- Non-emergency, Medically Necessary ambulance transportation between covered facilities (AR)
- Non-emergency ambulance transportation for Medically Necessary care when the Member’s medical condition prevents safe transportation by any other means (AR)

Notes: Please note that the Plan does not cover transportation by chair car or wheelchair van. 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 may be responsible for the costs of this treatment.

Cleft lip or cleft palate treatment and services for Children under age 18
The following Covered Services must be prescribed by the treating physician or surgeon, who must certify that the services are Medically Necessary and are required because of the cleft lip or cleft palate:

- Medical and facial surgery: Covered as described under “Day Surgery”, “Acute hospital services”, and “Reconstructive surgery and procedures” earlier in this chapter. This includes surgical management and follow-up care by plastic surgeons.
- Oral surgery: Covered as described under “Oral surgical procedures for non-dental medical treatment” in the “Oral Health Services” benefit earlier in this chapter. This includes surgical management and follow-up care by oral surgeons.
- Dental surgery or orthodontic treatment and management
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy.
- Speech therapy and audiology services: Covered as described under “Treatment of speech, hearing and language disorders” earlier in this chapter.
- Nutrition services: Covered as described under “Nutritional counseling” earlier in this chapter.
**Covered Services**, continued

**Other Health Services – continued**

**Extended Care** (requires prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)

The Plan covers the following Covered Services in an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

- Skilled nursing services (limit of 45 days per Member in a Contract Year)
- Chronic disease services
- Rehabilitative services

**Home health care** (requires prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)

The Plan covers home health care services to homebound Members. To be considered homebound, you do not have to be bedridden. However, you must usually be unable to leave the home without a considerable and taxing effort. You may be considered homebound if your absences from the home are infrequent, for periods of relatively short duration, or to receive medical treatment.

The following services are Covered Services when provided by an accredited home health agency under a physician’s written order:

- Home visits by a Tufts HP physician;
- Skilled nursing care and physical therapy; and
- The following services, if determined to be a Medically Necessary component of skilled nursing or physical therapy:
  - Speech therapy,
  - Occupational therapy,
  - Medical/psychiatric social work,
  - Nutritional consultation,
  - Durable Medical Equipment (see “Medical Appliances and Equipment” on page 64)
  - The services of a part-time home health aide.

**Note:** Home health services for physical and occupational therapies following an injury or illness are covered only if provided to restore lost or impaired function, as described under “Short term physical and occupational services” on page 55. However, those home health care services are not subject to the 30-visit limit.

**Hospice and End-of-Life care services**

Hospice provides multidisciplinary care designed to address the physical, social, emotional, and spiritual needs of persons likely to live 6 months of less. Hospice care has many benefits; better quality of life, better coping for you and your family, and longer survival time at home.

The Plan will cover the following hospice care services when a physician certifies (or re-certifies) that you have a medical prognosis of 6 months or less to live:

- Physician services
- Nursing care provided by or supervised by a registered professional nurse
- Social work services
- Volunteer services
- Counseling services (including bereavement counseling services for the Member’s family or a primary care person for up to one year following the Member’s death).
- Concurrent palliative chemotherapy and radiation therapy, if palliative, are permitted.

“Hospice care services” are a coordinated licensed program of services provided to Members with six months or less to live. Such services can be provided at home; on an Outpatient basis; and on a short-term Inpatient basis, to control pain and manage acute and severe clinical problems that cannot medically be managed at home.

If you have a medical prognosis of greater than six months to live, but you have symptoms like severe pain or difficulty breathing, the Plan covers palliative care services. Palliative care is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.
**Covered Services**, continued

**Other Health Services – continued**

Injectable, infused or inhaled medications (may require prior approval from an Authorized Reviewer)

The Plan covers injectable, infused or inhaled medications that are: (1) required for and are an essential part of an office visit to diagnose and treat illness or injury; or (2) administered at home by a home infusion Provider. Medications include, but are not limited to, total parenteral nutrition therapy, chemotherapy, and antibiotics.

**Notes:**
- Quantity limits may apply.
- The Plan has designated home infusion Providers for a select number of specialty pharmacy products and drug administration services, including, but not limited to, medications used to treat hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. These Providers offer clinical drug therapy management, nursing support, and care coordination to Members with acute and chronic conditions. Please contact Member Services at 800-870-9488 or visit tuftshealthplan.com for more information.
- Coverage includes the components required to administer these medications, including, but not limited to, hypodermic needles and syringes, Durable Medical Equipment, supplies, pharmacy compounding, and delivery of drugs and supplies.
- Some injectable, infused, or inhaled medications may be covered under your Tufts HP pharmacy benefit. These medications, which are listed on the Tufts HP website as covered under the pharmacy benefit, are not covered under the “Injectable, infused or inhaled medications” benefit. For more information, call Member Services or visit tuftshealthplan.com.
Other Health Services – continued

Medical Appliances and Equipment

(1) **Durable Medical Equipment**

*Durable Medical Equipment* includes devices or instruments of a durable nature that are:

- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not useful in the absence of illness or injury
- Able to withstand repeated use
- Intended to be used in the home.

Please call Member Services at 800-870-9488 if you need *Durable Medical Equipment*. *Tufts Health Plan* will decide whether to purchase or rent the equipment for you. This equipment must be purchased or rented from a *Durable Medical Equipment Provider* that has an agreement with *Tufts Health Plan*.

To be eligible for coverage, the equipment must be the most appropriate available amount, supply or level of service for the *Member*, considering potential benefits and harms to that individual.

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

**Note:** You may be responsible for paying a *Deductible* or *Coinsurance* towards the cost of *Durable Medical Equipment* covered at the *Unauthorized Level of Benefits*. To determine whether your *Durable Medical Equipment* benefit is subject to *Member Cost Sharing* at the *Unauthorized Level of Benefits*, please see the “Benefit Overview” section earlier in this *Member Handbook* or call Member Services at 800-870-9488.

**Examples of covered items (list is not all-inclusive).** Please call Member Services at 800-870-9488 with questions about whether a particular piece of equipment is covered:

- *Prosthetic Devices* (such as artificial legs, arms, eyes, or breasts) *(may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits)*
  - Breast prostheses provided in connection with a mastectomy do not require prior approval from an Authorized Reviewer.
  - Coverage for breast prostheses and prosthetic arms and legs (in whole or in part) is provided for the most appropriate Medically Necessary model, and includes coverage for the cost of repairs.
- Purchase of a manual or electric (non-hospital grade) breast pump, or the rental of a hospital grade electric breast pump for pregnant or post-partum *Members* (when prescribed by a *Provider*) *(Note: Breast pumps are covered in full at the Authorized Level of Benefits)*
- Gradient stockings (up to three pairs per *Contract Year*)
- Devices that extract oxygen from the air (for example, stationary and portable oxygen concentrators)
- Orthotic devices (such as knee and back braces)
- Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind
- Insulin pumps
- Oral appliances for the treatment of sleep apnea
- Hospital beds, wheelchairs, power/electric wheelchairs, crutches, and walkers

(continued on next page)
**Covered Services**, Continued

**Other Health Services – continued**

Medical appliances and equipment, continued

**Examples of excluded items (list is not all-inclusive):**

- Articles of special clothing, except for gradient pressure support aids for lymphedema or venous disease and clothing necessary to wear a covered device (e.g., mastectomy bras and stump socks)
- Bed-related items, including, but not limited to, bed cradles, bed trays, bed pans, over-the-bed tables, and bed wedges
- Car/van modifications
- Comfort or convenience devices, including, but not limited to, air conditioners, air purifiers, and dehumidifiers
- Dentures
- Exercise equipment
- Fixtures to real property (e.g., ceiling lifts, elevators, ramps, stair climbers)
- Foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease
- Heating pads
- Home blood pressure apparatus (manual) with cuff and stethoscope
- Hot tubs, Jacuzzis, shower chairs, swimming pools, or whirlpools
- Hot water bottles
- Mattresses, except for mattresses used in conjunction with a hospital bed and ordered by a physician. Commercially available standard mattresses (e.g., Tempur-Pedic® or Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered.
- Saunas
- Self-monitoring devices, except for certain devices that Tufts Health Plan determines would provide a Member with the ability to detect or prevent the onset of a sudden life-threatening condition
- Thermal therapy devices
- Wheelchair trays

(2) **Other Medical Appliances and Equipment**

- The first pair of eyeglass lenses (frames are not covered) or contact lenses following cataract surgery
- Contact lenses, including the fitting of the lenses, when required to treat keratoconus
- Hearing aids, including the fitting of the hearing aid, are covered when prescribed by a physician and obtained from a hearing aid supplier.
  - Children 21 and under: the Plan provides full coverage for hearing aid evaluations, the fitting and adjusting of hearing aids, and supplies (including ear molds) for one hearing aid per ear per prescription change. Limit of $2,000 per ear every 36 months.
  - Members 22 and over: the Plan covers the first $500 in full and 80% of the next $1,500, up to a limit of $1,700 per Member every 24 months. The Member is responsible for paying 20% of charges from $500-$2,000 (plus any balance).

When there is a pathological change in the Member’s hearing or the hearing aid is lost, benefits for a replacement hearing aid are also covered subject to the benefit limit.

**Note:** Over-the-counter replacement hearing aid batteries are not covered.
Covered Services, Continued

Other Health Services -- continued

Personal Emergency Response Systems (PERS)
Covered Services are provided only for installation and rental charges for a hospital-based Personal Emergency Response System when:

- The system is used as an alternative to reduce or divert Inpatient admissions.
- The Member is homebound and medically at risk, as determined by Tufts Health Plan.
- The Member is alone for at least four (4) hours each day, five (5) days a week and is functionally impaired.

Covered Services do not include the purchase of a Personal Emergency Response System.

Note: Covered PERS benefits are limited to a total of $50 per Member for installation charges and $40 per Member each month for rental of the system. The Navigator Plan pays 80% of the charges up to these maximum allowed installation and rental charges. You are responsible for paying the remaining 20% of those charges, as well as any additional fees or charges for the system.

Private duty nursing
Inpatient private duty nursing services qualify as Covered Services when:

- The Member is a Hospital Inpatient for the treatment of a medical condition,
- The health care facility's regular nursing staff could not perform the services, due to the frequency and complexity of the skilled nursing care
- The services are Medically Necessary, as determined by Tufts Health Plan

Private duty nursing services provided in the Member's home qualify as Covered Services when:

- The administration of treatment and the evaluation of the patient's response to the treatment require the skills of a registered nurse, due to the frequency and complexity of the skilled nursing care.
- The services are Medically Necessary, as determined by Tufts Health Plan.
- The services are approved by an Authorized Reviewer.

Note: Covered private duty nursing services (whether as an Inpatient, at home, or both) are limited to a total of $8,000 per Member in a Contract Year (Authorized and Unauthorized Levels combined).

Scalp hair prostheses or wigs
Covered Services include scalp hair prostheses or wigs worn for hair loss due to (1) alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury; or (2) the treatment of any form of cancer or leukemia.

Special medical formulas
This benefit includes special medical formulas, nonprescription enteral formulas, and low protein foods, when prescribed by a physician to treat the below conditions:

- Special Medical Formulas (may require prior approval from an Authorized Reviewer at both the Authorized and Unauthorized Level of Benefits)
  - Phenylketonuria
  - Tyrosinemia
  - Homocystinuria
  - Maple syrup urine disease
  - Propionic acidemia
  - Methylmalonic acidemia
- Nonprescription enteral formulas (may require prior approval from an Authorized Reviewer)
  - Malabsorption caused by Crohn's disease
  - Ulcerative colitis
  - Gastroesophageal reflux or gastrointestinal motility
  - Chronic intestinal pseudo-obstruction
  - Inherited diseases of amino acids and organic acids
    - Medically Necessary formulas, including infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure
- Low Protein Foods, when given to treat inherited diseases of amino acids and organic acids
Prescription Drug Benefit

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

- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- Tufts HP Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered
Prescription drugs will be considered Covered Services only if they comply with the Tufts Health Plan Pharmacy Management Programs section described below and are:

- Listed below under What is Covered
- Approved by the United States Food and Drug Administration (FDA)
- Provided to treat an injury, illness, or pregnancy
- Medically Necessary.

For a current list of covered drugs as well as a list of non-covered drugs, please go to Tufts Health Plan’s website at tuftshealthplan.com or call the Member Services Department at 800-870-9488.
Covered Services, Continued

Prescription Drug Benefit, continued

Prescription Drug Deductible

A $100 individual Prescription Drug Deductible and a $200 family Prescription Drug Deductible apply each Contract Year. Your family Prescription Drug Deductible is met once any combination of family members reaches $200; no family Member will pay more than his or her individual Prescription Drug Deductible per Contract Year.

The Prescription Drug Deductible is the amount you must first pay for covered prescription drugs before the Navigator Plan will pay for any covered prescription drugs. The amount you accrue towards your deductible when filling a prescription is calculated based upon Tufts Health Plan’s contracted rate at the time the prescription is filled and does not reflect any rebates that we may receive at a later date.

This Prescription Drug Deductible does not apply to smoking cessation agents or to generic buprenorphine-naloxone, naloxone, and naltrexone products.

Note: Copayments do not apply until you have met the Prescription Drug Deductible.

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
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<tbody>
<tr>
<td>DRUGS OBTAINED AT A RETAIL PHARMACY</td>
<td></td>
</tr>
<tr>
<td>Up to a 30-day supply of covered prescription drugs</td>
<td>Tier 1 drugs: $10 Copayment</td>
</tr>
<tr>
<td></td>
<td>Tier 2 drugs: $30 Copayment</td>
</tr>
<tr>
<td></td>
<td>Tier 3 drugs: $65 Copayment</td>
</tr>
<tr>
<td>DRUGS OBTAINED THROUGH THE TUFTS HP DESIGNATED SPECIALTY PHARMACY</td>
<td></td>
</tr>
<tr>
<td>Up to a 30-day supply of covered specialty drugs</td>
<td>Tier 1 drugs: $10 Copayment</td>
</tr>
<tr>
<td></td>
<td>Tier 2 drugs: $30 Copayment</td>
</tr>
<tr>
<td></td>
<td>Tier 3 drugs: $65 Copayment</td>
</tr>
<tr>
<td>MAINTENANCE MEDICATIONS OBTAINED AT A CVS/PHARMACY OR THROUGH THE TUFTS HP</td>
<td></td>
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<tr>
<td>DESIGNATED MAIL SERVICE PHARMACY</td>
<td></td>
</tr>
<tr>
<td>Up to a 90-day supply of most maintenance medications</td>
<td>Tier 1 drugs: $25 Copayment</td>
</tr>
<tr>
<td></td>
<td>Tier 2 drugs: $75 Copayment</td>
</tr>
<tr>
<td></td>
<td>Tier 3 drugs: $165 Copayment</td>
</tr>
</tbody>
</table>

*If the retail cost of your prescription is less than your Copayment, then you are only responsible for the actual retail cost.

Notes:
- If you use a retail pharmacy that is not a Tufts HP designated pharmacy, you will be required to pay for the entire cost of the drug up front and then contact Tufts HP for reimbursement. You will be responsible only for the Member Cost Sharing Amount.
- Tier 1 includes many generic drugs. However, generic drugs may be placed on any of the three tiers. Generic versions of drugs that are priced significantly lower than the brand-name version of the drug are usually placed on Tier 1. However, in situations where the generic price remains very close to the brand-name price, the generic may be placed on Tier 2. In addition, generic drugs that are both high-cost and offer no clinical advantage over other generics in the therapeutic category may be placed on Tier 3.
Covered Services, Continued

Prescription Drug Benefit, continued

PRESCRIPTION DRUG COVERAGE, continued

- In Massachusetts, and in many other states, when your physician prescribes a brand-name drug that has a generic equivalent, you will receive the generic drug and pay the applicable Tier Copayment. However, regardless of where you fill your prescription, if your physician requests that you receive the covered brand-name drug only, you will pay the Copayment applicable to the generic drug plus the difference between the cost of the generic drug and the cost of the covered brand-name drug. Please note that in most cases, there may be a significant difference in price between the brand-name drug and the generic drug, resulting in a significant difference in what you are required to pay.

