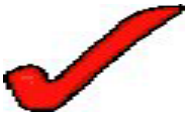
Tufts Medical Center

Exclusive Provider Option Select Network

Description of Benefits



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

This is a *Tufts Health Plan* EPO Select Network Option. This *Plan* has a limited network of *Providers* and is available in Massachusetts in Barnstable, Bristol, Essex, Franklin, Hampshire, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties, and additional *Providers* in New Hampshire and Rhode Island.

With Administrative Services Provided by

TUFTS Health Plan

1 Wellness Way
Canton MA 02021

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE

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

This health plan **meets Minimum Creditable Coverage standards** that were effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

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

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

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN
1 Wellness Way
Canton, Massachusetts 020210

Member Service Hours:
Monday through Thursday 8:00 am - 7:00 pm EST
Friday 8:00 am - 5:00 pm EST

IMPORTANT PHONE NUMBERS:

Emergency Care

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

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

Liability Recovery

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

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

Member Services Department

Call the *Tufts HP* Member Services Department at 1-800-462-0224 for general questions, assistance in choosing a *Primary Care Provider* (*PCP*), benefit and information regarding eligibility and billing . For help finding a *Tufts HP Provider*, call Member Services and follow the appropriate prompts. Our Member Services team can help you find a *Tufts HP Provider* who is appropriate for your age, condition and type of treatment.

Behavioral Health and Substance Use Disorder Services

If you need assistance locating a *Provider* finding information about your behavioral health/substance use disorder benefits, please contact Modern Assistance Program at 1-800-878-2004. This program is not administered by *Tufts Health Plan*.

Services for Hearing Impaired *Members*

If you are hearing impaired, the following services are provided:

Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call 711. You will reach the *Tufts HP* Member Services Department.

Massachusetts Relay (MassRelay)

711

Fraud, Waste and Abuse

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

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

Appeals and Grievances Department

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

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

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

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Website

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

Treatment Cost Estimator

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

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

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

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

For no cost translation in English, call the number on your ID card.

Arabic للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك.

Chinese 若需免費的中文版本，請撥打 ID 卡上的電話號碼。

French Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

Greek Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτας σας.

Haitian Creole Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

Japanese 日本語の無料翻訳については ID カードに書いてある番号に電話してください。

Khmer (Cambodian) សម្រាប់សេវាបកប្រែជាភាសាខ្មែរដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅកាន់លេខដែលមានៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

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

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

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

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

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

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

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

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

Telecommunications Device for the Deaf	711
MassRelay	711

Plan Information

***Plan* Name**	Tufts Medical Center Select Staff EPO Plan
Employer	Tufts Medical Center
Employer Address	750 Washington Street, MC Box 860, Boston MA 02111
Employer's ID Number (EIN)	97-1030123738
***Plan* Number**	10011-000
***Tufts Health Plan* Effective Date**	This *Plan* became effective as of January 1, 2021.
***Description of Benefits* Effective Date**	This *Description of Benefits* is effective January 1, 2022. It may be amended in accordance with Chapter 7.
***Plan* Year**	January 1 – December 31
Benefit Year	January 1 – December 31
***Plan Administrator* and Agent for Service of Legal Process**	Tufts Medical Center
Type of *Plan*	Medical Benefits.
***Plan* Administration**	The *Plan* is administered by the *Plan Administrator*. The cost of medical benefits is the responsibility of the Sponsor under a self-funded arrangement.
Collective Bargaining Agreement	The health benefits option under the *Plan* described in this *Description of Benefits* is not maintained pursuant to a collective bargaining agreement.
***Plan* Fiscal Year**	The fiscal records of the *Plan* are kept on a plan year basis ending on each December 31st.
Loss of Benefits	The Sponsor may terminate the *Plan* at any time, or may modify, amend, or change the provisions, terms and conditions of the *Plan*. No consent of any participant or *Member* shall be required to terminate, modify, amend or change the *Plan*.
Employee Contribution to Benefits	Benefits for employee only: • The employee is required to contribute to the cost of benefits. Benefits for employee and *Dependents*: • The employee is required to contribute to the cost of benefits.

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Benefit Overview

This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COPAYMENTS

- ***Emergency* Care:**
  - Emergency room…….. $150 *Copayment* applies per visit.

  Notes:
  - An Emergency room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.
  - *A Day Surgery Copayment* may apply if *Day Surgery* services are received.
- **Other *Covered Services*:**
  - Office Visit to *PCP*…… $20 *Copayment* applies per visit.
  - Office Visit to any other *Provider*…… $20 *Copayment* applies per visit.
  - Visit to a *Free-Standing Urgent care Center*…… $25 *Copayment* applies per visit.
  - *Inpatient* Services……*Deductible* and then $250 *Copayment* applies per visit.
  - *Day Surgery*……*Deductible* and then $250 *Copayment* applies per visit.

Notes: In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, preventive care visits, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription - are now covered in full. For more information on what services are now covered in full, please see **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services**. If you have any questions about whether specific services are considered preventive under the ACA, please call Member Services.

Diagnostic *Outpatient* services rendered in conjunction with a routine physical examination (i.e., a preventive care visit) may be subject to *Cost Sharing Amounts*. For example, diagnostic testing and diagnostic laboratory tests provided during a preventive care visit are covered as described under "Diagnostic testing" and "Laboratory tests" below.

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

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

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

- type of *Provider (PCP* vs. *Specialist*);
- location where services are provided (for example, *Provider's* office, *Limited Service Medical Clinic*, *Free-standing Urgent Care Center*, or Emergency room);
- and any additional Diagnostic *Outpatient* services provided during the visit. Such services including but are not limited to laboratory tests, x-rays, or *Durable Medical Equipment* may be subject to separate *Cost Sharing Amounts* (see the Benefit Overview.) For more information, please call Member Services.

Benefit Overview

This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

DEDUCTIBLE

The *Deductible* is the amount you and the enrolled *Members* of your family must pay each year for certain *Covered Services* at the *Authorized Level of Benefits* before payments are made under this *Certificate*.

The *Deductible* applies to all *Covered Services* at the *Authorized Levels of Benefit* except as listed below. The minimum *Deductible* dollar amount is adjusted each year to meet Internal Revenue Service requirements.

The amount of the *Deductible* which applies to each individual *Member* in each *Benefit Year* is $200 per person.

The amount of the *Deductible* which applies to you and the enrolled *Members* of your family (if applicable) each *Benefit Year* is: $400 per family.

***Please note:**

- The Family *Deductible* is satisfied with any combination of *Deductible* payments for *Covered Services* for any enrolled *Members*. If any enrolled *Member* in a family meets the Individual *Deductible* before the Family *Deductible* is met, then coverage will begin for that *Member*: (1) subject to any other *Cost Sharing Amounts* that may apply; and (2) any such cost sharing will not count toward the Family *Deductible*.

Please note:

- **The following amounts do not count towards your *Deductible*:**
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*. This includes prescription drugs and pediatric dental care because coverage is not provided by the *Plan*.
  - Costs in excess of the *Reasonable Charge*.

Benefit Overview

This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

OUT-OF-POCKET MAXIMUM

This *Description of Benefits* has an individual *Out-of-Pocket Maximum* of $2,500 per *Member* per calendar year for all *Covered Services*. *Copayments* and *Coinsurance* count towards the *Out-of-Pocket Maximum*.

Your family (both *Subscriber* and *Dependents* covered) *Out-of-Pocket Maximum* is $5,000 per family per calendar year.

Note: Under a family plan,

- any combination of enrolled *Members* in a family can contribute toward meeting the Family *Out-of-Pocket Maximum*. Once the Family *Out-of-Pocket Maximum* is met during a calendar year, we begin to pay for *Covered Services* for all enrolled *Members* in a family under the terms of this *Description of Benefits*. If any enrolled *Member* in a family meets the Individual *Out-of-Pocket Maximum* before the Family *Out-of-Pocket Maximum* is met, then: (1) that *Member* has met his/her *Out-of-Pocket Maximum* requirement; and (2) we will begin to pay for his/her *Covered Services*, subject to the terms of this *Description of Benefits*.

The following amounts do not count towards your *Out-of-Pocket Maximum*:

- Any amount you pay for services, supplies, or medications that are not *Covered Services*. This includes prescription drugs because this coverage is not provided through *Tufts Health Plan*.
- Costs in excess of the *Reasonable Charge*.