- The Plan has set up a program for maintenance medications, called the “Maintenance Choice” program. This program is described in more detail on page 72.

- Under the Affordable Care Act, the plan covers the following in full:
  - Oral contraceptives, diaphragms, and other hormonal contraceptives that by law require a prescription, and FDA-approved over-the-counter female contraceptives (e.g., female condoms or contraceptive spermicides) prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription.
  - Oral fluoride for Children under age 6
  - Folic acid for women between the ages of 13 and 44
  - Prescription and generic over-the-counter smoking cessation agents (when prescribed by a physician).
  - Certain medications used for bowel preparation in colonoscopy procedures provided at the Authorized Levels of Benefits. This applies to Members aged 50 through 74. For more information, please call Member Services or see the formulary at tuftshealthplan.com.

- Orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered in full. These medications are not subject to the Prescription Drug Deductible.

- Generic buprenorphine-naloxone, naloxone, and naltrexone products are covered in full, and are not subject to the Prescription Drug Deductible. Prior authorization is not required for these drugs.

- Certain drugs on our formulary are designated as part of our low cost drug program. Your retail pharmacy Copayments for these low cost drugs are $5 for up to a 30-day supply and $10 for a 31-90 day supply. Please visit www.tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy or call Member Services for more information.
Covered Services, Continued

Prescription Drug Benefit, continued

What is Covered under this Prescription Drug Benefit

The Navigator Plan covers the following under this Prescription Drug Benefit:

- Prescribed drugs that by law require a prescription and are not listed under “What is Not Covered” (below)
- Hormone replacement therapy for peri- and post-menopausal women
- Diabetes supplies, including insulin, insulin pens, and insulin needles and syringes; oral diabetes medications (hypoglycemics); and urine glucose and ketone monitoring strips
- Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that legally require a prescription and that are mandated benefits under the Affordable Care Act.

  Note: See “Family Planning” on page 50 of this Navigator Member Handbook for information about other contraceptive drugs and devices that qualify as Covered Services under the Affordable Care Act.

- Fluoride for Children.

- Injectables and biological serum, except as covered under “Injectable medications” on page 63. Medically Necessary hypodermic needles and syringes required to inject these medications are also covered.

- Prefilled sodium chloride for inhalation (both prescription and over-the-counter (with a prescription))

- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS, provided that at least one of the following recognizes the drug for such treatment
  - One of the standard reference compendia
  - The medical literature
  - The Massachusetts Commissioner of Insurance

- Compounded medications, if, by law, at least one active ingredient requires a prescription. Please call Member Services at 800-870-9488 to confirm coverage for a specific compound medication or kit.

- Prescription and over-the-counter (with a prescription) smoking cessation agents

- Over-the-counter drugs included in the list of covered drugs on the Tufts HP Web site when prescribed by a Provider. Please call Member Services for more information.

  Note: Certain prescription drug products may be subject to one of the Pharmacy Management Programs described below.


Covered Services, Continued

Prescription Drug Benefit, Continued

What is Not Covered under this Prescription Drug Benefit

The Navigator Plan does not cover the following under this Prescription Drug Benefit:

- Homeopathic medications
- Drugs that, by law, do not require a prescription (unless listed as covered in the “What is Covered” section above)
- Drugs that are not listed on the “Tufts Health Plan Prescription Drug List”
  - For additional information, see “Pharmacy Management Programs” and “Notes” later in this chapter, or call Member Services at 800-870-9488.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, and fluoride for Children)
- Topical and oral fluorides for adults.
- Medications for the treatment for idiopathic short stature.
- Experimental drugs
- Prescriptions filled at pharmacies other than Tufts Health Plan designated pharmacies, except for Emergency care.
- Drugs for asymptomatic onchomycosis, except for Members with diabetes, vascular compromise, or immune deficiency status.
- Acne medications, unless Medically Necessary.
- Drugs dispensed in an amount or dosage that exceeds Tufts Health Plan’s established quantity limitations.
- Compounded medications, if no active ingredients legally require a prescription. Some exceptions may apply. For more information, call Member Services at 800-870-9488 or tuftshealthplan.com.
- Prescriptions filled through an internet pharmacy, unless it is a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Oral non-sedating antihistamines.
- Prescription medications that are available over-the-counter.
  - Both the specific medication and the entire class of prescription medications may not be covered.
- Prescription medications packaged with non-prescription products.
- Over-the-counter medications if not included on the list of covered drugs on the Tufts HP website.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
- Prescription medications when therapeutically equivalent medications with the same active ingredient (or a modified version of an active ingredient) are available over-the-counter.
  - Both the specific medication and the entire class of prescription medications may not be covered.
  - Excluded medications include, but are not limited to: topical acne medications with benzoyl peroxide ≤ 10%; and H₂ blockers with nizatidine, famotidine, cimetidine, or ranitidine. For a complete list of these excluded medications, visit tuftshealthplan.com or call Member Services at 800-870-9488.

Note: Certain drugs and products are not covered under your prescription drug benefit but may be covered elsewhere under the Plan. These services include:
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etinorgestrel), levonorgestrel implants), Depo-Provera (may be provided under your Outpatient care benefit – see “Family planning procedures, services, and contraceptives” on page 50)
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products (may be provided as described in “Medical Appliances and Equipment” on page 64)
- Immunization agents (may be provided under “Preventive health care” on page 54)
Covered Services, Continued

Prescription Drug Benefit, Continued

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

- **Quantity Limitations Program** - *Tufts Health Plan* limits the quantity of selected medications that Members can receive in a given time period, for cost, safety and/or clinical reasons.

- **Prior Authorization Program** - *Tufts Health Plan* restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from *Tufts Health Plan* for such drugs.
  - *Step Therapy PA Program* – Step therapy is an automated form of prior authorization which uses previous claims history for approval at the pharmacy. Step therapy programs help encourage the use of clinically proven appropriate, cost-effective therapies first, before other, possibly more expensive treatments may be covered.

- **Designated Specialty Pharmacy Program** - Members must obtain some medications from Caremark Specialty Pharmacy, which specializes in providing specific medications for the treatment of complex diseases and offers clinical support services from nurses. Caremark Specialty Pharmacy can dispense up to a 30-day supply of medication at one time, and delivers them directly to the Member's home via mail. This is not part of the mail order pharmacy benefit. Extended day supplies and Copayment savings do not apply to these designated specialty drugs. Medications may be added to this program from time to time.

- **Non-Covered Drugs with Suggested Alternatives** - While *Tufts Health Plan* covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. Drugs may not be covered for safety reasons, if they are new on the market, if they become available over-the-counter, or if a generic version of a drug becomes available. These non-covered drugs are listed on the *Tufts Health Plan* website. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. For up-to-date information on these non-covered drugs and their suggested alternatives, please visit [tuftshealthplan.com](http://tuftshealthplan.com) or call Member Services at 800-870-9488.

- **New-To-Market Drug Evaluation Process** - New-to-market drug products are reviewed for safety, clinical effectiveness, and cost by *Tufts Health Plan*’s Pharmacy and Therapeutics Committee. *Tufts Health Plan* then makes a coverage determination based on the Committee’s recommendation. New drug products will not be covered until this process is completed – usually within 6 months of the product’s availability.

- **Maintenance Choice Program** - Under the Maintenance Choice program, you can choose where to obtain maintenance medications for chronic conditions (i.e., hypertension, diabetes or asthma). You may obtain a 30-day supply of maintenance medication from any retail pharmacy, or a 90-day supply from either the *Tufts Health Plan* designated mail order pharmacy, or from a CVS/pharmacy. The Copayments for a 90-day supply of these medications from the mail order or CVS/pharmacy provide cost savings over obtaining three 30-day supplies from retail pharmacies.

  If you do choose to obtain your maintenance medications through a retail pharmacy, you will be able to get the initial 30-day prescription and then one 30-day refill at that pharmacy. **If you want to continue filling your prescription at this pharmacy in 30-day supplies, you must opt out of the Maintenance Choice program by calling CVS Caremark at 888-424-6618.** If you do not opt out of the program before refilling your prescription for a second time, you will be required to pay the full cost of the prescription. Please note that if you do opt out of the program, you will only be able to obtain up to a 30-day supply of the maintenance medication each time you refill it, and will pay higher costs than in the Maintenance Choice program.

- **Split Fill Program** – This program applies only to certain medications. Medications in the Split Fill Program are dispensed in “split fills”, with only a partial supply of the medication filled at a time. You will be responsible for paying a pro-rated Cost Sharing Amount instead of the Cost Sharing Amount for the full 1-30 day supply.
**Notes:**

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the *Pharmacy Management Programs* described above, he or she may submit a request for coverage. We will approve the request if it meets our guidelines for coverage and will provide you with notification of our coverage determination within 72 (seventy-two) hours after receiving the request. If *Tufts Health Plan* approves a request is made to cover medications that are part of the “New-to-Market Drug Evaluation Process” program or the “Non-Covered Drugs with Suggested Alternatives” program, the medications will generally be covered on Tier-3.
- The *Tufts Health Plan* website lists covered drugs and their tiers. *Tufts Health Plan* may change a drug’s tier during the year. For example, if a brand drug’s patent expires, *Tufts Health Plan* may (a) move the brand drug from Tier-2 to Tier-3; or (b) add the brand drug to our list of non-covered drugs (see the website at tuftshealthplan.com) when a generic alternative becomes available. (Many generic drugs are available on Tier-1.)
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check [tuftshealthplan.com](http://tuftshealthplan.com), or call Member Services at 800-870-9488.


Covered Services, Continued

Prescription Drug Benefit, Continued

Filling Your Prescription

Where to Fill Prescriptions
You can fill your prescriptions at any pharmacy; however, Tufts Health Plan designated pharmacies will only charge you the Member Cost Sharing Amount at the time you fill your prescription. For the majority of prescriptions, Tufts Health Plan designated pharmacies include most pharmacies in Massachusetts, New Hampshire, and Rhode Island and additional pharmacies nationwide. For a select number of drug products, you must fill your prescription through a small number of specially designated pharmacies. (For more information about Tufts Health Plan’s special designated pharmacy program, see “Pharmacy Management Programs” earlier in this Prescription Drug Benefit section or call Member Services.)

Notes: Your prescription drug benefit is honored only at Tufts Health Plan designated pharmacies. For information about where to fill your prescriptions or reimbursement for prescription drug claims at non-Plan designated pharmacies, please call Member Services at 800-870-9488.

Filling Prescriptions for Maintenance Medications - Tufts HP offers you three choices for filling your prescription for maintenance medications:

- Directly from a Tufts HP designated retail pharmacy for up to a 30-day supply;
- Directly from a CVS/ pharmacy for up to a 90-day supply; or
- Mailed to you through a Tufts HP designated mail services pharmacy for up to a 90-day supply (applies to most, but not all, maintenance medications). Tufts HP designated mail services pharmacies may not offer:
  - Medications for short-term medical conditions
  - Certain controlled substances and other prescribed drugs subject to exclusions or restriction
  - Medications that are part of the Plan’s Quantity Limitations or Special Designated Pharmacy programs.

For more information about maintenance medications, please see the “Maintenance Choice Program” above.

Note: Your Copayments for maintenance medications are shown in the Prescription Drug Coverage Table on page 68.
Exclusions from Benefits

The Plan does not cover a service, supply, or medication that is:

- Not Medically Necessary, as determined by Tufts Health Plan
- Not a Covered Service
- Not essential to treat an injury, illness, or pregnancy, except for preventive care services
- Able to be safely and effectively provided to you via a (a) less intensive level of service, supply, setting, or medication or (b) more cost-effective alternative
- Primarily for personal comfort or convenience
- Obtained outside of the 50 United States. The only exceptions to this rule are for Emergency care services or Urgent Care services while traveling
- Custodial Care
- Related to non-covered services
- Charges for missed appointments that you do not cancel in advance, if the Provider’s office policy is to charge for such appointments
- A drug, device, medical treatment or procedure (collectively “treatment”) that is Experimental or Investigative, or for any related treatments
  Note: This exclusion does not apply to the following services, as per Massachusetts law: 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 the off-label use of prescription drugs to treat cancer or HIV/AIDS.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in Part 5.
- Medications and other products that can be purchased without a prescription, except as described earlier in Part 5.
- Laboratory tests ordered by a Member (online or through the mail), even if performed at a licensed laboratory.
- Provided by an immediate family member (by blood or marriage), even if the relative is a Tufts HP Provider and the services are authorized by your own PCP. If you are a Tufts HP 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).
- Required by a third party (i.e., employer, insurance company, school or court) and not otherwise Medically Necessary.
- 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 incurred when the Member, for his or her convenience, chooses to remain an Inpatient beyond the discharge hour
- 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 for a non-Covered Service
- Dental care and treatment, except as provided under “Oral health services” on page 56. Exclusions include, but are not limited to, preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea), including those for TMJ disorders.
  Note: This exclusion does not apply to the treatment of cleft lip or cleft palate for Members under 18, as described under “Cleft lip or cleft palate treatment and services for Children” earlier in this chapter.
Exclusions from Benefits, continued

- Surgical removal or extraction of teeth, except as provided under “Oral health services” on page 56

- Cosmetic (i.e., meant to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under “Reconstructive surgery and procedures” on page 61
  
  **Note:** Breast reconstruction following a *Medically Necessary* mastectomy is covered, as described in “Reconstructive surgery and procedures” on page 61.

- Rhinoplasty, except as provided under “Reconstructive surgery and procedures” on page 61; liposuction; the removal of tattoos; brachioplasty

- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo

- Hair removal (e.g., electrolysis, laser hair removal), except when *Medically Necessary* to treat an underlying skin condition or in relation to transgender genital surgery (with prior approval by an Authorized Reviewer).

- Costs associated with home births or services provided by a doula.

- Circumcisions performed in any setting other than a hospital, *Day Surgery* facility, or a physician’s office.

- Infertility services, infertility medications, and associated reproductive technologies (such as IVF, GIFT and ZIFT) for *Members* who do not meet the definition of Infertility as described in the “Infertility services” benefit on page 51. Exclusions include, but are not limited to:
  
  o *Experimental* infertility procedures
  
  o The costs of surrogacy, including: (1) all costs (including, but not limited to, costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos) incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a *Member*.

  **Notes:** 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.

  o Reversal of voluntary sterilization.
  
  o Long-term (longer than 90 days) sperm or embryo cryopreservation not associated with active infertility treatment

  **Note:** Tufts HP may authorize short-term (less than 90 days) cryopreservation of sperm, oocytes, or embryos for certain medical conditions that may impact a *Member’s* future fertility. *(Prior approval from an Authorized Reviewer is required.)*

  o Donor recruitment fee for donor egg or donor sper
  
  o Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.

  o Costs associated with donor recruitment and compensation
  
  o Infertility services that are necessary for conception as a result of voluntary sterilization or after an unsuccessful reversal of a voluntary sterilization
  
  o Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an Authorized Reviewer and the *Member* is the sole recipient of the donor’s eggs.