Important Note about your coverage under the Affordable Care Act ("ACA"): Under the ACA, preventive care services -- including women's preventive health services, preventive care visits, -- are now covered in full. These services are listed in the following "Benefit Overview". For more information on what services are now covered in full, please see the website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services.**

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
Emergency Care	
Treatment in an Emergency room	$150 *Copayment* per visit. (waived if admitted as an *Inpatient,* or for *Day Surgery*) **Note:** *Observation* services will take an *Emergency* room *Copayment*.
Notes: • **A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* care is received. If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts HP* within 48 hours.** • **If you are admitted as an *Inpatient* after receiving *Emergency* care, please call *Tufts Health Plan* in order to have your *Emergency* room *Copayment* waived.** • **A *Day Surgery Cost Sharing Amount* may apply if *Day Surgery* services are received.**	

COVERED SERVICE	YOUR COST
***Outpatient* Care**	
Allergy testing and treatment	*Deductible* and then covered in full. **Note:** You may be charged an Office Visit Copayment when these services are provided in conjunction with an office visit.
Allergy injections	$20 *Copayment* applies per visit.
Autism spectrum disorders – diagnosis and treatment **(AR)**	***Habilitative* or rehabilitative care (including applied behavioral analysis);** • When provided by a *Paraprofessional*: $20 *Copayment* per visit.. • When provided by a *Board-Certified Behavior Analyst (BCBA)*: $20 *Copayment* per visit. • When provided by a licensed physical or occupational therapist: $25 *Copayment* per visit. • When provided by a licensed speech-language therapist or audiologist: $25 *Copayment* per visit. **Psychiatric and psychological care:** Covered as described under "Behavioral Health/Substance Use Disorder Services".
Cardiac rehabilitation	$20 Office Visit *Copayment* per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider*.
Chemotherapy administration **Note:** For information about your coverage for the medications used in chemotherapy, please see "Injectable, infused or inhaled medications" later in this "Benefit Overview".	*Deductible* and then covered in full.

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Chiropractic care See "Spinal manipulation"	
Cleft lip and cleft palate treatment and services for *Children.* See "Cleft lip and cleft palate treatment and services for *Children"* under "Other Health Services" later in this table.	
Colonoscopies See "Diagnostic or preventive screening procedures" later in this table.	
Diabetes self-management training and educational services	$20 Office Visit *Copayment* per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider.*
Diagnostic Imaging **(AR)** • General imaging (such as x-rays and ultrasounds) and • MRI / MRA, CT/CTA, PET and nuclear cardiology	**General imaging:** *Deductible* and then covered in full. **MRI/MRA, CT/CTA, PET, and nuclear cardiology:** *Deductible* and then $200 *Copayment* per visit. Note: *Cost Sharing Amounts* for diagnostic imaging, (except for general imaging) will be covered in full when the imaging is required as part of an active treatment plan for a cancer diagnosis. Please contact Member Services for more information.
Diagnostic or preventive screening procedures (for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies) **(AR)**	**Screening for colon or colorectal cancer in the absence of symptoms, with or without surgery:** Covered in full. **Diagnostic procedure only (for example, colonoscopies associated with symptoms):** *Deductible* and then covered in full. **Diagnostic or preventive screening procedure accompanied by treatment/surgery (for example, polyp removal):** *Deductible* and then $250 *Copayment* per visit.
Diagnostic testing **(AR)**	*Deductible* and then covered in full.
Early intervention services for a *Dependent Child* from birth until their third birthday	Covered in full.
Family planning (procedures, services, and contraceptives) Note: Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full. To determine whether a specific family planning service is covered in full or subject to a *Cost Sharing Amount,* please see https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services or call Member Services.	Office Visit: $20 Office Visit *Copayment* per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider.* *Day Surgery: Deductible* and then $250 *Copayment.*
Hemodialysis	*Deductible* and then covered in full.
Human leukocyte antigen (HLA) testing	*Deductible* and then covered in full.
Immunizations and vaccinations	Covered in full.

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer.* Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Infertility services **(AR)**	$20 Office Visit *Copayment* per visit to PCP. $25 Office Visit *Copayment* per visit to any other Provider. Note: Approved Assisted Reproductive Technology services are subject to a *Deductible* and then $250 *Copayment*
Laboratory tests **(AR)** Note: In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full.	*Deductible* and then covered in full.
Lead screenings	Covered in full.
Mammograms	**Routine mammograms:** Covered in full. **Diagnostic mammograms:** *Deductible* and then covered in full.
Maternity care **Notes:** • In accordance with the ACA, routine laboratory tests associated with maternity care are covered in full. *Member* cost-sharing will apply to diagnostic tests or diagnostic laboratory tests when they are ordered during a routine maternity care visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services.	**Routine maternity care:** Covered in full. **Non-routine maternity care:** $20 *Copayment* applies per visit to PCP. $25 Office Visit *Copayment* per visit to any other Provider.
Nutritional counseling **Note:** Nutritional services are covered in full when they are provided as preventive services, as defined by the U.S. Preventive Services Task Force, Please see "Nutritional counseling" in Chapter 3 for more information.	**Preventive nutritional counseling:** Covered in full **All other nutritional counseling:** $20 Office Visit *Copayment* per visit to *PCP.* $25 Office Visit *Copayment* per visit to any other *Provider.*
Office visits to diagnose and treat illness and injury **Note:** This includes consultations, and visits at a *Limited Service Medical Clinic*.	$20 Office Visit *Copayment* per visit to *PCP.* $25 Office Visit *Copayment* per visit to any other *Provider.*
Oral Health Services **(AR)**	**Office Visit**: Please see "Surgery in a *Provider's* office", below. **Emergency room:** $150 *Copayment* applies per visit. ***Inpatient* Services:** *Deductible* and then $250 *Copayment: Deductible* and then $250 *Copayment.* (subject to *Day Surgery Copayment* Maximum).
Pap smears	**Routine annual pap smears:** Covered in full. **Diagnostic pap smears:** *Deductible* and then covered in full.

*A free-standing imaging center is a facility not affiliated with a hospital or a hospital system.
(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer.* Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions.	$20 Office Visit *Copayment* per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider*.
Preventive health care for *Members* under age 6 Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an Office Visit *Copayment Member* cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	Covered in full.
Preventive health care for *Members* age 6 and older Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an Office Visit *Copayment*. *Member* cost-sharing will also apply to diagnostic tests or laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	Covered in full.
Radiation therapy **(AR)**	*Deductible* and then covered in full.
Respiratory therapy/pulmonary rehabilitation services	*Deductible* and then covered in full.
Rehabilitative and *Habilitative* physical and occupational therapy services **(AR) (BL)** **Note:** Visit limits do not apply to the treatment of autism spectrum disorders.	**Physical Therapy:** $25 Office Visit *Copayment* per visit. **Occupational Therapy:** $25 Office Visit *Copayment* per visit.

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Routine annual gynecological exam	Covered in full. Notes: • Any follow-up care determined to be *Medically Necessary* as a result of a routine annual gynecological exam is subject to an Office Visit *Copayment*. • *Member* cost-sharing will also apply to diagnostic tests or laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.
Smoking cessation counseling services	Covered in full.
Speech, hearing, and language disorder treatment **(AR)**	$25 Office Visit *Copayment.* Note: *Cost Sharing Amounts* for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).
Spinal manipulation **(BL)**	$20 Office Visit *Copayment* per visit.
Surgery in a *Provider's* office	$20 Office Visit *Copayment* per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider.*
Telemedicine services obtained through a *Tufts HP Provider.*	$20 Office Visit Copayment per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider.*

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer.* Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Outpatient* Care, continued**	
Urgent Care	
In a *Provider's* office	$20 Office Visit *Copayment* per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider*.
In a *Limited Service Medical Clinic*	$20 Office Visit *Copayment* per visit.
In a *Free-standing Urgent Care Center*	$25 Office Visit *Copayment* per visit.
In a hospital-based *Outpatient* walk-in clinic	$20 Office Visit *Copayment* per visit to *PCP*. $25 Office Visit *Copayment* per visit to any other *Provider*.
Routine eye exam **(BL)**	$20 Office Visit *Copayment* per visit.
Vision care services	
Other vision care services (non-routine services) **Note:** *Member* cost sharing will also apply to diagnostic tests or laboratory services when they are ordered during a visit for other vision care services. Please see "Diagnostic testing" and "Laboratory tests" for information about your *Cost Sharing Amounts* for these services.	$25 Office Visit *Copayment* per visit. **Note:** One pair of eyeglass lenses and standard frames following cataract surgery or other surgery to replace the natural lens of the eye are covered in full. See Chapter 3 for more information.
Day Surgery	
Day Surgery facility services **(AR)**	*Deductible* and then $250 *Copayment* per visit.
Physician surgical & medical services	*Deductible* and then covered in full.

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
***Inpatient* Care**	
Physician surgical & medical	*Deductible* and then covered in full.
Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants **(AR)**	*Deductible* and then $250 *Copayment* applies per admission.
Cleft lip and cleft palate treatment and services for *Children* See "Cleft lip and cleft palate treatment and services for *Children*" under "Other Health Services" later in this table.	
Extended care **(AR) (BL)**	*Deductible* and then covered in full.
Gender reassignment surgery **(AR)**	***Inpatient* care:** *Deductible* and then $250 *Copayment* applies per admission. ***Day Surgery*:** Covered as described under "*Day Surgery"* above. ***Outpatient* medical care:** Covered as described under "Office visits to diagnose and treat illness or injury" above. **Behavioral Health care:** Covered as described under "Behavioral Health and Substance Use Disorder services" below.
Hospital *Inpatient* care (acute care) facility services **(AR)**	*Deductible* and then $250 *Copayment* applies per visit.
Maternity care	*Deductible* and then $250 *Copayment* applies per visit.
Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases and conditions	*Deductible* and then $250 *Copayment* applies per visit
Reconstructive surgery and procedures **(AR)**	*Deductible* and then $250 *Copayment* applies per visit.

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer.* Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
Behavioral Health and Substance Use Disorder Services To contact our Behavioral Health Department, call 1-800-208-9565. **(See "Benefit Limits" and Chapter 3 for visit, day, and dollar limits)**	
Outpatient services*	$20 *Copayment* applies per office visit.
Medication assisted treatment, including methadone maintenance	$5 *Copayment* applies per office visit.
Inpatient services including *Medically Necessary* treatment in a behavioral health residential treatment facility **(AR)**	*Deductible* and then $250 *Copayment* applies per visit.
Medically Necessary treatment in a behavioral health residential treatment facility **(AR)**	*Deductible* and then covered in full.
Intermediate care **(AR)**	*Deductible* and then covered in full.

COVERED SERVICE	YOUR COST
Other Health Services	
Ambulance services **(AR)**	Covered in full.
Cleft lip and cleft palate treatment and services for *Children*	**Medical or facial surgery:** • *Inpatient* services: Covered as described under "Hospital services (acute care)" or "Reconstructive surgery and procedures". • *Day Surgery*: Covered as described under "*Day Surgery*". **Oral surgery:** Covered as described under "Oral Health Services". **Dental surgery or orthodontic treatment and management:** Covered in full. **Preventive and restorative dentistry:** Covered in full (see "Cleft lip and cleft palate treatment and services for *Children*" in Chapter 3 for more information about what is covered under this benefit). **Speech therapy and audiology services:** Covered as described under "Speech, hearing, and language disorder treatment". **Nutrition services:** Covered as described under "Nutritional counseling".

*Certain *Outpatient* behavioral health and substance use disorder services may require approval by an *Authorized Reviewer*. Please see "Behavioral Health and Substance Use Disorder Services" in Chapter 3 or contact the Behavioral Health Department for more information.

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this *Plan*. Please see the table below and the "Benefit Limits" section for detailed explanations, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST
Other Health Services	
Diabetic monitoring strips **(BL)**	Covered in full up to 100 strips per 30-day supply (or more if *Medically Necessary*)
Durable Medical Equipment **(AR)**	*Deductible* and then 30% *Coinsurance*.
Hearing aids **(BL)**	**Hearing aids for *Children* age 21 and under:** *Deductible* and then 30% *Coinsurance*
Home health care **(AR)**	*Deductible* and then covered in full.
Hospice care **(AR)**	*Deductible* and then covered in full.
Injectable, infused or inhaled medications **(AR)**	*Deductible* and then covered in full.
Medical supplies **(AR)**	*Deductible* and then covered in full.
Prosthetic devices **(AR)**	*Deductible* and then 20% *Coinsurance*
Scalp hair prostheses or wigs for cancer or leukemia patients **(BL)**	*Deductible* and then covered in full.
Special formulas **(AR)**	
Low protein food **(AR) (BL)**	Covered in full.
Nonprescription enteral formulas **(AR)**	Covered in full.
Special medical formulas **(AR)**	Covered in full.
Prescription drugs are not covered as part of this *Plan*. Please contact Caremark customer service at 1-800-386-9404 or visit the website at www.caremark.com.	

(AR) – These services or certain services in this benefit class may require approval by an *Authorized Reviewer*. Your *Provider* will obtain this approval for you. Please see "*Authorized Reviewer* Approval" in Chapter 1 for more information.
(BL) – Benefit Limit applies. See "Benefit Limits" and "*Covered Services*" in Chapter 3 for more information.

Benefit Limits

Diabetic Monitoring Strips
Covered up to 100 strips per 30-day supply, or more if *Medically Necessary*.

Extended Care Services
Covered up to 100 days per calendar year.

Hearing Aids
Hearing aids for *Children* age 21 and under are covered up to $2,000 per ear every 36 months. This includes both the amount the *Plan* pays and the *Member's Cost Sharing Amount*.

Rehabilitative and *Habilitative* Physical and Occupational Therapy Services
The maximum benefit payable in each calendar year for rehabilitative physical therapy services is 30 visits.

The maximum benefit payable in each calendar year for *Habilitative* physical therapy services is 30 visits.

The maximum benefit payable in each calendar year for rehabilitative occupational therapy services is 30 visits.

The maximum benefit payable in each calendar year for *Habilitative* occupational therapy services is 30 visits.

Note: This benefit limit does not apply to the treatment of autism spectrum disorders or for physical or occupational therapy provided as part of home health care, as described in the "Home Health Care" benefit in Chapter 3.

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of $350 per calendar year

Spinal manipulation
The maximum benefit payable in each calendar year is 8 visits per person.

Chapter 1

How Your Exclusive Provider Option Plan Works

Overview

Introduction

This booklet contains your *Description of Benefits*. It describes the Tufts Medical Center Health Plan, which is referred to here as the "*Plan*." This is a self-funded plan, which means your employer is responsible for the cost of the *Covered Services* you receive under it. Italicized words are defined in the Glossary in Appendix A.

How the *Plan* works

The *Group* has contracted with *Tufts Health Plan* ("*Tufts HP*"). *Tufts HP* is a preferred provider organization and performs certain services for the *Plan*, such as claims processing and enrollment. *Tufts HP* also offers you access to a network of preferred providers known as *Tufts HP Select Network*.

The Exclusive Provider Option plan means that, except in an *Emergency*, all your health care must be provided or authorized by your *Tufts HP Primary Care Provider* (*PCP*). Your *PCP* will provide primary care to you or will refer you to the appropriate specialist within the Select network of *Providers*. If you choose on your own to receive care not provided or authorized by your *PCP*, no benefits will be paid by the *Plan* (except if the care was due to an *Emergency*).

About the *Tufts HP Select* Network

The *Tufts HP Select Network* of preferred *Providers* consists of hospitals, community-based physicians and other health care professionals who work out of their private offices throughout the *Tufts HP Service Area*.

Tufts HP enters into arrangements with these *Providers*, and they, in turn, provide you with *Covered Services*. This means that *Tufts HP* itself does not provide these services. *Tufts HP Select Network* are independent contractors and are not, for any purposes, employees or agents of the *Plan* or *Tufts HP*.

With the Exclusive Provider Option plan, you must choose a *PCP* from the searchable *Tufts HP Directory of Health Care Providers*. Your *PCP* will manage your care by providing you with primary care and will arrange for appropriate specialty care when necessary. (In the event you require *Inpatient* behavioral health or *Inpatient* substance use disorder services, you may go to any Designated Facility without authorization from your PCP. See "*Inpatient* and intermediate behavioral health/substance use disorder services" later in this chapter for more information.) Specialty care will be provided within the network of *Tufts HP Select Network*. In the rare instance when the care you need is not available within the *Tufts HP Select Network*, your *PCP*, after obtaining prior approval from an *Authorized Reviewer*, will refer you to a *Provider* not affiliated with *Tufts HP*.

Eligibility for Benefits

When you join the *Plan*, you agree to receive your care from *Tufts HP Select Network*. The *Plan* covers only the services and supplies described as *Covered Services* in Chapter 3.

There are no pre-existing condition limitations under this *Plan*. You are eligible to use your benefits as of your *Effective Date.*

In accordance with federal law (45 CFR § 148.180), *Tufts Health Plan* does not:

- adjust *Premiums* based on genetic information;
- request or require genetic testing; or
- collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

Calls to Member Services

The *Tufts HP* Member Services Department is committed to excellent service.

All calls are recorded for training and quality purposes.

This is a Tufts Health Plan EPO Select Network Option. This *Plan* has a limited network of Providers and is available in Massachusetts in Barnstable, Bristol, Essex, Franklin, Hampshire, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester Counties, and additional providers in New Hampshire and Rhode Island.

How the *Plan* Works

Primary Care Providers

Each *Member* must choose a *Primary Care Provider*. The *PCP* is responsible for providing or authorizing all of your health care services. If you do not choose a *PCP*, the *Plan* will not pay for any services or supplies except for *Emergency* care.

> **Note:** If you require non-emergency health care services, always call your *PCP*. Without authorization from your *PCP*, services will not be covered. Never wait until your condition becomes an *Emergency* to call.

Medically Necessary services and supplies

The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*.