- Reversal of gender reassignment surgery.

- Reversal of voluntary sterilization.

- Over-the-counter contraceptive agents, except as described in the “Prescription Drug Benefit” earlier in this chapter.

- The purchase of an electric, hospital-grade breast pump; donor breast milk.

- Human organ transplants, except as described on page 57. Expenses for transportation and lodging in connection with human organ transplants are not covered.

- Services provided to a non-*Member*, except as described earlier in Part 5 for the following:
  
  o Organ donor charges under “Bone Marrow Transplants for Breast Cancer, Hematopoietic Stem Cell Transplants, and Human Solid Organ Transplants” (see page 57)
  
  o Bereavement counseling services under “Hospice care services” (see page 62);
  
  o Procurement and processing of donor sperm, eggs, or embryos under “Infertility services” (to the extent such costs are not covered by the donor’s health coverage, if any).
Exclusions from Benefits, continued

- Acupuncture, except for acupuncture detoxification for substance use disorder; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; neuromuscular stimulators and related supplies; chiropractic services, except as described in “Chiropractic services” on page 49; chiropractic services (spinal manipulation) for Members age 12 and under; any type of thermal therapy device; Inpatient and Outpatient weight-loss programs and clinics; exercise classes; relaxation therapies; massage therapies, except as described under “Short term physical and occupational therapy services” earlier in this chapter; services by a personal trainer; 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
- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies or procedures, and all services, procedures, labs and supplements associated with this type of medicine
- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; educational, vocational, or recreational settings; Outward Bound; or wilderness, camp or ranch programs), even if performed or provided by licensed Providers (including, but not limited to, nutritionists, nurses or physicians)
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products
  Note: This exclusion does not apply to the following blood services and products:
  - Blood processing
  - Blood administration
  - Monoclonal and recombinant Factor products for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval from an Authorized Reviewer is required)
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval from an Authorized Reviewer is required)
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Multi-purpose general electronic devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PADs), tablets, and smartphones. All accessories for multi-purpose general electronic devices, including USB devices and direct connect devices (e.g., speakers, microphones, cables, cameras, batteries, etc.). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet and all related accessories.
- Examinations, evaluations or services for educational purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in Part 5. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and services to treat speech, hearing and language disorders in a school-based setting.
- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described in “Medical Appliances and Equipment” on page 64, the Navigator Plan will not pay for eyeglasses, contact lenses or contact lens fittings.
- Hearing aids or hearing aid fittings, except as described under "Medical appliances and equipment" on page 64.
- Methadone maintenance or methadone treatment related to substance use disorders. These services are covered under the mental health and substance use disorder benefit offered by Beacon Health Options (described later in this document).
Exclusions from Benefits, Continued

- 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 routine foot care for Members diagnosed with diabetes. It also does not apply to therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease when (1) the need for therapeutic shoes and inserts has been certified by the Member’s treating doctor, and (2) 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.

- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" on page 61.

- Lodging related to receiving any medical service, including lodging related to obtaining gender reassignment surgery or related services.
Part 6 – How to File a Claim and the Member Satisfaction Process

How to File a Claim

**Tufts HP Providers**
When you obtain care from a *Tufts HP Provider*, you do not have to submit claim forms. The *Tufts HP Provider* will submit claim forms for you. *Tufts HP* will make payment directly to the *Tufts HP Provider*.

**Non-Tufts HP Providers**
As described below, when you obtain care from a *Non-Tufts HP Provider*, it may be necessary to file a claim form. Claim forms are available from *Tufts HP* (see “To Obtain Claim Forms” below).

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

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

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

- If you do not sign the appropriate section on the claim form, *Tufts HP* will make the appropriate payment directly to you. If you have not already done so, you will be responsible for paying the *Non-Tufts HP Provider* for the services rendered. If you are responsible for paying any portion of the bill above what the Plan pays, an explanation of benefits statement will be sent to you. The explanation of benefits statement will tell you how much you owe to the *Non-Tufts HP Provider*.

**To Obtain Claim Forms**
Claim forms are available by calling the *Tufts HP* Member Services Department at 800-462-0224.

**Where to Send Medical Claim Forms**
Send completed claim forms to:

*Tufts Health Plan*
POS Claims
P.O. Box 9171
Watertown, MA 02471-9171

Separate claim forms should be submitted for each family member. If you have any questions about filing forms, call Member Services at 800-870-9488.

**Pharmacy Expenses**
If you obtain a prescription at a non-designated or out-of-network pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a Member Specialist or through our website at [tuftshealthplan.com](http://tuftshealthplan.com).

**Note:** Italicized words are defined in Part 8.
Member Appeals Process

Tufts Health Plan (“Tufts HP”) has a Member Satisfaction Process to address your concerns promptly. This process addresses:

- Internal Inquiry;
- Member Grievance Process; and
- Appeals:
  - Internal Member Appeals, and
  - Expedited Appeals.

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

**Tufts Health Plan**
Navigator Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193
Fax: 617-972-9509

All calls should be directed to the Member Services Department at **800-870-9488**. Alternatively, you may submit your grievance or appeal at the address listed above.

**Internal Inquiry**

Call the Member Services Department at 800-870-9488 to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell a Member Specialist that you are not satisfied with the response you have received from Tufts HP, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

**Grievances**

A grievance is a formal complaint about actions taken by Tufts HP or a Tufts HP 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 either verbally or in writing. If you choose to file a grievance verbally, please call a Tufts HP Member Specialist, who will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- Your name and address;
- Your Member ID number;
- A detailed description of your concern (including relevant dates, any applicable medical information, and Provider names); and
- Any supporting documentation.

**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**

An administrative grievance is a complaint about a Tufts HP employee, department, policy, or procedure, or about a billing issue.
Member Appeals Process, continued

Administrative Grievance Timeline

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

- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concern within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

- Tufts HP will review your grievance and will send you a letter regarding the outcome within thirty (30) calendar days of receipt.

- The time limits in this process may be waived or extended 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 from a Tufts HP Provider. If you have concerns about your medical care, you should discuss them directly with your Provider. If you are not satisfied with your Provider’s response or do not wish to address your concerns directly with your Provider, you may contact Member Services to file a clinical grievance.

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

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

Internal Member Appeals

Requests for coverage that was denied as specifically excluded in this Navigator Member Handbook (or subsequent updates) or for coverage that was denied based on medical necessity determinations are reviewed as appeals through Tufts Health Plan’s Internal Appeals Process. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

(i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the address listed above under “Grievances”. Tufts HP encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- Your complete name and address
- Your ID number
- A detailed description of your concern
- Copies of any supporting documentation

You may also submit your appeal in person at the address listed at the beginning of this chapter.

(continued on next page)
Member Appeals Process, continued

Internal Member Appeals, continued

(ii) Within forty-eight (48) hours following *Tufts Health Plan*’s receipt of your verbal or written appeal, a *Tufts Health Plan* Appeals and Grievances Analyst will send you an acknowledgment letter, a summary of our understanding of your concerns, and, if appropriate, a request for authorization for the release of your medical and treatment information related to your appeal.

Once you have signed and returned the authorization for the release of medical and treatment information to *Tufts Health Plan*, an Appeals and Grievances Analyst will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to *Tufts Health Plan* within 30 calendar days of the day you requested a review of your case, *Tufts HP* may, in its discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

(iii) The *Tufts Health Plan* Benefits Committee will review appeals concerning specific benefits and exclusions and make determinations. The *Tufts Health Plan* Appeals Committee will make utilization management (*medical necessity*) decisions. If your appeal involves an adverse determination (*medical necessity determination*), it will be reviewed by a medical director and/or a practitioner in the same or in a similar specialty that typically manages the medical condition, performs the procedure, or provides the treatment that is under review. The medical director and/or practitioner will not have previously reviewed your case.

(iv) The Appeals and Grievances Analyst will notify you in writing of the Committee’s decision within no more than 30 calendar days of the receipt of your appeal. A copy of the decision will be sent to your physician, unless you request otherwise. A determination of claim denial will set forth:

- *Tufts Health Plan*$’s understanding of the request
- The reason(s) for the denial
- The specific contract provisions on which the denial is based
- The clinical rationale for the denial, if the appeal involves a *medical necessity* determination.

*Tufts Health Plan* maintains records of each inquiry made by a Member or by that Member’s designated representative.

Expedited (Fast) Appeals

*Tufts HP* recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. *Tufts HP* will expedite an appeal when your health may be in serious jeopardy or, in the opinion of your treating *Provider* (the practitioner responsible for the treatment or proposed treatment), you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If your request meets the guidelines for an expedited (fast) appeal, it will be reviewed by a Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner in the same (or in a similar) specialty that typically manages the medical condition, performs the procedure or provides the treatment that is under review. This Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner will not have previously reviewed your case.

Your review will generally be conducted within two (2) business days, but not later than 72 hours (whichever is less) after *Tufts HP*$’s receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.
External Review
For certain types of claims, you or your authorized representative have the right to request an independent, external review of our Appeals decision. Should you choose to do so, send your request within four months of your receipt of written notice of the denial of your appeal to:

Tufts Health Plan
Appeals & Grievances Department
705 Mt. Auburn Street
Watertown, MA 02471-9193
(fax) 617-972-9509

In some cases, Members may have the right to an expedited (fast) external review. An expedited external review may be appropriate in urgent situations. An urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. Additionally, if Tufts Health Plan has not met all of our major procedural requirements (as listed above under internal appeals) for matters subject to external review, you can immediately file an external appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the appeal decision, the service or supply will be covered under the Plan.

If You Have Questions or Need Help Submitting a Grievance or Appeal, please call the Member Services Department at 800-870-9488 for assistance.
Bills from Providers

Occasionally, you may receive a bill from a Non-Network 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 website or by contacting the Tufts HP Member Services Department
- The documents listed on the Member Reimbursement Medical Claim Form

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

**Note:** You must contact Tufts HP regarding your bill(s) or send your bill(s) to Tufts HP within 24 months from the date of service. If you do not submit them in this timeframe, the bill cannot be considered for payment. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

If you receive Covered Services from a Non-Network Provider, the Plan will pay up to the Reasonable Charge for the services. You are responsible for any amounts in excess of the Reasonable Charge, as well as any applicable Deductible, Coinsurance, and/or Copayments.

**Important Note:**
Certain services you receive from Non-Network Providers at a Tufts HP facility may be reimbursable. Some examples of these types of Providers include Emergency room specialists and radiologists, pathologists, and anesthesiologists who work in Tufts HP Hospitals.

If you receive Covered Services from a Non-Network Provider outside of the Service Area, in most instances, we will directly reimburse the Non-Network Provider.

The Plan reserves the right to be reimbursed by the Member for payments made due to Tufts HP’s error.

**Limitation on Actions**
You cannot file a lawsuit against either Navigator or Tufts Health Plan for any claim under this health care program more than two (2) years after the Navigator Plan denies the claim, unless you do it within two (2) years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under the Navigator Plan, you must first complete our Member Satisfaction Process and then file your lawsuit within two years of first being sent a notice of the denial. Going through our Member Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage.
Subrogation and Right of Recovery

The provisions of this section apply to all current and former plan participants and also to the parents, guardians, or other representatives of a Dependent Child who incurs claims and is or has been covered by the Plan. This Plan’s right to recover (whether by subrogation or reimbursement) shall apply to the personal representatives of your estate, your decedents, minors, and incompetent or disabled persons. “You” and “your” includes anyone on whose behalf the Plan pays benefits. No adult Subscriber hereunder may assign any rights that it may have to recover medical expenses from any person or entity responsible for causing your injury, illness, or condition or any other person or entity to any minor child or children of said adult Subscriber without the prior express written consent of the Plan.

The Plan’s right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness, or condition for which the Plan has paid medical claims (including, but not limited to, any disability award or settlement, premises or homeowners’ medical payments coverage, premises or homeowners’ insurance coverage, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds form any insurance coverage or other source will be made until the health plan’s subrogation and reimbursement interests are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the plan are conditioned upon your agreement to reimburse the plan in full from any recovery you receive for your injury, illness, or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any Provider), you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan’s subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representint the amount of benefits paid by the Plan, including, but not limited to, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.
Subrogation and Right of Recovery, continued

Subrogation Agent

*Tufts Health Plan* administers subrogation recoveries for the *Plan* and may contract with a third party to administer subrogation recoveries for the *Plan*. In such case, that subcontractor will act as *Tufts Health Plan’s* agent.

Assignment

In order to secure the *Plan’s* recovery rights, you agree to assign to the *Plan* any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the *Plan’s* subrogation and reimbursement claims. This assignment allows the *Plan* to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting from the *Plan*, you acknowledge that the *Plan’s* recovery rights are a first priority claim and are to be repaid to the *Plan* before you receive any recovery for your damages. The *Plan* shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the *Plan* will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The *Plan* is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical payments the *Plan* provided or purports to allocate any portion of such settlement or judgement to payments of expenses other than medical expenses. The *Plan* is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The *Plan’s* claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the *Plan’s* efforts to recover benefits paid. It is your duty to notify the *Plan* within 30 days of the date when any notice given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the *Plan* or its representatives notices of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice information requested by the *Plan*, *Tufts Health Plan* or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the *Plan* may reasonably request and all documents related to or filed in personal injury protection. Failure to provide this information, failure to assist the *Plan* in pursuit of its subrogation rights or failure to reimburse the *Plan* from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until:

- the *Plan* is reimbursed in full,
- termination of your health benefits, or
- the institution of court proceedings against you.

You shall do nothing to prejudice the *Plan’s* subrogation or recovery interest or prejudice the *Plan’s* ability to enforce the terms of this *Plan* provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the *Plan* or disbursement of any settlement proceeds or other recovery prior to fully satisfying the *Plan’s* subrogation and reimbursement interest.

You acknowledge that the *Plan* has the right to conduct an investigation regarding the injury, illness, or condition to identify potential sources of recovery. The *Plan* reserves the right to notify all parties and his/her agents of lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the *Plan* has notified you that it has the right pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.
Subrogation and Right of Recovery, continued

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. The Plan will not provide coverage for any injury or illness for which it determines that the Member is entitled to benefits pursuant to any workers’ compensation statute or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers’ compensation coverage as required by law).

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

Future Benefits

If you fail to cooperate with and reimburse the Plan, the health plan may deny any future benefit payments on any other claim made by your until the plan is reimbursed in full. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.
Coordination of Benefits

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

The Navigator Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for Covered Services with benefits payable by other plans, consistent with state law.

Primary and secondary plans
The Plan will coordinate benefits by determining:

- Which plan (Navigator or your other plan(s)) has to pay first when you make a claim; and
- Which plan (Navigator or your other plan(s)) has to pay second.

These determinations will be made according to applicable state law and Division of Insurance regulations.

Right to receive and release necessary information
When you complete your membership application, you must include information on your membership application about other health coverage you have. After you enroll, you must notify Tufts Health Plan of new coverage or termination of other coverage. Tufts Health Plan may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with Tufts HP’s COB program.

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

For more information
For more information about COB, call the Liability and Recovery Department at 888-880-8699, x. 21098.

Use and Disclosure of Medical Information

Use and disclosure of medical information
For information about how Tufts Health Plan uses and discloses your medical information, please contact the Member Services Department. Information is also available on the Tufts Health Plan website at tuftshealthplan.com.

For information about how the GIC uses and discloses your medical information, please contact the GIC.
Additional Plan Provisions

**Tufts Health Plan and Providers**

*Tufts Health Plan* arranges for health care services. *Tufts Health Plan* does not provide health care services. *Tufts Health Plan* has agreements with *Providers* practicing in their private offices throughout the *Service Area*. These *Providers* are independent. They are not Navigator’s or *Tufts Health Plan*’s employees, agents or representatives. *Providers* are not authorized to change this *Member Handbook*, or assume or create any obligation for either Navigator or *Tufts Health Plan*.