Service Area (see Appendix A)

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

Provider network

Under *Tufts HP's* EPO Select Plan, we offer *Members* access to a select network of physicians, hospitals, and other *Providers* throughout the *Service Area*.

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

If you have any questions about the availability of a *Provider*, please call a Member Representative.

Coverage

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

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

Care that could have been foreseen before leaving the *Service Area* is not covered. This includes, but is not limited to:

- deliveries within one month of the due date, including postpartum care and care provided to the newborn *Child;* or
- long-term conditions that need ongoing medical care.

Emergency Care and *Urgent Care*

Emergency Care

Definition of *Emergency*: See Appendix A.
Follow these guidelines for receiving *Emergency* care

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.
- You do not need approval from your *PCP* before receiving *Emergency* care.
- If you receive *Outpatient Emergency* care at an emergency facility, you or someone acting for you should call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. You are encouraged to contact your *Primary Care Provider* so your *PCP* can provide or arrange for any follow-up care that you may need.
- If you receive *Emergency Covered Services* from a non-*Tufts Health Plan Provider,* the *Plan* will pay the *Provider* up to the *Reasonable Charge.* You will only be responsible for the applicable *Copayment*). You may receive a bill from the non-*Tufts Health Plan Provider*. If you receive a bill, please call Member Services or see "Bills from *Providers*" in Chapter 6 for more information on what to do if you receive a bill.

Urgent Care

Definition of *Urgent Care*: See Appendix A.
Follow these guidelines for receiving *Urgent Care*

Place of Service	*Tufts HP Provider*	Non-*Tufts HP Provider*/Inside of the *Service Area*	Non-*Tufts HP Provider*/Outside of the *Service Area*
Limited Service medical Clinic or *Free-Standing Urgent Care Center*	You are covered for *Urgent Care*. No referral is required.	You are covered for *Urgent Care* with a referral from your *PCP*.	You are covered for *Urgent Care*. No referral is required.
Emergency room	You are covered for *Urgent Care*. No referral is required.	You are covered for *Urgent Care*. No referral is required.	You are covered for *Urgent Care*. No referral is required.
Primary Care Provider's (*PCP's*) office	You are covered for *Urgent Care*. No referral is required.	Not applicable.	Not applicable.
Provider's office (non-*PCP*) or hospital-based walk-in clinic	You are covered for *Urgent Care* with a referral from your *PCP*.	You are covered for *Urgent Care* with a referral from your *PCP*.	You are covered for *Urgent Care*. No referral is required.
Behavioral Health/Substance Use *Provider's* office	You are covered for *Urgent Care*. No referral is required.	You are covered for *Urgent Care*. No referral is required.	You are covered for *Urgent Care*. No referral is required.

Behavioral Health/Substance Use Disorder Services

Inpatient and intermediate behavioral health/substance abuse

If *you* require *Inpatient* or intermediate behavioral health or substance use disorder services, *you* may go to any of *Tufts HP's Designated Facilities*. There is no need to contact *your PCP* first. Simply call or go directly to any one of the *Designated Facilities*. Identify *yourself* as a *Tufts HP Member*. The *Designated Facilities* are responsible for providing all *Inpatient* and intermediate behavioral health and substance use disorder services. For more information, please call the *Tufts HP* Behavioral Health Department at 1-800-208-9565.

The *Designated Facilities*

Some *Designated Facilities* provide services only to adult *Members* (age 16 and over) and other *Designated Facilities* provide services only to *Children* (under age 16).

Urgent Care, continued

"**If you are in the Standard or Extended *Service Area***

- You may seek *Urgent Care*: in your *PCP's* office; in a *Provider's* office; in an Emergency room; in a hospital-based *Outpatient* walk-in clinic; at a *Limited Service Medical Clinic* or at a *Free-Standing Urgent Care Center.* If you receive *Urgent Care* services in the Standard or Extended *Service Area* in a *Tufts HP Provider's* office or from a *Tufts HP Provider* in a hospital-based walk-in clinic, a referral is required from your *PCP*. A referral is not required for *Urgent Care* services in the Standard or Extended *Service Area* when provided by your *PCP*, in an emergency room, or in a *Limited Service Medical Clinic* or *Free-Standing Urgent Care Center* affiliated with *Tufts Health Plan*.
- If you receive *Urgent Care* services in the Standard or Extended *Service Area* in a Non-*Tufts HP Provider's* office, from a Non-*Tufts HP Provider* in a hospital-based walk-in clinic, or in a *Free-Standing Urgent Care Center* or *Limited Service Medical Clinic* that is not affiliated with *Tufts Health Plan*, a referral is required from your *PCP*.
- A referral is not required for *Urgent Care* services provided in an emergency room."

If you are outside the *Service Area*

- You may seek *Urgent Care* in a *Provider's* office, a *Free-Standing Urgent Care Center*, a hospital-based *Outpatient* walk-in clinic or the Emergency room.
- You do not need a referral from your *PCP* before receiving *Emergency* care or *Urgent Care.*

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

- If you are admitted as an *Inpatient* after receiving *Emergency* or *Urgent Care Covered Services*, you or someone acting for you must call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. (Notification from the attending physician satisfies this requirement.)
- If you receive *Urgent Care* outside of the *Service Area*, you or someone acting for you must contact your *PCP* to arrange for any necessary follow-up care.
- *Emergency* or *Urgent Care* services are covered, whenever you need it, anywhere in the world. Continued services after the *Emergency* or *Urgent* condition has been treated and stabilized may not be covered if we determine, in coordination with the *Member's Providers*, that the *Member* is safe for transport back into the *Service Area* and it is appropriate and cost-effective to transport the *Member* back into the *Service Area.*
- If you receive care from a non-*Tufts Health Plan Provider*, the *Plan* will pay the *Provider* up to the *Reasonable Charge*. You will only be responsible the *Copayment* and any difference between what we paid and what the non-*Tufts Health Plan Provider* charged for the service. You may receive a bill for these services. Please call Member Services or see "Bills from *Providers*" in Chapter 6 for more information on what to do if you receive a bill.

***Inpatient* Hospital Services**

- If you need *Inpatient* services, in most cases, you will be admitted to your *PCP's Tufts Health Plan Hospital.*
- Charges after the discharge hour: If you choose to stay as an *Inpatient* after a *Tufts Health Plan Provider* has scheduled your discharge or determined that further *Inpatient* services are no longer *Medically Necessary,* we will not pay for any costs incurred after that time.
- If you are admitted to a facility which is not the *Tufts Health Plan Hospital* in your *PCP's Provider Organization*, and your *PCP* determines that transfer is appropriate, you will be transferred to the *Tufts Health Plan Hospital* in your *PCP's Provider Organization* or another *Tufts Health Plan Hospital.* Important: We may not pay for *Inpatient* care provided in the facility to which you were first admitted after your *PCP* has decided that a transfer is appropriate and transfer arrangements have been made.

Continuity of Care

If you are an existing *Member*

If your *Provider* is disenrolled from *Tufts Health Plan* for reasons other than quality or fraud, you may continue to see your *Provider* for the following continuing care conditions for up to 90 days from the date we notify you of your *Provider's* termination, unless otherwise indicated below:

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

Note: Serious and Complex Condition means:

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

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

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

To choose a new *PCP*, call a Member Representative. The Member Representative will help you to select one. You can also choose a *PCP* from the searchable *Tufts Health Plan Directory of Health Care Providers* available on our website. You can also visit the *Tufts Health Plan* website to choose a *PCP*.

If you are enrolling as a new *Member*

When you enroll as a *Member*, you may continue to see your *Provider* if:

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

Conditions for coverage of continued treatment

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

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

About Your *Primary Care Provider*

Importance of choosing a *PCP*

Each *Member* must choose a *PCP* when he or she enrolls. The *PCP* you choose will be associated with a specific *Tufts HP Provider Organization*. This means that you will usually receive *Covered Services* from health care professionals and facilities associated with that *Tufts HP Provider Organization*.

Once you have chosen a *PCP*, you are eligible for all *Covered Services*.

IMPORTANT NOTE: Until you have chosen a *PCP*, only Emergency care is covered.

What a *PCP* does

A *PCP* provides routine health care (including routine physical examinations), arranges for your care with other *Tufts HP Select Network*, and provides referrals for other health care services, except for behavioral health and substance use disorder services. See "Behavioral health/substance use disorder services"" earlier in this chapter for more information about these services. Please note that *Outpatient* behavioral health/substance use disorder services do not require a referral.

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

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

Choosing a *PCP*

You must choose a *PCP* from the list of *PCPs* in the *Tufts HP Directory of Health Care Providers*. If you already have a *Provider* who is listed as a *PCP*, in most instances you may choose him or her as your *PCP*. Once you have chosen a *PCP* who is part of the *Tufts HP Select Network,* you must inform *Tufts HP* of your choice in order to be eligible for all *Covered Services.*

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

Notes:

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

Contacting your new *PCP*

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

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

If you can't reach your *PCP*

Sometimes you may not be able to reach your *PCP* by phone right away. If your *PCP* cannot take your call at once, always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call.