Neither Navigator nor *Tufts Health Plan* is liable for the conduct of any *Provider*, including acts, omissions, representations, or any other behavior.

**Acceptance of the terms of the Agreement**

By enrolling in Navigator, *Subscribers* agree, on behalf of themselves and their enrolled *Dependents*, to all the terms and conditions of the Agreement between the *GIC* and *Tufts Health Plan*, including this *Member Handbook*.

**Payments for coverage**

Navigator is a self-funded plan. This means that the *GIC* is responsible for funding *Covered Services* for *Members* in accordance with the terms of the *Plan*.

**Changes to this Member Handbook**

The *GIC* may change this *Member Handbook*. Changes do not require any *Member*’s consent. Notice of changes will be sent to *Subscribers* and will include the effective date of the change. The *Plan* is responsible for notifying you of changes. Changes will apply to all benefits for services received on or after the effective date.

**Notice**

*Notice to Members*: When *Tufts Health Plan* sends a notice to you, it will be sent to your last address on file with the *Group Insurance Commission*. For this reason, it is important for *Members* to keep their address current with the *GIC*.

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

*Tufts Health Plan*

Navigator Plan

705 Mt. Auburn Street

P.O. Box 9173

Watertown, MA 02471-9173

**No Third Party Rights**

The *Plan* grants rights to *Members*. It is not deemed to create rights in any third parties.

**When this Member Handbook is Issued and Effective**

This *Member Handbook* is issued and effective July 1, 2017 and supersedes all previous *Member Handbooks*.

**Circumstances beyond Tufts HP’s reasonable control**

*Tufts Health Plan* is not responsible for a failure or delay to arrange for the provision of services due to circumstances beyond the reasonable control of *Tufts HP*. Such circumstances include, but are not limited to: major disaster, epidemic, war, riot, and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services.
Terms and Definitions

This section defines the terms used in this Member Handbook.

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

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

Annual Enrollment Period
The period each year when the Group Insurance Commission allows eligible persons to apply for and change coverage under Navigator and any other health plans the GIC offers.

Authorized Level of Benefits
The level of benefits that a Member receives when care is provided or authorized by his or her PCP. See Part 3 for more information.

Authorized Reviewer
Authorized Reviewers review and approve certain services and supplies to Members. Authorized Reviewers are either Tufts Health Plan’s Chief Medical Officer (or equivalent) or someone he or she names to perform this function.

Child (Children)
The Subscriber’s or Spouse’s Child by birth, stepchild, or Adoptive Child, or any other Child for whom the Subscriber or Spouse has legal guardianship until the end of the month following their 26th birthday.

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

- For services provided by a non-Tufts HP Provider, your share is a percentage of the Reasonable Charge for those services. You are responsible for costs in excess of the Reasonable Charge.
- For services provided by a Tufts HP Provider, your share is the lesser of:
  - A percentage of the applicable Tufts Health Plan fee schedule amount for those services; or
  - A percentage of the Tufts HP Provider’s actual charges for those services.

Contract Year
The 12-month period in which benefit limits and Deductibles are calculated. The Contract Year (sometimes referred to as a plan year) runs from July 1st through June 30th and is designated by the Group Insurance Commission.

Copayment
Fees you pay for certain Covered Services provided or authorized by your Tufts HP PCP. Copayments are paid to the Provider when you receive care unless the Provider arranges otherwise. Copayments are not applied towards any Deductible or Coinsurance.
Terms and Definitions, Continued

**Copayment Tier 1 PCP**
A Massachusetts *Primary Care Provider*, whose provider group (a) participates in the GIC’s Centered Care Program, and (b) provides the most efficient care.

**Copayment Tier 2 PCP**
A Massachusetts *Primary Care Provider* whose provider group (a) participates in the GIC’s Centered Care Program, and (b) provides less efficient care.

**Copayment Tier 3 PCP**
A Massachusetts *Primary Care Provider* whose provider group does not participate in the GIC’s Centered Care Program.

**Copayment Tier 1 Specialist**
A Massachusetts *Tufts HP Provider* that is an adult or pediatric specialist and whose provider group (a) participates in the GIC’s Centered Care Program, and (b) provides the most efficient care.

**Copayment Tier 2 Specialist**
A Massachusetts *Tufts HP Provider* that is an adult or pediatric specialist, and whose provider group (a) participates in the GIC’s Centered Care Program, and (b) provides less efficient care.

**Copayment Tier 3 Specialist**
A Massachusetts *Tufts HP Provider* that is an adult or pediatric specialist and whose provider group does not participate in the GIC’s Centered Care Program.

**Cosmetic Services**
Services performed solely for the purposes of improving appearance, which appearance is not the result of accidental injury, congenital anomaly or a previous surgical procedure or disease.

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

**Covered Services**
The services and supplies for which the *Plan* will pay. They must be:

- Described in Part 5 of this *Member Handbook* (see pages 47-74)
- *Medically Necessary*, as determined by *Tufts Health Plan*
- In some cases, approved by an *Authorized Reviewer*

**Note:** *Covered Services* include any surcharges on the plan such as the Massachusetts Health Safety Net Trust Fund or New York Health Care Reform Act surcharges, or later billed charges under provider network agreements, such as supplemental provider payments or access fee arrangements.

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

**Note:** *Custodial Care* is not covered by the *Plan*. 

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Terms and Definitions, Continued

Day Surgery
Any surgical procedure(s) provided to a Member at a facility licensed by the state to perform surgery, and with an expected departure the same day. For hospital census purposes, the Member is an Outpatient, and not an Inpatient.

Deductible
The amount incurred by the Member for Covered Services before any payments are made under this Member Handbook. Copayments do not count towards any Deductible, nor do costs in excess of the Reasonable Charge for services received at the Unauthorized Level of Benefits. See “Benefit Overview” at the front of this Member Handbook for more information.

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

Dependent
The Subscriber’s Spouse, former Spouse, Child, stepchild, eligible foster child, or Handicapped Child.

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

Directory of Health Care Providers
A separate booklet which lists:
- Tufts HP Provider physicians and their affiliated Tufts HP Hospital
- Hospitals in the Tufts Health Plan network (Tufts HP Hospitals)
- Certain other Tufts HP Providers

Note: This booklet is updated from time to time to show changes in Providers affiliated with Tufts Health Plan. For information about the Providers listed in the Directory of Health Care Providers, please call Member Services or check the website at tuftshealthplan.com/gic.

Durable Medical Equipment
Devices or instruments of a durable nature that are:
- Medically Necessary
- Prescribed by a physician
- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not useful in the absence of illness or injury
- Able to withstand repeated use
- Used in the home

Effective Date
The date, according to Tufts Health Plan’s records, when you become a Member and are first eligible for Covered Services
Terms and Definitions, Continued

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

- Serious jeopardy to the physical and/or mental health of a Member, another person, or a pregnant Member’s unborn child;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, inadequate time to safely transfer to another hospital before delivery, or a threat to the safety of the Member or her unborn child if they were transferred to another hospital before delivery.

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

**Experimental or Investigative**
A service, supply, treatment, procedure, device, or medication (collectively “treatment”) is considered Experimental or Investigative if any of the following apply:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished
- The treatment, or the “informed consent” form used for 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 evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis
- Evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or 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

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

**Group Insurance Commission (GIC)**
The Massachusetts state agency that provides health insurance for state and Participating Municipality employees, retirees, and their Dependents.

**Habilitative**
Health care services provided in accordance with the federal Affordable Care Act (ACA) in order for a person to attain, maintain or prevent deterioration of a life skill or function never learned or acquired due to a disabling condition. These services may include physical and occupational therapy, and speech-language pathology services in various Inpatient and Outpatient settings.

**Handicapped Child**
The Subscriber’s Child who:

- Became permanently, physically or mentally disabled before age 19
- Is incapable of supporting himself or herself due to disability
- Was covered under the Subscriber's Family Plan immediately before reaching age 19 and who receives approval from the GIC to continue coverage under the Family Plan.
Individual Contract
An agreement between Tufts Health Plan and the Subscriber under which Tufts HP agrees to provide individual coverage, and the Subscriber agrees to pay a premium to Tufts HP.

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

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

Inpatient Copayment Tier 1
The Copayment you are responsible for paying for an Inpatient admission in a Tufts HP Hospital whose provider group (a) participates in the GIC’s Centered Care Program and (b) provides the most efficient care.

Inpatient Copayment Tier 2
The Copayment you are responsible for paying for an Inpatient admission in a Tufts HP Hospital whose provider group (a) participates in the GIC’s Centered Care Program and (b) provides less efficient care.

Inpatient Copayment Tier 3
The Copayment you are responsible for paying for an Inpatient admission in a Tufts HP Hospital whose provider group does not participate in the GIC’s Centered Care Program.

Inpatient Notification (formerly known as “Preregistration”)
Tufts Health Plan's process of validating all information required for all Inpatient admissions and transfers. Inpatient Notification is not a guarantee of payment. See Part 3 for more information.

Limited Service Medical Clinic
A walk-in medical clinic licensed to provide limited services, generally based in a retail store. Care is provided by a nurse practitioner. A Limited Service Medical Clinic offers an alternative to certain emergency room visits for a patient who needs less urgent care or is not able to visit his or her Primary Care Provider due to scheduling or other challenges. The services at a Limited Service Medical Clinic are only available to patients 24 months or older.

Medical Supplies and Equipment
Items prescribed by a physician and which are Medically Necessary to treat disease and injury.

Member
A person enrolled in the Navigator Plan. Also referred to as "you"
Terms and Definitions, Continued

Member Handbook
This document, including any future amendments, which describe the Navigator Plan

Non-Tufts HP Provider
A Provider who does not have an agreement with Tufts HP to provide Covered Services to Members

Notification Penalty (formerly known as “Preregistration Penalty”)
The amount a Member will be required to pay if he or she does not follow the Inpatient Notification guidelines described in Part 3. The Notification Penalty does not count toward Coinsurance, Deductibles, or the Out-of-Pocket Limit. The Notification Penalty is shown in “Benefit Overview” at the front of this Member Handbook.

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

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

- A physician's office
- A Day Surgery or ambulatory care unit
- An Emergency room or outpatient clinic

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

Out-of-Pocket Limit
The Out-of-Pocket Limit is the maximum amount of money paid by a Member during a Contract Year for Covered Services.

An Out-of-Pocket Limit consists of the Deductible, Coinsurance and Copayments at the Authorized Level of Benefits, and consists of the Deductible and Coinsurance at the Unauthorized Level of Benefits. It does not include any Notification Penalties, costs for health care services that are not Covered Services, costs in excess of the Reasonable Charge, or services or supplies listed in the “Note” for the “Out-of-Pocket Limit” provisions on pages 29 and 31.

Participating Municipality
A city, town or district of the Commonwealth of Massachusetts that participates in the health coverage offered by the Group Insurance Commission

Plan
Navigator by Tufts Health Plan™, the Group Insurance Commission’s self-funded plan administered by Tufts Health Plan, which provides you with the benefits described in this Member Handbook

Primary Care Provider (also referred to as PCP or Tufts HP PCP)
The Tufts HP physician, physician assistant, or nurse practitioner who has an agreement with Tufts HP to provide primary care and to authorize, when appropriate, the provision of other Covered Services to Members. Members choose PCPs from among those listed in the Directory of Health Care Providers, subject to the PCP’s availability.

Prosthetic Devices
Medically Necessary items (i.e., breast prostheses and artificial limbs) prescribed by a physician that replace all or part of a bodily organ or limb.
Terms and Definitions, Continued

Provider
A health care professional or facility licensed in accordance with applicable law including, but not limited to, hospitals, Limited Service Medical Clinics (if available), Urgent Care Centers (if available), physicians, doctors of osteopathy, physician assistants, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, licensed speech-language pathologists, and licensed audiologists.

The Navigator Plan will only cover services of a Provider, if those services are listed as Covered Services in Part 5 of this Member Handbook (see pages 47-78) and within the scope of the Provider’s license.

Reasonable Charge
For care received at the Authorized Level of Benefits from a Tufts HP Provider, the Reasonable Charge is based upon Tufts HP’s contracted rate with the Tufts HP Provider (applicable Authorized Deductible and Coinsurance or Copayment will apply).

For care received from a Non-Tufts HP Provider, the Reasonable Charge is the lesser of the:

- Amount charged by the Non-Tufts HP Provider; or
- Amount that Tufts Health Plan determines to be reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to: Medicare fee schedules and allowed amounts, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society coding and clinical guidelines.

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

Service Area
The geographical area approved by the Massachusetts Commissioner of Insurance within which Tufts Health Plan has developed a network of Providers to give Members adequate access to Covered Services.

Spouse
The Subscriber’s legal spouse, according to the law of the state in which you reside.

Subscriber
The person who:

- Is an employee, a non-Medicare eligible retired employee, or non-Medicare eligible surviving spouse of an employee or retiree of the Commonwealth of Massachusetts or a Participating Municipality
- Enrolls in Navigator and signs the membership application form on behalf of himself or herself and any Dependents
- In whose name the premium contribution is paid

Tobacco Cessation Counselor
Providers who are not physicians but who have completed at least eight (8) hours of instruction in tobacco cessation from an accredited institute of higher learning. Tobacco cessation counselors must work under the supervision of a physician.

Tufts Health Plan or Tufts HP
Total Health Plans, Inc., a Massachusetts Corporation d/b/a Tufts Health Plan. Tufts Health Plan enters into arrangements with groups or payers underwriting health benefit plans to make available a network of Providers and to provide certain administrative services to the health benefit plans including, but not limited to, processing claims for benefits and performing preregistration. Tufts HP does not insure the Navigator Plan.

Tufts HP Hospital
A hospital that has an agreement with Tufts Health Plan to provide certain Covered Services to Members. Tufts HP Hospitals are independent. They are not owned by Tufts Health Plan. Tufts HP Hospitals are not agents or representatives of Tufts Health Plan, and their staffs are not Tufts Health Plan’s employees.
Terms and Definitions, Continued

Tufts HP Provider
A Provider with whom Tufts Health Plan has an agreement to provide Covered Services to Members. Tufts HP Providers are not employees, agents or representatives of Tufts Health Plan.

Unauthorized Level of Benefits
The level of benefits that a Member receives when care is not provided or authorized by his or her Tufts HP PCP. See “Benefit Overview“ at the front of this Member Handbook and Part 3 earlier in this Member Handbook for more information.

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

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

Urgent Care Center
A medical facility (or clinic or medical practitioner office) that offers an alternative to certain emergency room visits for Members who are not able to visit their Primary Care Provider or health care Provider in a timely enough manner as warranted by their condition or symptoms. To find an Urgent Care Center in our network, please visit our website at tuftshealthplan.com, and click on “Find a Doctor”.

You, Your
This term has the following meaning in this Member Handbook, regardless of whether it is capitalized: the Member.
Part 9 – Navigator Plan *Inpatient* Hospital *Copayment* Levels

Under the Navigator Plan, *Copayments* for *Inpatient* hospital stays at *Tufts HP Hospitals* are grouped into three *Inpatient* Hospital *Copayment Tiers*, which are based upon whether the hospital’s provider group participates in the GIC’s Centered Care Program, and the efficiency of care it provides (Please call Member Services for more information about hospital groupings.)