If you need medical services after hours, please contact your *PCP* or a *Covering Provider*. Your *PCP*, or a *Covering Provider*, is available 24 hours a day, 7 days a week. If you need *Inpatient* behavioral health or substance use disorder services after hours, please call Modern Assistance Program 1-800-878-2004 for assistance. This program is not administered by *Tufts Health Plan*.

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

Changing your *PCP*

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

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

Note: You may not change your *PCP* while you are an *Inpatient* or in a partial hospitalization program, except when approved by *Tufts HP* in limited circumstances.

Canceling appointments

If you must cancel an appointment with any *Provider*, always give as much notice to the *Provider* as possible (at least 24 hours). If your *Provider's* office charges for missed appointments that you did not cancel in advance, the *Plan* will not cover the charges.

Referrals for specialty services

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

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

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

Notes:

- A referral to a specialist must be obtained from your *PCP* **before** you receive any *Covered Services* from that specialist. If you do not obtain a referral **prior** to receiving services, you will be responsible for the cost of those services.
- *Covered Services* provided by non-*Tufts HP Select Network* are not paid for unless authorized in advance by your *PCP* and approved by an *Authorized Reviewer*.
- For *Outpatient* behavioral health and substance use disorder services, you do not need a referral from your *PCP*; however, you may need authorization for certain services from a *Tufts HP* Behavioral Health *Authorized Reviewer*. You may also need authorization from a *Tufts HP* Behavioral Health *Authorized Reviewer* for *Inpatient* behavioral health and substance use disorder services. See "*Inpatient* and intermediate behavioral health/substance use disorder services" and "*Outpatient* behavioral health/substance use disorder services" earlier in this chapter for more information.

Referral forms for specialty services

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

Authorized Reviewer approval

If the specialist refers you to a non-*Tufts HP Provider*, the referral must be approved by your *PCP* and an *Authorized Reviewer*. In addition, certain *Covered Services* described in Chapter 3 must be authorized in advance by an *Authorized Reviewer,* or for behavioral health and substance use disorder services*,* from a *Tufts HP* Behavioral Health *Authorized Reviewer.* If you do not obtain that authorization, the *Plan* will not cover those services and supplies.

When referrals are not required

The following *Covered Services* do not require a referral from your *Primary Care Provider.* You must obtain these services from a *Tufts HP Provider* in the Select Network except: (1) as listed in this chapter; (2) for *Urgent Care* outside of the *Service Area*; or (3) for *Emergency* care.

- *Urgent Care* within the *Service Area*, when received from your *PCP,* in an emergency room, or from a *Limited Service Medical Clinic* or *Free-Standing Urgent Care Center* that participates with *Tufts Health Plan.* **IMPORTANT NOTE:** A referral is required for coverage of *Urgent Care* services received within the *Service Area* at a *Limited Service Medical Clinic* or *Free-Standing Urgent Care Center* that is not affiliated with *Tufts Health Plan*. Additionally, *Urgent Care* services received within the *Service Area* in a *Provider's* office or hospital-based *Outpatient* walk-in clinic require a referral from your *PCP*. This includes services provided by both *Tufts HP Providers* and non-*Tufts HP Providers.*
- Mammograms at the following intervals:
  - one baseline at 35-39 years of age;
  - one every year at age 40 and older; or
  - as otherwise *Medically Necessary*.
- Pregnancy terminations.
- Routine eye exam
- Medical treatment received from a *Provider* of optometry services.
- *Outpatient* behavioral health/substance use disorder services.
- 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
- Spinal manipulation.
- The following specialty care provided by a *Tufts HP Provider* in the Select Network who is an obstetrician, gynecologist, certified nurse midwife, family practitioner, or any other licensed *Provider* offering these services within the scope of their license:
  - Maternity care.
  - *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions.
  - Routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Financial Arrangements between *Tufts HP* and *Tufts HP Select Network*

Methods of payment to *Tufts HP Select Network*

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

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

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

Member Identification Card

Introduction

Tufts HP gives each *Member* a member identification card (Member ID card).

Reporting errors

When you receive your Member ID card, check it carefully. If any information is wrong, call a Member Representative.

Identifying yourself as a *Tufts HP Member*

Your Member ID card is important because it identifies you as a *Tufts HP Member*. Please:

- carry your Member ID card at all times;
- have your Member ID card with you for medical, hospital and other appointments; and
- show your Member ID card to any *Provider* before you receive health care.

When you receive services, you must tell the office staff that you are a *Tufts HP Member*.

IMPORTANT NOTE: If you do not identify yourself as a *Tufts HP Member*, then
- the *Plan* may not pay for the services provided, and
- you would be responsible for the costs.

Membership requirement

You are eligible for benefits if you are a *Member* when you receive care. A Member ID card alone is not enough to get you benefits. If you receive care when you are not a *Member*, you are responsible for the cost.

Membership identification number

If you have any questions about your member identification number, please call Member Services.

Utilization Management

Introduction

This section describes *Tufts HP's* utilization management program.

Utilization management

Tufts HP has a utilization management program. This is employed to evaluate whether health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner.

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

Medical Necessity Guidelines are:

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

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

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

Prospective review is used to determine whether proposed treatment is *Medically Necessary* before that treatment begins. It is also referred to as "pre-service review".

Concurrent review is used to:

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

Retrospective review is used to evaluate the *Medical* Necessity of care after it has been provided. In some circumstances, *Tufts HP* engages in retrospective review to more accurately determine If a *Member's* health care services are appropriate . Retrospective review is also referred to as "post-service review".

TIMEFRAMES TO REVIEW YOUR REQUEST FOR COVERAGE

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

*Timeframes for determinations may be extended under certain circumstances.

***Note:**

- See "Processing of Plan Benefits" in Appendix B for determination procedures under the Department of Labor's (DOL) Regulations.

Utilization review helps *Members* in the following ways:

- Prospective and concurrent reviews let *Members* know if proposed health care services are *Medically Necessary* and covered under their plan. This allows *Members* to make informed decisions about their care.
- Utilization review can enhance the quality of care and convenience for the Member by evaluating if treatment is *Medically Necessary* and the most appropriate for the *Member*.
- By evaluating treatment cost effectiveness, *Member Cost Sharing Amounts* may be reduced.
- Helping to control overall plan costs plays an important part in making sure health care plans continue to be affordable.

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

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

IMPORTANT NOTE: Members can call *Tufts Health Plan* at the following numbers to determine the status or outcome of utilization review decisions:

- Behavioral health or substance use disorder utilization review decisions: Please contact Modern Assistance Program at 1-800-878-2004;
- All other utilization review decisions: Call Member Services.

Care Management

Some *Members* with Severe Illnesses or Injuries may warrant care management intervention under *Tufts HP's* case management program. Under this program, *Tufts HP*:

- encourages the use of the most appropriate and cost-effective treatment; and
- supports the *Member's* treatment and progress.

If a *Member* is identified by us as an appropriate candidate for care management or referred to the program, we may contact that *Member* and his or her *Tufts HP Provider* to discuss a treatment plan and establish prioritized goals. A *Tufts HP* Complex Care Manager may suggest alternative services or supplies available to the *Member*.

Tufts HP may periodically review the *Member's* treatment plan. *Tufts HP* will contact the *Member* and the *Member's Tufts HP Provider* if *Tufts HP* identifies alternatives to the *Member's* current treatment plans that:

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

A Severe Illness or Injury may include, but is 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.

Individual case management (ICM)

In certain circumstances, *Tufts HP* may authorize an individual case management ("ICM") plan for a *Member* with a Severe Illness or Injury who is already participating in the care management program. The ICM plan is designed to arrange for the most appropriate health care services and supplies for the *Member*.

As a part of the ICM plan, *Tufts HP* may authorize coverage for certain alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if *Tufts HP* determines, in its sole discretion, 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* to treat the *Member's* condition;
- the alternative services and supplies are provided directly to the *Member* with the condition;
- the alternative services and supplies are provided in place of or to prevent more expensive services or supplies that the *Member* otherwise might have occurred during the current episode if illness;
- the *Member* and an *Authorized Reviewer* agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

Tufts HP 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, *Tufts HP* may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan at our sole discretion. Please note that ICM plans are not used to authorized services or supplies that are specifically excluded under the *Member's* plan or that fall within the parameters of the Utilization Review program described above and do not meet the relevant *Medical Necessity* criteria for authorization.

Authorized Reviewer Approval

Prior approval by an *Authorized Reviewer* is required for certain *Covered Services*. *Covered Services* that may require this authorization are identified by **(AR)** in the "Benefit Overview".

If you receive these services from or authorized by your *Tufts HP PCP*, your *PCP* (or other *Tufts HP Provider*) is responsible for obtaining approval from the *Authorized Reviewer*.