- *Tufts HP Hospitals* whose provider group (a) participates in the GIC’s Centered Care Program and (b) provides the most efficient care are in *Inpatient Copayment Tier 1*. *Inpatient* services at a *Tufts HP Hospital* included in *Inpatient Copayment Tier 1* are subject to a *$275 Copayment* per admission.*

- *Tufts HP Hospitals* that participate in the GIC’s Centered Care Program and are determined to provide less efficient care are grouped in *Inpatient Copayment Tier 2*. *Inpatient* services at a *Tufts HP Hospital* included in *Inpatient Copayment Tier 2* are subject to a *$500 Copayment* per admission.*

- *Tufts HP Hospitals* that do not participate in the GIC’s Centered Care Program are grouped in *Inpatient Copayment Tier 3*. *Inpatient* services at a *Tufts HP Hospital* included in *Inpatient Copayment Tier 3* are subject to a *$1500 Copayment* per admission.*

*Subject to the *Inpatient Care Copayment* Limit listed in the “*Inpatient Care Copayment* Limit” provision on page 28 of this Navigator Member Handbook.

**Important Note:** *Copayments* for admissions to *Tufts HP Hospitals* that do not participate in the Centered Care Program, but to whom Centered Care Providers refer, are based on the tier of the referring *Provider*.

There are other services for which the *Inpatient* Hospital *Copayment* Tiers do not apply at the *Authorized Level of Benefits*. These include:

- Services for newborn *Children* who stay in the hospital beyond the mother’s discharge are subject to the *Authorized Deductible*, then covered in full.

- Covered transplant services for *Members* are subject to a *$275 Copayment per admission* when performed at a facility in *Tufts Health Plan’s* designated transplant network. Any additional *Inpatient* admission to a *Tufts HP Hospital* for *Covered Services* related to the transplant procedure(s) is subject to the applicable *Inpatient Hospital Copayment*. Please see pages 98-103 of this Navigator Member Handbook for those *Copayment* amounts in effect as of July 1, 2017.

- *Copayments* are waived for readmissions within 30 days of discharge in the same *Contract Year*. If you are billed an *Inpatient Copayment* for a readmission within 30 days of discharge within the same *Contract Year*, please call Member Services to have your claim adjusted.

*Subject to the *Inpatient Care Copayment* Limit listed in the “*Inpatient Care Copayment* Limit” provision on page 28 of this Navigator Member Handbook.

The Navigator *Inpatient* Hospital *Copayment* List, which appears in the following table, lists hospitals and their applicable *Copayments*. 

---

-98-
## Navigator Inpatient Hospital Copayment List

### Eastern Massachusetts

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna Jaques Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Beth Israel Deaconess Hospital – Milton Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Beth Israel Deaconess Hospital – Needham</td>
<td>$275</td>
</tr>
<tr>
<td>Beth Israel Deaconess Hospital – Plymouth</td>
<td>$275</td>
</tr>
<tr>
<td>Beth Israel Deaconess Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Boston Children's Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Boston Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Brigham and Women’s Faulkner Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Brigham and Women’s Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Cambridge Hospital (part of Cambridge Health Alliance)</td>
<td>$275</td>
</tr>
<tr>
<td>Cape Cod Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Dana-Farber Cancer Institute</td>
<td>$500</td>
</tr>
<tr>
<td>Emerson Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Falmouth Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Hallmark Health Systems (Lawrence Memorial or Melrose Wakefield Hospitals)</td>
<td>$500</td>
</tr>
<tr>
<td>Lahey Hospital and Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Lawrence General Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Lowell General Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Martha’s Vineyard Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Massachusetts Eye and Ear Infirmary</td>
<td>$500</td>
</tr>
<tr>
<td>Massachusetts General Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Metrowest Medical Center - Framingham</td>
<td>$275</td>
</tr>
</tbody>
</table>

Please note that the status and Copayment levels of our network of Providers listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.
**Eastern Massachusetts, continued**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metrowest Medical Center – Leonard Morse</td>
<td>$275</td>
</tr>
<tr>
<td>Mount Auburn Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Nantucket Cottage Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>New England Baptist Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Newton-Wellesley Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>North Shore Medical Center (Salem or Union Campuses)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Northeast Hospital Corporation (Addison Gilbert or Beverly Hospitals)</td>
<td>$500</td>
</tr>
<tr>
<td>Signature Healthcare Brockton Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Southcoast Hospitals Group – Charlton Memorial Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Southcoast Hospitals Group – St. Luke’s Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Southcoast Hospitals Group – Tobey Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>South Shore Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Steward Carney Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Steward Good Samaritan Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Steward Holy Family Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Steward Holy Family Hospital at Merrimack Valley</td>
<td>$275</td>
</tr>
<tr>
<td>Steward Morton Hospital and Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Steward Norwood Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Steward Saint Anne’s Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Steward St. Elizabeth’s Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Sturdy Memorial Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Tufts Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Winchester Hospital</td>
<td>$500</td>
</tr>
</tbody>
</table>

Please note that the status and Copayment levels of our network of Providers listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.
**Central Massachusetts**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Athol Memorial Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Clinton Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Harrington Memorial Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>HealthAlliance Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Heywood Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Marlborough Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Milford Regional Medical Center</td>
<td>$1,500</td>
</tr>
<tr>
<td>Steward Nashoba Valley Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>St. Vincent Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>UMass Memorial Medical Center</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

**Western Massachusetts**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baystate Franklin Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Baystate Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Baystate Noble Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Baystate Wing Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Berkshire Medical Center</td>
<td>$275</td>
</tr>
<tr>
<td>Cooley Dickinson Hospital</td>
<td>$1,500</td>
</tr>
<tr>
<td>Fairview Hospital</td>
<td>$275</td>
</tr>
<tr>
<td>Holyoke Medical Center</td>
<td>$1,500</td>
</tr>
<tr>
<td>Mercy Medical Center</td>
<td>$275</td>
</tr>
</tbody>
</table>

Please note that the status and Copayment levels of our network of Providers listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.
### Maine Inpatient Hospital Copayment List, continued

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Southern Maine Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>York Hospital</td>
<td>$500</td>
</tr>
</tbody>
</table>

### New Hampshire

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice Peck Day Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Androscoggin Valley Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Catholic Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Cheshire Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Concord Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Cottage Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Dartmouth-Hitchcock Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Elliot Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Exeter Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Franklin Regional Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Frisbie Memorial Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Huggins Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Lakes Region General Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Littleton Regional Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Memorial Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Monadnock Community Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>New London Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Parkland Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Portsmouth Regional Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Southern New Hampshire Regional Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Speare Memorial Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>St. Joseph Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Upper Connecticut Valley Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Valley Regional Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Weeks Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Wentworth-Douglass General Hospital</td>
<td>$500</td>
</tr>
</tbody>
</table>

Please note that the status and Copayment levels of our network of Providers listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.
**Rhode Island**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Landmark Medical Center</td>
<td>$500</td>
</tr>
<tr>
<td>Memorial Hospital of RI</td>
<td>$500</td>
</tr>
<tr>
<td>Miriam Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Newport Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Rhode Island Hospital – including Hasbro Children’s Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Roger Williams Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>South County Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>St. Joseph Hospital – including Fatima Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Westerly Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Women and Infants Hospital of Rhode Island</td>
<td>$500</td>
</tr>
</tbody>
</table>

**Vermont**

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Inpatient Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brattleboro Memorial Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Mount Ascutney Hospital</td>
<td>$500</td>
</tr>
<tr>
<td>Southwestern Vermont Medical Center</td>
<td>$500</td>
</tr>
</tbody>
</table>

Please note that the status and Copayment levels of our network of Providers listed above are in effect as of July 1, 2017. For the most up-to-date status, please contact Member Services at 800-870-9488.
Beacon Health Options

Mental Health, Substance Use Disorder, and Enrollee Assistance Programs

Description of Benefits
PART A -- HOW TO USE THIS PLAN

As a member of this plan, you are automatically enrolled in the mental health and substance use disorder benefits program, as well as the Enrollee Assistance Program (EAP), administered by Beacon Health Options (Beacon). Beacon offers easy access to a wide variety of services, including assistance with day-to-day and acute mental health and substance use disorder treatment. Beacon’s comprehensive coverage ranges from traditional and intensive outpatient services to acute residential treatment and inpatient care.

Beacon’s member-driven and provider-centric approach seeks to improve your well-being and functioning as quickly as possible. Our primary goal is to offer you and your family “the right care, in the right setting, for the right amount of time” through our network of high quality, skilled providers.

How to Contact Beacon Health Options

<table>
<thead>
<tr>
<th>Phone</th>
<th>TDD: 866-727-9441</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website</td>
<td>beaconhealthoptions.com/gic</td>
</tr>
</tbody>
</table>

The website offers wellness articles, a Beacon provider directory, benefits information, and other helpful tools.

How to Get Optimal Benefits

Taking two important steps will help you to receive the highest level of benefits and lower your out-of-pocket expenses:

1. **Use a provider or facility that is part of the Beacon Health Options network.**
2. **Call Beacon Health Options to obtain a referral for EAP services or to obtain prior authorization for non-routine outpatient and inpatient care.** For a list of non-routine services, see the “Definitions of Beacon Health Options Behavioral Health Terms”.

**In-network providers** -- Beacon has a comprehensive network of experienced providers all of whom have met our rigorous credentialing process. These in-network providers -- including providers in physical setting and telehealth providers -- offer you the highest level of quality care for mental health, substance use disorder, and EAP services.

**Out-of-network providers** -- Your benefits will be lower if you receive care from a provider or facility that is not part of Beacon’s network. These reduced benefits are called out-of-network benefits.

**Note:** Benefits will be denied if your care is not considered a covered service.

We encourage you to call Beacon at 855-750-8980 (TTY: 711) before using your mental health, substance use disorder, or EAP benefits. A qualified Beacon clinician will answer your call 24 hours a day, seven days a week, to verify your coverage and refer you to a specialized EAP resource or an in-network provider.

**Note:** Italicized words in this section are defined in Part C.

Supervisors monitor random calls to Beacon Health Options’ customer services department as part of Beacon’s quality control program.
Referral/Prior Authorization for EAP and Non-Routine Services

You must obtain prior authorization for non-routine outpatient services and inpatient care requests. You must also obtain a referral from Beacon for EAP services. Beacon clinicians are available 24 hours a day, seven days a week at 855-750-8980 (TDD: 711) to provide referrals and prior authorization.

After you obtain prior authorization, you can then call the provider of your choice directly to schedule an appointment. Beacon maintains an extensive database at beaconhealthoptions.com/gic, where you can search for in-network providers. You can also call Beacon for assistance finding an in-network provider.

If you (or your provider) do not call Beacon to obtain prior authorization or a referral, your benefits may be reduced or not paid at all.

Emergency Care

You should seek emergency care if you (or your covered dependents) need immediate clinical attention because you present a significant risk to yourself or others.

- In a life-threatening emergency, you should seek care immediately at the closest emergency facility.
- Beacon will not deny emergency care. However, you, a family member or your provider must notify Beacon within 24 hours of an emergency admission.

Although a representative may call on your behalf, it is always your responsibility to make certain that Beacon has been notified of an emergency admission. Your benefits may be reduced or denied if you do not notify Beacon.

**Note:** If you call Beacon seeking non-life threatening emergency care, Beacon will connect you with appropriate services within six (6) hours.

Urgent Care

You should seek urgent care if you have a condition that may become an emergency if it is not treated quickly. In such situations, our providers will have appointments to see you within 48 hours of your initial call to Beacon.

Contact Beacon at 855-750-8980 if you need assistance finding an in-network provider with urgent care appointment availability.

Routine Care

Routine care is appropriate if you have a condition that presents no serious risk, and is not likely to become an emergency. In-network providers will have appointments to see you within ten days of your initial call to Beacon for routine care. Contact Beacon at 855-750-8980 if you need assistance finding an in-network provider with appointment availability.

Confidentiality

When you use your EAP, mental health and substance use disorder benefits under this plan, you consent to release necessary clinical records to Beacon for case management and benefit administration. This information is provided only to the extent necessary to administer and manage the care provided when you use your benefits, and in accordance with state and federal laws. All of your records, correspondence, claims and conversations with Beacon staff are kept completely confidential in accordance with federal and state laws. No information may be released to your supervisor, employer or family without your written permission, and no one will be notified when you use your EAP, mental health and substance use disorder benefits. However, if you inform Beacon that you are seriously considering harming yourself or others, Beacon is legally required to notify emergency services to ensure your safety, even without your permission.

Coordination of Benefits (COB)

You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use coordination of benefits (COB) to determine coverage for your mental health and substance use disorder benefits. All benefits under this plan are subject to COB. Beacon may request information from you about other health insurance coverage in order to process your claim correctly.
PART B – BENEFITS

BENEFITS EXPLAINED

Your Member Costs

Deductible – A deductible is the amount you must pay each plan year before Beacon starts to pay your out-of-network behavioral health (mental health and substance use disorder) benefits. You have a deductible for $500 per individual or $1,000 per family for out-of-network behavioral health treatment. The most you’ll owe for any one family member is $500, until the family as a whole reaches the $1,000 deductible limit. This deductible is shared between all covered medical and out-of-network behavioral health services.

Copayments (copays) – Copays are a set amount you pay when you get certain mental health or substance use disorder services. You have two different types of copays for behavioral health services under this plan:
- Per-occurrence copays – These are copays you pay every time you have a particular services. Outpatient visits all have per-occurrence copays.
- Quarterly copays – You pay quarterly copays only once per quarter, no matter how many times you get that service during the quarter. There are quarterly copays for inpatient and intermediate mental health and substance use disorder care. (The quarters are: July/August/September, October/November/December, January/February/March, and April/May/June.)

Coinsurance – Coinsurance is your share of the cost of a covered service when that service isn’t covered at 100%. Your provider is responsible for billing you for coinsurance.

Out-of-Pocket Limit – The out-of-pocket limit is the maximum amount you will pay in coinsurance, deductibles, and copays for your medical, mental health and substance use disorder care in one plan year. When you have met your out-of-pocket limit, all care will be covered at 100% of the allowed amount until the end of the year. You have two separate out-of-pocket limits: an out-of-pocket limit for in-network services, and an out-of-pocket limit for out-of-network services. Neither limit includes the following:
- Charges for out-of-network care that exceeds the maximum number of days or visits
- Charges for care that is not a covered service
- Charges in excess of Beacon’s allowed amounts

In-Network Benefits

Covered in-network services are paid at 100%, after copays (see the “Benefits Chart” below). If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will only pay one copay. (The higher copay will apply.)

In-network care is not subject to the deductible.

The out-of-pocket limit for in-network services is $5,000 for one person or $10,000 for the entire family, shared with your in-network medical and pharmacy expenses. Only copays for covered in-network services count towards this limit. The cost of treatment that is subject to exclusions does not count toward the out-of-pocket limit. Once you reach your in-network out-of-pocket limit in a year, all covered in-network services you receive are covered at 100% until the end of that plan year.
Out-of-Network Benefits

Out-of-network benefits are paid at a lower level than in-network benefits and are subject to deductibles, copays, and coinsurance. Out-of-network benefits are paid based on allowed amounts, which are Beacon’s “reasonable and customary” fees, a percentage of Medicare, or negotiated fee maximums. Allowed amounts are subject to change at any time without notice. If your out-of-network provider or facility charges more than these allowed amounts, you may be balance billed (asked to pay for charges above the allowed amount). Beacon does not cover balance bills.

Beacon’s in-network providers must accept the Plan’s allowed amounts, so you won’t be balance billed as long as you use providers in the Beacon network. Call Beacon at 855-750-8980 (TTY: 711) for help finding an in-network provider.

You have a deductible of $500 for one person or $1,000 for the entire family for out-of-network mental health and substance use disorder treatment.

The out-of-pocket limit for out-of-network services is $5,000 for one person and $10,000 for the entire family. Your out-of-network out-of-pocket limit is shared with your out-of-network medical expenses. The only charges that satisfy the out-of-network out-of-pocket limit are the deductible, copays and coinsurance for out-of-network covered services. Once each covered member reaches his or her out-of-network out-of-pocket limit in a plan year, all covered out-of-network services that person receives are covered at 100% of the allowed amount until the end of that year.

Important! Once you have met your annual out-of-pocket limit, you continue to pay for any costs in excess of allowed amounts.
The following chart outlines your costs for mental health, substance use disorder, and EAP services.

### BENEFITS CHART: MENTAL HEALTH, SUBSTANCE USE DISORDER, AND EAP

<table>
<thead>
<tr>
<th><strong>Covered Services</strong></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>None</td>
<td>$500 for one person, or $1,000 for the entire family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shared with applicable medical expenses</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong></td>
<td>$5,000 for one person, or $10,000 for the entire family</td>
<td>$5,000 for one person, or $10,000 for the entire family</td>
</tr>
<tr>
<td></td>
<td>Shared with applicable medical and pharmacy expenses.</td>
<td>Shared with applicable medical expenses.</td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td>$200 inpatient care copay per calendar quarter&lt;sup&gt;2&lt;/sup&gt;.</td>
<td>80% coverage of the allowable amount</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td>Subject to deductible.</td>
</tr>
<tr>
<td>General hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Substance Use Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General hospital or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>substance use disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate Care</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$200 inpatient care copay per calendar quarter&lt;sup&gt;2&lt;/sup&gt;.</td>
<td>80% coverage of the allowed amount</td>
</tr>
<tr>
<td>Including, but not limited to,</td>
<td></td>
<td>Subject to deductible.</td>
</tr>
<tr>
<td>crisis stabilization, acute</td>
<td></td>
<td></td>
</tr>
<tr>
<td>residential treatment (Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5), day/partial hospitals,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>structured outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual and Family Therapy</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$10 copay</td>
<td>80% coverage of the allowed amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject to deductible.</td>
</tr>
</tbody>
</table>

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<sup>1</sup>You must obtain prior authorization for most inpatient, intermediate, and hospital care. Please see chart titled, "What This Plan Pays: Summary of Covered Services" (Part B) or call Beacon at 855-750-8980 for details. You must notify Beacon within 24 hours of emergency admissions to receive maximum benefits.

<sup>2</sup>Waived if readmitted within 30 days with a maximum of one inpatient/intermediate care copay per calendar quarter.
### Covered Services

<table>
<thead>
<tr>
<th>Outpatient Care — Mental Health, Substance Use Disorder and Enrollee Assistance Program (EAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty Outpatient Services</strong></td>
</tr>
<tr>
<td>Autism Spectrum Disorder services, ECT, TMS, psychiatric VNA, neuropsychological/psychological testing, acupuncture detox, &amp; DBT</td>
</tr>
<tr>
<td>$10 copay</td>
</tr>
<tr>
<td>Subject to deductible</td>
</tr>
<tr>
<td><strong>Group Therapy</strong></td>
</tr>
<tr>
<td>Including Autism Spectrum Disorder group therapy visits</td>
</tr>
<tr>
<td>$10 copay</td>
</tr>
<tr>
<td>Subject to deductible</td>
</tr>
<tr>
<td><strong>Medication Management</strong></td>
</tr>
<tr>
<td>$10 copay</td>
</tr>
<tr>
<td>Subject to deductible</td>
</tr>
<tr>
<td><strong>Telehealth Services</strong> (online video-based counseling or medication management provided by American Well)</td>
</tr>
<tr>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>Drug Screening (Urine)</strong> (In conjunction with in-network substance use disorder treatment)</td>
</tr>
<tr>
<td>No copay</td>
</tr>
</tbody>
</table>

### Enrollee Assistance Program (EAP)

Including, but not limited to, depression, marital issues, family problems, alcohol and drug use, and grief.

Also includes referral services – legal, financial, and child and elder care.

**Note:** All EAP services require you to obtain a referral from Beacon. Failure to do so results in loss of coverage.

**Counseling:** Up to 3 visits per member per year, with no copay.

**Legal:** 30-minute consultation with a local independent attorney and 25% off the hourly rate for service beyond the initial consultation.

**Financial:**
- 30-minute phone consultation with a financial counselor for assistance with issues such as credit repair, debt management, and budgeting.
- 30-minute phone consultation with a local, independent financial planner, and 15% off his/her standard rate for preparing a financial plan.

**Child and elder care:** Access to referrals in your area

**Domestic violence resources:** Access to a confidential hotline and supportive services

### Provider Eligibility:
Provider must be independently licensed in their specialty area or working under the supervision of an independently licensed clinician in a facility or licensed clinic. Some examples include: MD psychiatrist, PhD, PsyD, EdD, LICSW, LMHC, LMFT, RNCS, BCBA

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3You receive up to 26 medically necessary individual/family therapy visits per member, per plan year without prior authorization. Prior authorization is required for individual/family visits (including therapy done in conjunction with medical management) beyond 26 per benefit year.
The Plan pays for the services listed in the chart below. All services must meet medical necessity criteria to be covered.

<table>
<thead>
<tr>
<th>Service</th>
<th>Applicable Copay/Co-insurance Type (see grid above for copay amounts)</th>
<th>Prior Authorization Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Withdrawal Management</td>
<td>Individual/Family Therapy</td>
<td></td>
</tr>
<tr>
<td>Acute Inpatient Psychiatric Services</td>
<td>Inpatient Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Acute Residential Treatment</td>
<td>Intermediate Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Adolescent Acute Inpatient Withdrawal Management and Rehabilitation for Substance Use Disorders (Level 3.5)</td>
<td>Inpatient Care</td>
<td></td>
</tr>
<tr>
<td>Adult Crisis Stabilization Unit (CSU)</td>
<td>Intermediate Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulatory Withdrawal Management</td>
<td>Medication Management</td>
<td>No</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA)</td>
<td>Individual/Family Therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Stabilization Services (CSS) for Substance Use Disorder (Level 3.5)</td>
<td>Intermediate Care</td>
<td></td>
</tr>
<tr>
<td>Community Based Acute Treatment (CBAT)</td>
<td>Intermediate Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Support Programs (CSP)</td>
<td>Intermediate Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>Intermediate Care</td>
<td>Yes</td>
</tr>
<tr>
<td>Dialectical Behavioral Therapy (DBT)</td>
<td>Individual/Family Therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Drug Screening (Urine)</td>
<td>No copay (covered in-network only)</td>
<td>No</td>
</tr>
</tbody>
</table>

In-Network: No
Out-of-Network, MA DPH Licensed Provider: Notification of admission required within 48 hours
Out-of-Network, Non-MA DPH Licensed Provider: Prior authorization required.

In-Network, or Out-of-Network, MA DPH Licensed Provider: Notification of admission required within 48 hours.
Out-of-Network, Non-MA DPH Licensed Provider: Prior authorization required.
<table>
<thead>
<tr>
<th>Service</th>
<th>Applicable Copay/Co-insurance Type</th>
<th>Authorization Required?</th>
</tr>
</thead>
</table>
| Dual Diagnosis Acute Treatment (DDAT) (Level 3.5)                      | Intermediate Care                   | In-Network, or Out-of-Network, MA DPH Licensed Provider: Notification of admission required within 48 hours.  
Out-of-Network, Non-MA DPH Licensed Provider: Prior authorization required. |
| Electroconvulsive Therapy (ECT)                                       | Individual/Family Therapy           | Yes                                                                                     |
| Emergency Service Programs (ESP)                                      | No copay                           | No                                                                                      |
| Enrollee Assistance Program (EAP)                                     | No copay                           | Yes (referral)                                                                          |
| Family Stabilization Team (FST)                                       | Intermediate Care                   | Yes                                                                                     |
| Group Therapy                                                          | Group Therapy                       | No                                                                                      |
| Individual/Family Therapy (conducted in the provider's office/facility, or, when appropriate, in a member’s home) | Individual/Family Therapy           | Prior authorization is required for more than 26 visits per plan year                    |
| Inpatient Substance Use Disorder Services-Medically Managed (Level 4 detox) | Inpatient Care                      | In-Network, or Out-of-Network, MA DPH Licensed Provider: Notification of admission required within 48 hours.  
Out-of-Network, Non-MA DPHLicensed Provider: Prior authorization required. |
| Intensive Outpatient Programs (IOP) for mental health                 | Intermediate Care                   | In-Network: No, for first 6 units within 14 days. Authorization required for subsequent units.  
Out-of-Network: Prior authorization required.                              |
| Intensive Outpatient Programs (IOP) for Substance Use Disorder (Level 2.1) | Intermediate Care                   | In-Network: No, for first 6 units within 14 days. Authorization required for subsequent units.  
Out-of-Network, MA DPH Licensed Provider: Notification of admission required within 48 hours.  
Out-of-Network, Non-MA DPH Licensed Provider: Prior authorization required. |
<p>| Medication Management                                                 | Medication Management               | No                                                                                      |
| Methadone Maintenance                                                 | No copay                           | No                                                                                      |
| Observation                                                            | Inpatient Care                      | No                                                                                      |
| Partial Hospitalization Programs (PHP) for Mental Health              | Intermediate Care                   | Yes                                                                                     |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Applicable Copay/Co-insurance Type (see grid above for copayment amounts)</th>
<th>Authorization Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization Programs (PHP) for Substance Use Disorder (Level 2.5)</td>
<td>Intermediate Care</td>
<td>MA DPH Licensed Provider: Notification of admission required within 48 hours.  Out-of-Network, Non-MA DPH Licensed Provider: Prior authorization required.</td>
</tr>
<tr>
<td>Psychiatric Visiting Nurse services</td>
<td>Individual/Family Therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychological and Neuropsychological Testing</td>
<td>Individual/Family Therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Use Disorder Assessment and Referral</td>
<td>No copay</td>
<td>No</td>
</tr>
<tr>
<td>Telehealth services (online video-based counseling or medication management from American Well or Beacon telehealth providers)</td>
<td>Telehealth services</td>
<td>Therapy: Prior authorization is required for more than 26 visits per plan year.  Medication management: No authorization required. Please call Beacon for referrals.</td>
</tr>
<tr>
<td>Transcranial Magnetic Stimulation (TMS)</td>
<td>Individual/Family Therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Transitional Care Unit (TCU) – (for children in custody of Department of Children &amp; Families)</td>
<td>Intermediate Care</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1These services are subject to certain exclusions, which are found under "What’s Not Covered – Exclusions" (Part B). Failure to obtain prior authorization, when required, may result in no coverage. All services must be deemed covered services and all charges are subject to the Plan’s allowed amount for that service.
COVERED SERVICES

Routine Services

Routine outpatient services (listed below) do not require prior authorization:

• Outpatient therapy (individual/family therapy including therapy done in conjunction with medication management), up to 26 visits per member, per year.
• Group therapy that is 45 to 50 minutes in duration
• Medication management, either in person or via telehealth
• Methadone maintenance
• In-network urine drug screening as a medically necessary part of substance use disorder treatment
• Emergency service programs (ESP)
• Telehealth services (online video based counseling up to 26 visits per member, per year)

Note: Outpatient therapy visits (including telehealth counseling) beyond 26 per benefit year are defined as non-routine and require prior authorization.

Routine out-of-network outpatient care is paid at 80% of the allowed amount. Out-of-network outpatient care is subject to the deductible.

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one copay. (The higher copay will apply.)

Non-Routine (Specialty) Outpatient Services

You must obtain prior authorization for most non-routine outpatient care. Please see table “What This Plan Pays: Summary of Covered Services” for details on authorization requirements. Only routine services do not require prior authorization. Failure to obtain prior authorization for non-routine outpatient care may result in no coverage.

Note: Please see “Definitions of Beacon Health Options Behavioral Health Terms” (Part C), for a full listing of non-routine services.

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one copay. (The higher copay will apply.)

Autism Spectrum Disorders: The plan will cover medically necessary services provided for the diagnosis and treatment of autism spectrum disorders. Coverage is pursuant to the requirements of the plan and to Massachusetts law, including without limitation (1) professional services, including care by appropriately credentialed, licensed or certified psychiatrists, psychologists, social workers, and board certified behavior analysts; and (2) habilitative/rehabilitative care, including, but not limited to, Applied Behavior Analysis (ABA) by a board certified behavior analyst as defined by law.

Beacon’s specialized autism care managers can provide any necessary prior authorization and help you locate an in-network provider. Please call Beacon at 855-750-8980 to speak to an autism case manager.

• Applied Behavioral Analysis Services (ABA): Coverage for ABA-related services is based on medical necessity criteria. You must obtain prior authorization for all ABA services. Failure to obtain prior authorization may result in no coverage. Covered services include:
  o Skills assessment by a Board Certified Behavioral Analyst (BCBA) or qualified licensed clinician
  o Conjoint supervision of paraprofessionals by a BCBA or qualified licensed clinician with clients present
  o Treatment planning conducted by a BCBA or qualified licensed clinician
  o Direct ABA services by a BCBA, licensed clinician, or paraprofessional (if appropriately supervised)
Psychiatric Services for Autism Spectrum Disorders -- Psychiatric services for autism spectrum disorders are focused on treating maladaptive/stereotypic behaviors that pose a danger to self, others and/or property, and impair daily functioning:

- Diagnostic evaluations and assessment
- Treatment planning
- Referral services
- Medication management
- Inpatient/24-hour supervisory care (prior authorization required)
- Partial hospitalization/Day treatment (prior authorization required)
- Intensive Outpatient Treatment (prior authorization required)
- Services at an Acute Residential Treatment Facility (prior authorization required)
- Individual, family, therapeutic group, and provider-based case management services
- Psychotherapy, consultation, and training sessions for parents and paraprofessional and resource support to family
- Crisis intervention
- Transitional care (prior authorization required)

Psychological/Neurological Testing -- You must obtain prior authorization for psychological testing, and for neuropsychological testing for mental health conditions. Failure to obtain prior authorization may result in no coverage. Neuropsychological testing for medical conditions is covered under the medical component of your plan.

Drug Screening (Urine) – In-network urine drug screening is covered when it is a medically necessary part of substance use disorder treatment. (Screening that is conducted as part of methadone treatment is billed as part of the methadone services.)

- Urine drug screening must be done by certified in-network providers. Beacon does not provide coverage for out-of-network providers or laboratories, or for in-network providers who are not certified.
- Urine drug screens completed by laboratories or out-of-network providers may be covered by the medical component of your plan. Contact Tufts Health Plan at 800-870-9488 for information about coverage under the medical component of your plan.

Intermediate Care
In-network intermediate care in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $200 copay per calendar quarter. The copay is waived if you are readmitted within 30 days of discharge. Out-of-network intermediate care is paid at 80% of the allowed amount. Out-of-network intermediate care is subject to the deductible.

You or your provider must obtain prior authorization for intermediate care. Failure to obtain prior authorization may result in no coverage.

Inpatient Care
In-network inpatient care in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $200 copay per calendar quarter. The copay is waived if you are readmitted within 30 days of discharge. Out-of-network inpatient care is paid at 80% of the allowed amount. Out-of-network inpatient care is subject to the deductible. If you are admitted to an out-of-network inpatient facility through an emergency room, and there are no in-network providers available, you will only be responsible for your in-network copay. Beacon will reimburse the facility the out-of-network allowed amount for the service. Please check with the facility to determine if you will be subject to balance billing.