For more information about *Authorized Reviewer* approval, please call Member Services.

If a request for coverage is denied, you have a right to appeal. Please see Chapter 7, "*Member* Satisfaction Process" for information on how to file an appeal.

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

Chapter 2

Eligibility, Enrollment and Continuing Eligibility

Eligibility

Waiting Period

The waiting period is the period of continuous full-time employment which you must serve with your employer before you are eligible for coverage under the *Plan*.

The waiting period chosen by your *Plan* is the first of the month of following your date of hire.

Eligibility rule

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

- meet the *Plan's* eligibility rules (including the requirement for minimum hours described below); and
- live, work, or reside in the *Service Area.**

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

- qualifies as a *Dependent*, as defined in this *Description of Benefits*;
- meets the *Plan's* eligibility rules; and
- lives, works, or resides in the *Service Area.**

*Note: *Children* are not required to maintain live, work, or reside in the *Service Area.* However, care outside the *Service Area* is limited to *Emergency* or *Urgent Care* only.

Minimum Hours

In order to be eligible for coverage under the *Plan*, *you* must work a minimum of 20 hours per week.

If *you* do not live, work, or reside in *Tufts HP's Service Area*

If *you* do not live, work, or reside in *Tufts HP's Service Area*, *you* can be covered only if:

- *you* are a *Child*;
- *you* are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced *Spouse* for whom coverage is required.

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

Proof of eligibility

Tufts HP may ask *you* for proof of *you* and *your Dependents*' eligibility or continuing eligibility. *You* must give *Tufts HP* proof when asked.

This may include proof of residence, marital status, birth or adoption of a *Child*, and legal responsibility for health care coverage.

Enrollment

When to enroll

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

- during the annual *Open Enrollment Period*; or
- within 30 days of the date *you* or *your Dependent* is first eligible for this coverage.

Note: If *you* fail to enroll for this coverage when first eligible, *you* may be eligible to enroll *yourself* and *your* eligible *Dependents*, if any, at a later date. This will apply only if *you*:

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

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

- *your* coverage under the other health coverage ends involuntarily;
- *your* marriage; or
- the birth, adoption, or placement for adoption of *your Dependent Child*.

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

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

Effective Date of coverage

If the *Plan* accepts your application and receives the needed contribution, coverage starts on the date chosen by your *Group*. Enrolled *Dependents'* coverage starts when the *Subscriber's* coverage starts, or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

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

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

Adding *Dependents*

When *Dependents* may be added

After *you* enroll, *you* may apply to add any *Dependents* who are not currently enrolled under the *Plan* only:

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

Adding *Dependents*, continued

How to add *Dependents*

Follow the steps in the table below to add *Dependents*.

Step	Action
1	Do *you* have *Family Coverage*? • If yes, go to the next step. • If no, ask *your Group* to change *your Individual Coverage* to *Family Coverage*.
2	Fill out either a group approved form or a *Tufts Health Plan* form listing the *Dependents*.
3	Give the form to *your Group* either: • during *your Group's Open Enrollment Period*, or • within 30 days after the date of an event listed above, under "When *Dependents* may be added."

Effective Date of *Dependents'* coverage

If the *Plan* accepts *your* application to add *Dependents*, the *Plan Administrator* will notify *you* of the *Effective Date* of each *Dependent's* coverage.

Effective Dates will be no later than:

- the date of the *Child's* birth, adoption or placement for adoption; or
- in the case of marriage or loss of prior coverage, the date of the qualifying event.

Availability of benefits after enrollment

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

Note: The *Plan* will only pay for Covered Services which are provided on or after *your Effective Date*.

Newborn *Children* and *Adoptive Children*

Introduction

This topic explains why it is very important to enroll and choose a *PCP* for newborn *Children* and *Adoptive Children*.

Importance of enrolling and choosing a *PCP* for newborn *Children* and *Adoptive Children*

You must enroll *your* newborn *Child* within 30 days after the *Child's* birth for the *Child* to be covered from birth. Otherwise, *you* must wait until the next *Open Enrollment Period* to enroll the *Child*. Choose a *PCP* for the newborn *Child* before or within 48 hours after the newborn *Child's* birth. That way, the *PCP* can manage *your Child's* care from birth.

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

How to choose a *PCP* for newborn *Children* and *Adoptive Children*

Follow the steps in the table below to choose a *PCP* for a newborn *Child* or *Adoptive Child*.

Step	Action
1	Choose a *PCP* from the list of *PCPs* in the searchable *Tufts HP Directory of Health Care Providers* (available on our website) or call a Member Representative for help.
2	Call the *Provider* and ask him or her to be the newborn or *Adoptive Child's PCP*.
3	If he or she agrees, call a Member Representative to report *your* choice.

Continuing Eligibility for *Dependents*

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

Coverage after termination
When a *Child* loses coverage under this *Description of Benefits*, he or she may be eligible for federal continuation coverage or to enroll in coverage under an individual contract. See Chapter 5 for more information.

How to continue coverage for *Disabled Dependents*
The *Subscriber* must follow the steps in the table below to continue coverage for a *Disabled Dependent*.

Step	Action
1	About 30 days before the *Child* no longer meets the definition of *Dependent*, call a Member Representative at **1-800-462-0224** or go to our website at **www.tuftshealthplan.com**for instructions on Step 2 below.
2	Give proof, acceptable to *Tufts HP*, of the *Child's* disability.

When coverage ends
Disabled Dependent coverage ends when:

- the *Dependent* no longer meets the definition of a *Disabled Dependent*, or
- the *Subscriber* fails to give *Tufts HP* proof of the *Dependent's* continued disability.

Coverage after termination
The former *Disabled Dependent* may be eligible for federal continuation coverage or to enroll in coverage under an individual contract. See Chapter 5 for more information.

Keeping the *Plan's* records current
You must notify the *Plan* of any changes that affect *you* or *your Dependents'* eligibility. Examples of these changes are:

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

Forms to report these changes are available from *your Plan Administrator*.

Chapter 3

Covered Services

Covered Services

When health care services are *Covered Services*

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

- listed as *Covered Services* in this chapter;
- *Medically Necessary*;
- 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 on our website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview** or by calling Member Services;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your *PCP*, except in an *Emergency* or for *Urgent Care* (see "When You Need *Emergency* or *Urgent Care*" earlier in this *Description of Benefits* for more information);
- approved by an *Authorized Reviewer*, in some cases; and
- in the case of *Inpatient* or intermediate behavioral health/substance use disorder services, provided or authorized by a *Designated Facility*.

***Authorized Reviewer* approval:** Certain *Covered Services* described in this chapter must be authorized in advance by an *Authorized Reviewer*. If such authorization is not obtained, you may be responsible for the full cost of those services and supplies .

Emergency care (no *PCP* referral required)

Notes:

- The Emergency room *Copayment* is waived if the Emergency room visit results in immediate *Inpatient, Observation* or for *Day Surgery.* If you are admitted as an *Inpatient* after receiving *Emergency* care, please call *Tufts Health Plan* in order to have your *Emergency* room *Copayment.*
- 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 only be responsible for the applicable *Copayment*. You may receive a bill for these services. Please call Member Services or see "Bills from *Providers*" in Chapter 6 for more information on what to do if you receive a bill.
- An Emergency room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.
- A *Day Surgery Cost Sharing Amount* may apply if *Day Surgery* services are received.

Outpatient care

Please note: The *Plan* covers services for pain management that are alternatives to opioids. Services include, but are not limited to:

- Physical therapy
- Spinal manipulation
- Nutrition counseling

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

Please note that prior approval for these services may be required. Please see the "Benefit Overview" to determine if these services require prior approval.

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

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

Autism spectrum disorders – diagnosis and treatment (prior approval by an *Authorized Reviewer* is required)
Coverage is provided for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of *Behavioral Health Disorders*, and include:

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

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

- *Habilitative* or rehabilitative care, which are professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA)* supervised by a *Board-Certified Behavior Analyst (BCBA)*. For more information about these programs, call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565. Prior approval by an *Authorized Reviewer* is required.
- services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers. **Note:** Visit limits for services described under the "Rehabilitative or *Habilitative* physical or occupational therapy" benefit do not apply to coverage for autism spectrum disorders. Prior approval by an *Authorized Reviewer* is required.
- psychiatric and psychological care, covered under your "Behavioral Health and Substance Use Disorder Services" benefit, described in Chapter 3;

*For the purposes for 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.

Cardiac rehabilitation services
Services for *Outpatient* treatment of documented cardiovascular disease that are initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

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

Note: The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.

Chemotherapy administration
For information about coverage for the medications used in chemotherapy, please see "Injectable, inhaled or infused medications" later in this chapter.

Outpatient care (continued)

Chiropractic care
See "Spinal manipulation".

Colonoscopies
See "Diagnostic or preventive screening procedures" later in this chapter.