If you require psychiatry visits/consultations while receiving inpatient care, these visits will be covered at 100%. You or your provider must obtain prior authorization for inpatient care. Failure to obtain prior authorization may result in no coverage.
Telehealth Services

Beacon is committed to providing access to quality behavioral health care when and where you need it. Beacon has enhanced our network by adding online video-based counseling services (telehealth), through American Well.

Telehealth services through American Well (AmWell) allows you to easily access a range of behavioral health services, including assessments, counseling, and medication management, from the comfort of your home. Telehealth is immediate, secure, and confidential. It is also easy to use — all you need is a smartphone, tablet or computer with Internet access and a camera.

To schedule a live session with a Beacon AmWell telehealth provider, call Beacon’s Member Services at 855-750-8980. A member services representative can either schedule your appointment or register you with American Well so you can choose a provider and schedule an appointment yourself. You can also directly register and search for a provider at amwell.com. All telehealth services received through AmWell are considered in-network and subject to a $10 copay.

Beacon also offers telehealth services through your local in-network behavioral health providers. If you’re interested in locating a local behavioral health provider that offers telehealth services, please contact Beacon member Services at 855-750-8980 or log on to beaconhealthoptions.com/gic. All Beacon telehealth services are subject to a $10 copay.

The following requirements apply to telehealth services:

- The provider you use must be licensed in the state in which you receive the services.
- There is no coverage for out-of-network telehealth services.
- For in-network telehealth services not received through American Well, in-network providers are required to sign Beacon’s telehealth attestation form prior to claims approval.
Enrollee Assistance Program (EAP)

The Enrollee Assistance Program (EAP) is an in-network only benefit.

Beacon’s EAP can help with the following types of problems:
1. Breakup of a relationship
2. Divorce or separation
3. Becoming a stepparent
4. Helping children adjust to new family members
5. Death of a friend or family member
6. Communication problems
7. Conflicts in relationships at work
8. Legal difficulties
9. Financial difficulties
10. Childcare or eldercare needs
11. Aging
12. Traumatic events

Call 855-750-8980 (TTY: 711) to use your EAP benefit. A Beacon clinician will refer you to a trained EAP provider and/or other specialized resource (e.g., attorney, dependent care service) in your community. The Beacon clinician may recommend mental health and substance use disorder services if the problem seems to require help that is more extensive than EAP services can provide.

You must call to receive a referral from Beacon for all EAP services. Failure to obtain a referral may result in no coverage.

Covered services include:

EAP Counseling Visits -- You have access to up to three EAP counseling visits per member, per year, with an in-network licensed provider. Telehealth counseling visits provided through American Well may qualify as EAP visits. EAP counseling visits can help with problems affecting work/life balance or daily living, such as marital problems, stress at work, or difficulties adjusting to life changes. These visits are covered at 100%.

Legal Services -- Legal assistance services include confidential access to a local attorney to help you answer legal questions, prepare legal documents and help solve legal issues. The following free or discounted services are provided through your legal benefit:
- Free referral to a local attorney
- Free 30-minute consultation (phone or in-person) per legal matter
- 25% off the attorney’s hourly rate (if the attorney charges by the hour) for services beyond the initial consultation
- Free online legal information, including common forms and wills kits

Financial Counseling and Planning -- Your financial counseling and planning benefit includes:
- A 30-minute initial phone consultation with a financial counselor for assistance with issues such as credit repair, debt management and budgeting.
- A 30-minute initial phone consultation with a local, independent financial planner, and 15% off of his or her standard rate for preparing a financial plan.

Child/Elder Care Referral Service -- Beacon’s EAP can help you locate a child or elder care provider. You will receive a packet that contains informational literature, links to federal and private agencies, and a list of independent referrals in your area. There is no cost to this referral service.

Domestic Violence Resources and Assistance -- You have 24/7 access to a confidential, toll-free hotline that provides crisis intervention, safety planning, supportive listening and help connecting to appropriate resources. Beacon’s EAP can also provide referrals to a wide range of supportive services, including specialized counseling, temporary emergency housing, and legal assistance.
Employee Assistance Program for Agency Managers and Supervisors

The Group Insurance Commission offers an Employee Assistance Program for managers and supervisors of agencies and municipalities, which offers:

- Critical incident response services (also available to non-managers and supervisors)
- Confidential consultations
- Resources for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness and substance use disorder
- Team trainings on topics such as stress management and coping with challenging workplace behaviors.

Case Management

Beacon's clinical case managers are available to support you and your family. Case managers will:

- Help determine the appropriate treatment for you
- Review your case using objective and evidence-based clinical criteria
- Help coordinate services among multiple providers
- Work with providers to support your needs
- Provide available resources
- Work with your medical plan to help coordinate benefits and services
- Provide psychoeducation
- Encourage the development of a care plan to help with transitions in care

If you would like help dealing with your behavioral health situation, call Beacon at 855-750-8980 (TTY: 711) and ask to speak with a case manager.
WHAT'S NOT COVERED — EXCLUSIONS

This plan does not cover services, supplies or treatment relating to the below exclusions. The exclusions apply even if the services, supplies or treatment are recommended or prescribed your provider, or if they are the only available options for your condition.

Excluded services include:

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.
- Prescription drugs or over-the-counter drugs and treatments *(Note: These supplies may be covered under the prescription drug component of your plan.)*
- Services or supplies for mental health/substance use disorder treatment that, in Beacon’s reasonable judgment, fits any of the following descriptions:
  - Is not consistent with the symptoms and signs for diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder
  - Is not consistent with prevailing national standards of clinical practice for the treatment of such conditions
  - Is not consistent with prevailing professional research, which would demonstrate that the service or supplies will have a measurable and beneficial health outcome
  - Typically does not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with Beacon’s level-of-care clinical criteria, clinical practice guidelines, or best practices as modified from time to time.

  Beacon may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.
- Services, supplies or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment or device is the only available treatment for a particular condition will not result in it being a *covered service* if it is considered unproven, investigational or experimental.
- Custodial care, unless necessary for acute stabilization or to return you to your baseline level of individual functioning. Care is considered custodial when it:
  - is primarily intended for detention in a protected, controlled environment
  - Is chiefly designed to assist in the activities of daily living, or cannot reasonably be expected to restore you to a level of functioning that would enable you to function outside a structured environment. (This applies to *members* for whom there is little expectation of improvement, despite any and all treatment attempts.
  - Is provided by a Department of Mental Health (DMH) continuing care facility or other DMH run program.
- Neuropsychological testing solely to determine a diagnosis of attention-deficit hyperactivity disorder *(Note: Neuropsychological testing for medical conditions is covered under the medical component of your plan.)*
- Urine drug screening is excluded when:
  - conducted as part of your participation in methadone treatment, which is billed as part of the methadone services
  - completed by *out-of-network providers*, laboratories, or *in-network providers* who are not certified.
- Examinations or treatment, when:
  - required solely for purposes of career, education, housing, sports or camp, travel, employment, insurance, marriage, or adoption; or
  - ordered by a court except as required by law; or
  - conducted for purposes of medical research; or
  - required to obtain or maintain a license of any type.

  *(Note: The above examinations or treatment may be covered if they are: (1) otherwise considered covered behavioral health services, and (2) determined by Beacon to be medically necessary.)*
- Herbal medicine, or holistic or homeopathic care, including herbal drugs or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Biofeedback
- Equestrian or pet therapy
- Expenses related to service animals.
- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; therapeutic/residential schools, educational, vocational, or recreational settings;
daycare or preschool settings; Outward Bound; or wilderness, camp or ranch programs), even if performed or provided by licensed providers (including, but not limited to, nutritionists, nurses or physicians)

- Telehealth services provided out-of-network, or via non-HIPAA compliant technology (i.e., Skype, telephone), or performed by a provider who is not licensed in the state where the member receives the service.
- The cost of the necessary technology or equipment needed to provide HIPAA compliant telehealth services.
- Genetic testing for behavioral prescribing.
- Services conducted by providers who are found to have sanctions against them.
- Non-acute residential treatment, including, but not limited to, recovery residences, sober homes, Clinically Managed Low-Intensity Residential Services (Level 3.1), and Clinically Managed Population Specific High-Intensity Residential Services (Level 3.3).
- Acupuncture treatment (with the exception of acupuncture withdrawal management, which is a covered benefit)
- Multiple charges for the same service or procedure, on the same date
- Facility charges for covered outpatient services
- Nutritional counseling. (Note: These services are covered under the medical component of your plan.)
- Weight reduction or control programs, special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or services or treatment outside the scope of a provider’s licensure.
- Personal convenience or comfort items, including, but not limited to, TVs, telephones, computers, beauty or barber services, exercise equipment, air purifiers, or air conditioners.
- Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while you are confined in a facility.
- Surgical procedures including, but not limited to, gender reassignment surgery. (Note: The medical component of your plan provides coverage for many surgical procedures, including gender reassignment surgery.)
- Smoking cessation related services and supplies. (Note: These services and supplies are covered under the medical and prescription drug components of your plan.)
- Travel or transportation expenses, unless Beacon has requested and arranged for you to be transferred by ambulance from one facility to another.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as you.
- Mental health and substance use disorder services that you have no legal responsibility to pay, or that would not ordinarily be charged in the absence of coverage under the plan.
- Charges in excess of any specified plan limitations.
- Charges for missed appointments.
- Charges for record processing except as required by law.
- Services provided under another plan.
- Services or treatment that must be purchased or provided through other arrangements under federal, state or local law. This includes, but is not limited to, coverage required by workers’ compensation, no-fault auto insurance, no-fault auto insurance, or similar legislation. Benefits will not be paid if you could have elected workers’ compensation or coverage under a similar law (or could have it elected for you).
- Treatment or services received prior to your eligibility for coverage under the plan or after your coverage under the plan ends.
- Behavioral health services received as a result of war or any act of war (declared or undeclared) or caused during service in the armed forces of any country when you are legally entitled to other coverage.
PART C – DEFINITIONS, APPEALS, COMPLAINTS, AND GRIEVANCES

Definitions of Beacon Health Options Behavioral Health Terms

- **Allowed Amounts** – The maximum amount Beacon will reimburse for services or treatment. Beacon’s allowed amounts can be based on “reasonable and customary” fees, a percentage of Medicare, or negotiated fee maximums. If your out-of-network provider or facility charges more than these *allowed amounts*, you may be responsible for difference, in addition to any amount not covered by the benefit. Out-of-network rates or allowed amounts are not contracted rates and are subject to change at any time without notification.

- **Appeal** – A formal request for Beacon to reconsider any adverse determination or denial of coverage for admissions, continued stays, levels of care, procedures or services. Appeals can occur either concurrently or retrospectively.

- **Beacon Health Options (Beacon) Clinician** – A licensed master’s level or registered nurse behavioral health clinician who provides *prior authorization* for EAP, mental health and substance use disorder services. Beacon clinicians have three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers.

- **Case Management** – Beacon’s clinical case manager can help support you and your family by helping to determine the appropriate treatment; reviewing your case; coordinating benefits and services; providing available resources; working with your providers; encouraging development of a care plan; and/or providing psychoeducation.

- **Coinsurance** -- The amount you pay for certain services under Beacon. The amount of *coinsurance* is a percentage of the total amount for the service; the remaining percentage is paid by Beacon. The provider is responsible for billing the *member* for the remaining percentage.

- **Complaint** – A verbal or written statement of dissatisfaction to Beacon concerning a perceived adverse administrative action, decision, or policy.

- **Continuing review or concurrent review** – A clinical case manager works closely with the provider to determine the appropriateness of continued care, review the current treatment plan and progress, and discuss your future care needs.

- **Coordination of Benefits (COB)** – You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use coordination of benefits (COB) to determine the order and proportion of coverage for your mental health and substance use disorder benefits. COB regulations determine which insurer has primary responsibility for payment and pays first, and which insurer has secondary responsibility for any charges not covered by the primary plan.

- **Copayment (copay)** – A set amount you pay when you get certain mental health or substance use disorder services.

- **Cost-Sharing** -- The amount you pay for the cost of services. This includes any applicable copays, co-insurance, and deductibles.

- **Covered Services** – Services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance use disorder. Covered services are described in “What This Plan Pays”. The items under “What’s Not Covered – Exclusions” are not covered services.
• **Deductible** – A set amount you pay for certain mental health and substance use disorder services each plan year before Beacon starts paying for those services. Your deductible starts on July 1 each year.

• **Intermediate Care** – Care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. This includes, but is not limited to, partial hospitalization programs and acute residential withdrawal management.

• **In-network Provider** – A provider who participates in the Beacon network.

• **Member** – A person who is enrolled in this plan through the Group Insurance Commission.

• **Non-Routine** - Specialty services that require prior authorization. Non-routine services include:
  - Individual/family outpatient therapy visits (including therapy conducted in conjunction with medication visits) beyond 26 visits per member in a year.
  - Intensive outpatient treatment programs provided by a non-Massachusetts DPH-licensed provider.
  - Electroconvulsive treatment (ECT)
  - Psychological testing
  - Neuropsychological testing for a mental health condition
  - Applied Behavior Analysis (ABA)
  - Transcranial Magnetic Stimulation (TMS)
  - Acupuncture withdrawal management provided by a non-Massachusetts DPH-licensed provider
  - Ambulatory withdrawal management provided by a non-Massachusetts DPH-licensed provider
  - Community support programs
  - Day treatment
  - Dialectical Behavioral Therapy (DBT)
  - Enrollee Assistance Program (EAP)
  - Family stabilization team (FST)
  - Psychiatric visiting nurse services

• **Out-of-Network Provider** – A provider who does not participate in the Beacon network.

• **Out-of-Pocket Limit** – The maximum amount you will pay in coinsurance, deductibles, and copays for your medical, mental health, and substance use disorder care in one plan year. When you have met your out-of-pocket limit, all care will be covered at 100% of the allowed amount until the end of the year. This limit does not include charges for out-of-network care that exceeds the maximum number of covered days or visits, charges for care that is not a covered service, and charges in excess of Beacon’s allowed amounts.

• **Prior authorization** – The process of contacting Beacon prior to seeking non-routine mental health or substance use disorder care, or for a referral to Enrollee Assistance Program (EAP) services. All prior authorization is performed by Beacon clinicians.

• **Routine Services** -- A customary service that does not require prior authorization. Routine services include outpatient therapy (individual/family and telehealth counseling) up to 26 visits per member in a year, including therapy done in conjunction with medication management visits; group therapy of 45 to 50 minutes in duration; medication management and telehealth medication management; methadone maintenance; in-network urine drug screening as a medically necessary part of substance use disorder treatment; and emergency service programs (ESP). Outpatient therapy visits over 26 per year are considered non-routine and require prior authorization.
Filing Claims

In-network providers and facilities will file your claim for you. You are financially responsible for in-network copays. Out-of-network providers are not required to process claims on your behalf; you may have to submit the claims yourself. You are responsible for all deductibles, copays, and coinsurance. If you are required to submit the claim yourself, you can send completed CMS 1500 claim form, along with the out-of-network provider’s itemized bill, with your name, address and GIC ID number to the following address:

Beacon Health Options
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801

You may also submit a claim for reimbursement through our online portal: mybeacon.beaconhs.com or on a completed Member Reimbursement claim form, along with proof of payment, to the following address:

Beacon Health Options
GIC Member Reimbursements
PO Box 527
Woburn, MA 01801

The CMS 1500 form is available from your provider or at beaconhealthoptions.com/gic. The Member Reimbursement claim form can be found at beaconhealthoptions.com/gic. Beacon must receive all claims within 24 months of the date of service for you or your dependents. You must have been eligible for coverage on the date you received care, and treatment must be medically necessary. All claims are confidential. Please note: if you choose to submit claims via the online portal, and you decide to change health plans, you will need to re-register on the portal with your new member ID.

Complaints

We encourage you to speak with a Beacon customer service representative if you are not satisfied with any aspect of our program. You can reach Beacon at 855-750-8980 (TTY: 711) Monday through Friday from 8 a.m. to 7 p.m., Eastern Time (ET). Beacon’s member services representatives can resolve most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at Beacon, including clinicians, claims representatives, administrators, and other managers who report directly to senior corporate officers. We will respond to all inquiries within three (3) business days.

We want to hear from you. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal written complaint within 60 days of the date of our telephone call or letter of response. Beacon will respond to all formal complaints in writing within 30 days.

To submit a formal written complaint regarding a mental health or substance use disorder concern, please contact:

Ombudsperson
Beacon Health Options
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801

Formal written complaints should include any information you feel is relevant. Please specify the dates of service and any additional contact you have had with Beacon.
Appeals

Your Right to an Internal Appeal
You, your treating provider or someone acting on your behalf, has the right to request an appeal of Beacon’s benefit decisions. You may request an appeal by following the steps below.

Note: If your care needs are urgent (meaning that a delay in making a treatment decision could significantly increase your health risks or affect your ability to regain maximum functioning), please see the section below titled “How to Initiate an Urgently Needed Determination (Urgent Appeal).”

How to Initiate a First Level Appeal (Non-Urgent Appeal)
Your appeal request must be submitted to Beacon within 180 calendar days of your receipt of the notice of the coverage denial.

Written requests should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801
855-750-8980 (TTY: 711)
Fax: 781-994-7636

Appeal requests must include:
• The member’s name and identification number
• The date(s) of service(s)
• The provider’s name
• The reason you believe the claim should be paid
• Any documentation or other written information to support your request for claim payment.

The Appeal Review Process (Non-Urgent Appeal)
If you request an appeal review of a denial of coverage, the review will be conducted by someone who was not involved in the initial coverage denial, and who is not a subordinate to the person who issued the initial coverage denial.

• For a non-urgent appeal review, a Beacon clinician will review the denial and notify you of the decision, in writing, within 15 calendar days of your request.
• For an appeal review of a denial of coverage that already has been provided to you, Beacon will review the denial and will notify you in writing of Beacon’s decision within 30 calendar days of your request.

You may bypass Beacon’s internal review process and request an external review by an independent review organization, which will review your case and make a final decision, if:
• Beacon exceeds the time requirements for making a determination and providing notice of the decision; or
• Beacon continues to deny the payment, coverage or service requested.

Independent External Review Process (Non-Urgent Appeal)
You have the right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

You, your provider or someone you consent to act for you (your authorized representative) can make this request. Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.
Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive, Suite 103
Woburn, MA  01801
855-750-8980 (TTY: 711)
Fax: 781-994-7636

Independent External Review requests must include:

- Your name and identification number
- The dates of service that were denied
- Your provider’s name
- Any information you would like to have considered, such as records related to your current treatment, co-existing conditions or any other relevant information you believe supports your appeal.

If you request an independent external review, Beacon will complete a preliminary review within five business days to determine if your request is complete and is eligible for an independent external review.

Additional information about this process, and your member rights and appeal information, is available at beaconhealthoptions.com/gic, or by speaking with a Beacon representative.

How to Initiate an Urgently Needed Determination (Urgent Appeal)

Generally, an urgent situation is one in which your health may be in serious jeopardy or your physician believes that a delay in making a treatment decision could significantly increase the risk to your health or affect your ability to regain maximum function. If you believe your situation is urgent, contact Beacon immediately to request an urgent review. If your situation meets the definition of urgent, the review will be conducted on an expedited basis.

If you are requesting an urgent review, you may also request that a separate urgent review be conducted at the same time by an independent third party. You, your provider, or someone you consent to act for you (your authorized representative) may request a review. Contact Beacon if you would like to name an authorized representative on your behalf to request a review of the decision.

For an urgent review, Beacon will make a determination and will notify you verbally and in writing within 72 hours of your request. If Beacon continues to deny the payment, coverage, or service requested, you may request an external review by an independent review organization that will review your case and make a final decision. This process is outlined in the "Independent External Review Process (Urgent Appeal)" section that follows.

Independent External Review Process (Urgent Appeal)

You have a right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

Requests can be made by you, your provider, or someone you consent to act for you (your authorized representative). Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive, Suite 103
Woburn, MA  01801
855-750-8980 (TTY: 711)
Fax Number: 781-994-7636
Independent External Review requests must include:

- Your name and identification number
- The dates of service that were denied
- Your provider’s name
- Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions or any other relevant information.

If you request an independent external review, Beacon will complete a preliminary review immediately for an urgent request to determine if your request is complete and is eligible for an independent external review.

You can find additional information about this process and your member rights and appeal information at beaconhealthoptions.com/gic. You can also call 855-750-8980 (TTY: 711) to speak with a Beacon representative.
Group Insurance Commission Notices
GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA
GENERAL NOTICE

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission’s (GIC’s) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called ‘Qualifying Events.’ If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC’s plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a “Qualified Beneficiary”) has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

• If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC’s health benefits program, you have the right to choose COBRA coverage if
  • You lose your group health coverage because your hours of employment are reduced; or
  • Your employment ends for reasons other than gross misconduct.

• If you are the spouse of an employee covered by the GIC’s health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as “qualifying events”):
  • Your spouse dies;
  • Your spouse’s employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
  • You and your spouse legally separate or divorce.

• If you have dependent children who are covered by the GIC’s health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as “qualifying events”):
  • The employee-parent dies;
  • The employee-parent’s employment is terminated (for reasons other than gross misconduct) or the parent’s hours or employment are reduced;
  • The parents legally separate or divorce; or
  • The dependent ceases to be a dependent child under GIC eligibility rules.
HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members’ COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured’s death or divorce - occurs during the 18 months of COBRA coverage. You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration’s disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:
- The COBRA cost is not paid in full when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary’s pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee’s coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.
 HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage.

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse’s plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

 HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

 HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. If you do not make your first payment for COBRA coverage within 45 days after the date you elect it, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but you are responsible for paying for the coverage even if you do not receive a monthly statement. Payments should be sent to the GIC’s address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.

 CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance ‘conversion’ policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth’s Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.
YOUR COBRA COVERAGE RESPONSIBILITIES

- You must inform the GIC of any address changes to preserve your COBRA rights;
- You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, your group health benefits coverage will end.
- You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:
  - The employee’s job terminates or his/her hours are reduced;
  - The insured dies;
  - The insured becomes legally separated or divorced;
  - The insured or insured’s former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.

If you have questions about COBRA coverage, contact the GIC’s Public Information Unit at 617/727-2301, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor’s Employee Benefits Security Administration’s website at www.dol.gov/ebsa or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov or, in Massachusetts visit, www.mahealthconnector.org.
Important Notice from the Group Insurance Commission (GIC) About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and your options under Medicare’s prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage — particularly which drugs are covered, and at what cost — with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NON-GIC MEDICARE PART D DRUG PLANS.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join A Medicare Part D Drug Plan?
You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Non-GIC Medicare Drug Plan?
- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at [www.socialsecurity.gov](http://www.socialsecurity.gov) or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with a GIC plan and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty)
as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage....
Contact the GIC at (617) 727-2310, extension 1. NOTE: You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for the telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as “protected health information” or “PHI”) includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information (“PHI”) in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.
Required Disclosures: The GIC must use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party “Business Associates” that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

• Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
• Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
• Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
• Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
• Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
• Receive notification of any breach of your unsecured PHI.
• Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617)-227-8583.
The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.

Service members who elect to continue their GIC health coverage are required to pay the employee’s share for such coverage.

Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

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

For more information about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.
If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial [1-877-KIDS NOW](tel:1-877-KIDS-NOW) or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call [1-866-444-EBSA](tel:1-866-444-EBSA) (3272).

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If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</td>
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<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
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<tr>
<td>COLORADO – Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHP+)</td>
<td>IOWA – Medicaid</td>
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<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a></td>
</tr>
<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
<td>Phone: 1-888-346-9562</td>
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<tr>
<td>CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus</td>
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<tr>
<th>KANSAS – Medicaid</th>
<th>NEW HAMPSHIRE – Medicaid</th>
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<tr>
<td>Phone: 1-785-296-3512</td>
<td>Phone: 603-271-5218</td>
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<tr>
<th>KENTUCKY – Medicaid</th>
<th>NEW JERSEY – Medicaid</th>
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<tr>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
</tr>
<tr>
<td>Phone: 1-800-635-2570</td>
<td>Medicaid Phone: 609-631-2392</td>
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<tr>
<td></td>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
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<td></td>
<td>CHIP Phone: 1-800-701-0710</td>
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<tr>
<th>LOUISIANA – Medicaid</th>
<th>NEW YORK – Medicaid</th>
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<tr>
<td>Website: <a href="http://dhls.louisiana.gov/index.cfm/subhome/1/n/331">http://dhls.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
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<tr>
<td>Phone: 1-888-695-2447</td>
<td>Phone: 1-800-541-2831</td>
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<tr>
<th>MAINE – Medicaid</th>
<th>NORTH CAROLINA – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a></td>
<td>Website: <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a></td>
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<tr>
<td>Phone: 1-800-442-6003</td>
<td>Phone: 919-855-4100</td>
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<tr>
<td>TTY: Maine relay 711</td>
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<tr>
<th>MASSACHUSETTS – Medicaid and CHIP</th>
<th>NORTH DAKOTA – Medicaid</th>
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<tr>
<td>Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a></td>
<td>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
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<tr>
<td>Phone: 1-800-462-1120</td>
<td>Phone: 1-844-854-4825</td>
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<tr>
<th>MINNESOTA – Medicaid</th>
<th>OKLAHOMA – Medicaid</th>
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<tr>
<td>Website: <a href="http://mn.gov/dhs/people-weserve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp">http://mn.gov/dhs/people-weserve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp</a></td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
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<tr>
<td>Phone: 1-800-657-3739</td>
<td>Phone: 1-888-365-3742</td>
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<tr>
<th>MISSOURI – Medicaid</th>
<th>OREGON – Medicaid</th>
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<tr>
<td>Website: <a href="http://dss.mo.gov/mhd/participants/pages/hipp.htm">http://dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
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<td></td>
<td>Phone: 1-800-699-9075</td>
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<tr>
<th>MONTANA – Medicaid</th>
<th>PENNSYLVANIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP</a></td>
<td>Website:<a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a></td>
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<tr>
<td>Phone: 1-800-694-3084</td>
<td>Phone: 1-800-692-7462</td>
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<tr>
<td>State</td>
<td>Medicaid Website</td>
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<tr>
<td>NEBRASKA – Medicaid</td>
<td>Website: <a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a></td>
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<tr>
<td>RHODE ISLAND – Medicaid</td>
<td>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
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<tr>
<td>NEVADA – Medicaid</td>
<td>Medicaid Website: <a href="https://dwss.nv.gov/">https://dwss.nv.gov/</a></td>
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<tr>
<td>SOUTH CAROLINA – Medicaid</td>
<td>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
</tr>
<tr>
<td>SOUTH DAKOTA - Medicaid</td>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
</tr>
<tr>
<td>TEXAS – Medicaid</td>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
</tr>
<tr>
<td>WASHINGTON – Medicaid</td>
<td>Website: <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
</tr>
<tr>
<td>UTAH – Medicaid and CHIP</td>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
</tr>
<tr>
<td>WISCONSIN – Medicaid and CHIP</td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a></td>
</tr>
<tr>
<td>VERMONT – Medicaid</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
</tr>
<tr>
<td>WYOMING – Medicaid</td>
<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a></td>
</tr>
<tr>
<td>VIRGINIA – Medicaid and CHIP</td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)
PATIENT PROTECTION DISCLOSURE

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

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

You do not need prior authorization from Tufts Health Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or see our website at tuftshealthplan.com.
YOU ARE RECEIVING THIS NOTICE AS REQUIRED BY THE NEW NATIONAL HEALTH REFORM LAW (ALSO
KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

On January 1, 2014, the Affordable Care Act (ACA) will be implemented in Massachusetts and across the nation. The ACA will bring many benefits to Massachusetts and its residents, helping us expand coverage to more Massachusetts residents, making it more affordable for small businesses to offer their employees healthcare, and providing additional tools to help families, individuals and businesses find affordable coverage. This notice is meant to help you understand health insurance Marketplaces, which are required by the ACA to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. While you may or may not qualify for health insurance through the Massachusetts Health Connector, it may still be helpful for you to read and understand the information included here.

Overview: When key parts of the national health reform law take effect in January 2014, there will be an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: MAhealthconnector.org, or for non-Massachusetts residents, Healthcare.gov or (1-800-318-2596; TTY: 1-855-889-4325).

What is the Massachusetts Health Connector? The Health Connector is our state’s health insurance Marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state’s leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) Code.

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector begins Oct. 1, 2013, for coverage starting as early as Jan. 1, 2014. (And in future years, open enrollment will begin every Oct. 15.) You can find out more by visiting MAhealthconnector.org or calling 1-877-MA ENROLL (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector? Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting MAhealthconnector.org or calling 1-877-MA ENROLL (1-877-623-6765).

Does access to employer-based health coverage affect my eligibility for subsidized health insurance through the Health Connector? An offer of health coverage from the Commonwealth of Massachusetts, as the employer, could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- The Commonwealth of Massachusetts does not offer coverage to you, or
- The Commonwealth of Massachusetts offers you coverage, but:
  - The coverage the Commonwealth of Massachusetts provides you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or
The coverage the Commonwealth of Massachusetts provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs).

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by the Commonwealth of Massachusetts please note that you will lose the employer contribution (if any) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes. Health Connector premiums have different tax treatment.

As part of considering whether the ACA and Marketplaces will affect you as an employee it is important to understand what the Commonwealth of Massachusetts offers you.

- The Commonwealth offers benefited employees health coverage through the Group Insurance Commission. To be eligible for GIC health insurance, a state employee must work a minimum of 18 ¾ hours in a 37.5 hour workweek or 20 hours in a 40 hour workweek. The employee must contribute to a participating GIC retirement system, such as the State Board of Retirement, a municipal retirement board, the Teachers Retirement Board, the Optional Retirement Pension System for Higher Education, a Housing, Redevelopment Retirement Plan, or another Massachusetts public sector retirement system (OBRA is not such a public retirement system for this purpose). Visit [www.mass.gov/gic](http://www.mass.gov/gic) or see your GIC Coordinator for more information.

- Temporary employees, contractors, less-than-half time part time workers, and most seasonal employees are not eligible for GIC health insurance benefits. These employees may shop for health insurance through the Health Connector and may be eligible for advanced premium federal tax credits and/or state subsidies if their gross family income is at or below 400% Federal Poverty Level (which is approximately $46,000 for an individual and $94,000 for a family of four). Visit [www.MAhealthconnector.org](http://www.MAhealthconnector.org) or call 1-877-MA-ENROLL for more information.

If there is any confusion around your employment status and what you are eligible for, please email healthmarketplacenotice@massmail.state.ma.us or contact your HR department or GIC Coordinator.
ANTI-DISCRIMINATION NOTICE

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

Tufts Health Plan:

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

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

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

Tufts Health Plan
Attention: Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

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

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

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


tuftshealthplan.com | 800.462.0224
Index
This index lists the major benefits and limitations of the Navigator plan. Of course, it does not list everything in this Member Handbook. To fully understand all benefits and limitations, a Member must read through this Member Handbook carefully.

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