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

Important Notes:

- The *Plan* will only cover these services when 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 later in this chapter.

Diagnostic imaging
Includes general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA and PET tests, and nuclear cardiology (may require the approval of an *Authorized Reviewer*).

Diagnostic or preventive screening procedures
Includes, but is not limited to: colonoscopies, sigmoidoscopies, and proctosigmoidoscopies (requires the prior approval of an *Authorized Reviewer*).

Diagnostic testing
Examples include, but are not limited to: ambulatory EKG testing, sleep studies (performed in the home or a sleep study facility), and diagnostic audiological testing. Prior approval by an *Authorized Reviewer* may be required. Please call Member Services with questions about specific tests.

Early intervention services for a *Dependent Child*
Services provided by early intervention programs. Early intervention services include, but are not limited to:

- occupational therapy;
- physical therapy;
- speech therapy;
- nursing care; and
- psychological counseling.

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

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

- Procedures
  - sterilization
  - pregnancy terminations (no *PCP* referral required)
- Services
  - medical examinations;
  - consultations;
  - birth control counseling; and
  - genetic counseling.
- Contraceptives
  - cervical caps;
  - Intrauterine devices (IUDs);
  - Implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants);
  - Depo-Provera or its generic equivalent; and
  - any other *Medically Necessary* contraceptive device that has been approved by the United States Food and Drug Administration*.

Hemodialysis
- *Outpatient* hemodialysis, including home hemodialysis; and
- *Outpatient* peritoneal dialysis, including home peritoneal dialysis.

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 Department of Public Health. Services may require the approval of an *Authorized Reviewer*.

Immunizations and vaccinations

Infertility services
Diagnosis and treatment of infertility* in accordance with applicable law.

(I.) Diagnosis of infertility: Diagnostic procedures and tests are covered when provided in connection with an infertility evaluation.

Treatment of infertility: Infertility is defined as the condition of a *Member* who has been unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35. Attempts at conception to satisfy the diagnosis of Infertility may be done naturally or through artificial insemination.

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

The following procedures are *Covered Services* when approved in advance by an *Authorized Reviewer* **for *Members* with a diagnosis of infertility** who also:
- are Massachusetts residents;
- meet our eligibility requirements, which are based on the *Member's* medical history; and
- meet the eligibility requirements of our contracting Infertility Services *Providers*.

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

A. Assistive Reproductive Technology ("ART") procedures, including:
- in-vitro fertilization (IVF) and/or embryo transfer;
- frozen embryo transfer (FET);
- gamete intra-fallopian transfer (GIFT);
- donor oocyte (DO/IVF);
- donor embryo/frozen embryo transfer (DE/FET);
- assisted hatching (AH);
- cryopreservation of embryos/blastocysts;
- cryopreservation of sperm; and
- cryopreservation of oocyte.

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

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

Note: Donor sperm is only covered when the partner has a diagnosis of male factor infertility. For more information, please call Member Services and see the *Medical Necessity* Guidelines on our website.

Infertility services, continued

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

NOTE: Oral and injectable drug therapies used in the treatment of infertility associated with the *Covered Services* above are considered *Covered Services* only when the *Member* is covered by a Prescription Drug Benefit and the *Member* has been approved for associated infertility services. If applicable, see *your* Prescription Drug Benefit section for *your Cost Sharing Amounts*.

Laboratory tests
Including, but not limited to: blood tests, urinalysis, throat cultures, glycosylated hemoglobin (HbA1c), genetic testing, and urinary protein/microalbumin and lipid profiles. Laboratory tests must be ordered by a licensed *Provider* and must be performed at a licensed laboratory.

Notes:
- Prior authorization is required for some laboratory tests. An example of this is genetic testing. For a complete list of laboratory tests subject to prior authorization, see the *Medical Necessity* Guidelines on our website.
- Please note that certain laboratory tests associated with routine preventive care are covered in full when billed in accordance with our Preventive Services Payment Policy. An example of this is the colorectal cancer screening test Cologuard. If a laboratory test is not billed according to this policy, it will be subject to the *Member Cost Sharing Amount* for "Laboratory tests" specified in the "Benefit Overview." For additional information on this policy, please see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services.**

Lead screenings

Mammograms
Covered at the following intervals (no *PCP* referral required):
- one baseline at 35-39 years of age;
- one every year at age 40 and older; or
- as otherwise *Medically Necessary.*

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

Note:
- Routine prenatal tests are covered in full, in accordance with the ACA. *Member* cost-sharing will apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of routine maternity care. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services.

Nutritional counseling

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

- When *Medically Necessary*, for the purpose of treating an illness. Please see "Nutritional Counseling" in the "Benefit Overview" for the applicable *Cost Sharing Amount*; or
- As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, and behavior change and counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full. **Note**: Weight loss programs and clinics are not covered.

Office visits to diagnose and treat illness or injury

Note: This includes *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions (no *PCP* referral required), consultations, and visits to a *Limited Service Medical Clinic*.

Oral health services

- *Emergency* care

  X-rays and *Emergency* oral surgery in an emergency room to temporarily stabilize damaged tissues or reposition sound, natural, and permanent teeth that have moved or have broken due to injury. You must receive this care within 48 hours after the injury. The injury must have been caused by a source outside the mouth.

  Note: The Emergency room *Copayment* is waived if the Emergency room visit results in immediate hospitalization and *Day Surgery*.

- Non-*Emergency* care

  Important Note:
  - **Prior approval by an *Authorized Reviewer* is required for all Non-*Emergency* oral health services performed in an *Inpatient* or *Day Surgery*.**

  The following services are covered in an *Inpatient* or *Day Surgery* setting. Prior approval by an *Authorized Reviewer* is required. Hospital/facility, *Provider*, and surgical charges are included.

  - Extraction of seven or more permanent teeth during one visit;
  - Surgical treatment of skeletal jaw deformities;
  - Surgical repair related to Temporomandibular Joint Disorder (TMJ);
  - Surgical removal of impacted or unerupted teeth when embedded in bone;
  - Surgical treatment of cleft lip or cleft palate for *Children* under the age of 18.

  In addition, surgical removal of impacted or unerupted teeth when embedded in bone is covered in an office setting without *Authorized Reviewer* approval.

  Please see instructions at the beginning of this chapter about how to view *Medical Necessity* Guidelines on our website. You may also call Member Services for more information.

Oral Health Services, (continued)

Important Notes:

- Please go to our website to view the complete guidelines for determining *Medical Necessity* for these services.
- Coverage does not apply to Non-*Emergency* oral health services provided by a dentist. *Members* must receive these services from an oral surgeon.
- X-rays performed in association with Non-*Emergency* oral health services are covered as described under "Diagnostic imaging."

Pap Smears

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

Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions
To the extent required by applicable law, patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions 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.

Preventive health care for *Members* under age 6

- preventive care services from the date of birth until age 6, including:
  - physical examination, including limited developmental testing with interpretation and report;
  - history;
  - measurements;
  - sensory screening;
  - neuropsychiatric evaluation; and
  - developmental screening and assessment at the following intervals:
    - 6 times during the first year after birth,
    - 3 times during the second year after birth, and
    - annually from age 2 until age 6.
- Coverage is also provided for:
  - hereditary and metabolic screening at birth;
  - appropriate immunizations and tuberculin tests;
  - hematocrit, hemoglobin, or other appropriate blood tests;
  - urinalysis as recommended by a *Tufts HP Provider*; and
  - newborn auditory screening tests, as required by applicable law.

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an Office Visit *Copayment*. *Member* cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.

Preventive health care for *Members* age 6 and older

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

Note: For more information on what services are covered in full, please see our website at

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an Office Visit *Copayment*. *Member* cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.

Radiation therapy (prior approval by an *Authorized Reviewer* is required)

Rehabilitative and *Habilitative* physical and occupational therapy services
(Services may require the approval of an *Authorized Reviewer*)
Rehabilitative physical and occupational services, including cognitive rehabilitation or cognitive retraining, are covered. Services include up to 2 evaluations per *Calendar Year.* These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness. For these services to be covered, *Tufts HP* must determine that the *Member's* condition is subject to significant improvement within a period of 60 days from the initial treatment as a direct result of these therapies.

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

Massage therapy may be covered as a treatment modality when administered as part of a physical therapy visit that is:

- provided by a licensed *Provider*; and
- in compliance with *Tufts Health Plan's Medical Necessity* guidelines,.

Note: Benefit limits do not apply to the treatment of autism spectrum disorders or for physical or occupational therapy provided in conjunction with a *Provider's* approved home health care plan.

Respiratory therapy and pulmonary rehabilitation services

Routine annual gynecological exam
Including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam (no *PCP* referral required).

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine annual gynecological exam is subject to an Office Visit *Copayment*. *Member* cost sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine gynecological exam. Please see "Diagnostic testing" and "Laboratory tests" for information on your *Cost Sharing Amounts* for these services, and see the website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.

Smoking cessation counseling services
Smoking cessation counseling sessions, including individual, group, and telephonic smoking cessation counseling services that:

- are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
- meet the requirements of the federal Affordable Care Act.

Speech, hearing, and language disorder treatment (Services may require the approval of an *Authorized Reviewer*)

Note: Short-term cognitive retraining or cognitive rehabilitation services are covered under this benefit only when provided to restore function lost or impaired as the result of an accidental injury or sickness. In order 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. Also, please note that *Cost Sharing Amounts* for the diagnosis of speech, hearing, and language disorders vary depending the service provided (e.g., x-rays, diagnostic testing, office visits).

Spinal manipulation
Manual manipulation of the spine (no *PCP* referral required).

Outpatient care, (continued)

Surgery in a *Provider's* office (Services may require the approval of an *Authorized Reviewer*)

Telemedicine services

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

When you obtain telemedicine services from a *Tufts HP Provider*, you will pay the same *Cost Sharing Amount* that applies to an office visit with that *Provider*. In addition, you will need to follow the same rules about referrals when you receive telemedicine services through *Tufts HP Providers*.

Additionally, at your choice, audio-only consultation services are available to you. If you access such audio-only consultation services, the same *Cost Sharing Amount* as indicated for "Telemedicine services" applies.

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

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

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

Urgent care

Services may be provided to you in a *Provider's* office, a *Limited Service Medical Clinic,* a hospital-based *Outpatient* walk-in clinic, a *Free-Standing Urgent Care Center*, or in an emergency room. See "*Emergency* and *Urgent Care*" earlier in this document for more information about referrals for these services.

Vision care services

- Routine eye examination: Coverage is provided for one routine eye examination every 12 months per calendar year (no *PCP* referral required). **Note:** You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network in order to obtain coverage for these services. Please go to our website or contact Member Services for more information. Except as described below, in order to be covered for services to treat a medical condition of the eye, you must obtain a referral from your *PCP* for services from a *Tufts HP Provider*.
- Other vision care services: Coverage is provided for eye examinations and necessary treatment of a medical condition (no *PCP* referral is required for medical treatment provided by an optometrist). Prior approval by an *Authorized Reviewer* may be required.

  Note: One pair of eyeglass lenses and standard frames will be covered following a *Member's* cataract surgery or other surgery to replace the natural lens of the eye, when the *Member* does not receive an intraocular implant. See "Benefit Overview" earlier in this document to determine the *Cost Sharing Amount* applicable to these lenses and frames.

Outpatient care, (continued)

Day Surgery

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

Note: Certain *Day Surgeries* require the prior approval of an *Authorized Reviewer*. Please contact Member Services for information about which *Day Surgeries* require this approval.

Inpatient care

Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants (must be approved by an *Authorized Reviewer*)

- Bone marrow transplants for *Members* diagnosed with breast cancer that has progressed to metastatic disease.
- Hematopoietic stem cell transplants and human solid organ transplants provided to *Members*. These services must be provided at a *Tufts HP* designated transplant facility. The *Plan* covers charges incurred by the donor in donating the stem cells or solid organ to the *Member*, but only to the extent that charges are not covered by any other health care coverage. This includes:
  - evaluation and preparation of the donor, and
  - surgery and recovery services when those services relate directly to donating the stem cells or solid organ to the *Member.*

  Notes:
  - The *Plan* does not cover donor charges of *Members* who donate stem cells or solid organs to non-Members.
  - The *Plan* covers a *Member's* donor search expenses for donors related by blood .
  - The *Plan* covers the *Member's* donor search expenses for donors not related by blood when *Medically Necessary*. These services are only covered to the extent that such services are not covered by any other plan of health benefits or health care coverage.
  - The *Plan* covers a *Member's* human leukocyte antigen (HLA) testing. See "*Outpatient* medical care" earlier in this chapter for more information.

Extended care (Extended care services require prior approval by an *Authorized Reviewer*)
In an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

- skilled nursing services;
- chronic disease services; or
- rehabilitative services.

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

- *Inpatient* services, including female to male or male to female gender reassignment surgery and related surgical procedures;
- *Day Surgery* for surgical procedures related to the female to male or male to female gender reassignment surgery. These services are covered as described under "*Day Surgery*" earlier in this chapter.
- *Outpatient* medical care (pre-operative 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 chapter.
- Behavioral health care services (pre-operative or post-operative) related to gender reassignment surgery or the gender reassignment process. These services are covered as described under "Behavioral Health and Substance Use Disorder Services" later in this chapter.

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

Hospital *Inpatient* care (Acute care)

- anesthesia;
- diagnostic tests and lab services;
- drugs;
- dialysis;
- intensive care/coronary care;
- nursing care;
- physical, occupational, speech, and respiratory therapies;
- *Provider's* services while hospitalized.
- radiation therapy;
- semi-private room (private room when *Medically Necessary*); and
- surgery (may require prior approval by an *Authorized Reviewer*).

Maternity care (no *PCP* referral required)

- hospital and delivery services, and
- well newborn childcare in hospital.

Includes *Inpatient* care in hospital for mother and newborn *Child* for at least:

- 48 hours following a vaginal delivery; and
- 96 hours following a caesarean delivery.

Notes:

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

Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions

To the extent required by applicable law, patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions are covered to the same extent as those *Inpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Reconstructive surgery and procedures

Coverage is provided for the cost of:

- services required to relieve pain or to restore a bodily function that is impaired as a result of a congenital defect (including treatment of cleft lip or cleft palate for *Children* under the age of 18), birth abnormality, traumatic injury, or covered surgical procedure (must be approved by an *Authorized Reviewer*);
- the following services in connection with mastectomy:
  - reconstruction of the breast affected by the mastectomy,
  - surgery and reconstruction of the other breast to produce a symmetrical appearance, and
  - prostheses* and treatment of physical complications of all stages of mastectomy (including lymphedema).

  *Breast prostheses are covered as described under "Prosthetic devices" later in this chapter.

Removal of a breast implant is covered when any one of the following conditions exists:

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

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

Notes:

- Cosmetic surgery is not covered.
- Except as described above in connection with a mastectomy or in connection with treatment of cleft lip or cleft palate for *Children* under the age of 18, *Authorized Reviewer* approval is required before you receive any reconstructive surgery or procedure (regardless of whether the procedure is authorized by your *PCP*).

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

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

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

Services to diagnose and treat *Behavioral Health Disorders* (including diagnosis, detoxification, and treatment of substance use disorders), given by the following *Tufts HP Providers*:

- psychiatrists;
- psychologists;
- licensed behavioral health counselors;
- licensed independent clinical social workers;
- licensed psychiatric nurses who are certified as clinical specialists in psychiatric and behavioral health nursing.

Notes:
- *Outpatient* treatment of substance use disorders includes methadone maintenance or methadone treatment related to chemical dependency disorders.
- Psychological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury" as described earlier in this chapter.
- **Prior authorization by a *Tufts HP* Behavioral Health *Authorized Reviewer* is required for psychological testing and neuropsychological assessment services.**

Inpatient and intermediate behavioral health and substance use disorder services for *Behavioral Health Disorders* (Authorization is required for these services.

See "*Inpatient* and intermediate behavioral health/substance use disorder services" in Chapter 1 for more information.)

- *Inpatient* behavioral health and substance use disorder services for *Behavioral Health Disorders* in a facility that is licensed as a*:*
  - a general hospital;
  - a behavioral health hospital, or
  - a substance use disorder facility;
  - Intermediate behavioral health and substance abuse services: *Medically Necessary* behavioral health and substance use disorder services that are more intensive than traditional *Outpatient* behavioral health and substance use disorder services, but less intensive than 24-hour hospitalization. Some examples of Covered intermediate behavioral health and substance use disorder services are:
    - level III community-based detoxification;
    - crisis stabilization;
    - partial hospital programs; and
    - intensive *Outpatient* programs.

Other Health Services

Ambulance services

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

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

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

The following services are covered for *Children* under the age of 18:

- **Medical and facial surgery:** Covered as described under "*Day Surgery*", "Hospital *Inpatient* care (acute care)", and "Reconstructive surgery and procedures" earlier in this chapter. This includes surgical management and follow-up care by plastic surgeons. Prior approval by an *Authorized Reviewer* is required.
- **Oral surgery:** Covered as described under "Oral health services" earlier in this chapter. This includes surgical management and follow-up care by oral surgeons.
- **Dental surgery or orthodontic treatment and management:** No referral is required from the *Child's PCP* for these services.
- **Preventive and restorative dentistry** to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy. No referral is required from the *Child's PCP* for these services.
- **Speech therapy and audiology services:** Covered as described under "Speech, hearing and language disorder treatment" earlier in this chapter. Prior approval by an *Authorized Reviewer* is required
- **Nutrition services:** Covered as described under "Nutritional counseling" earlier in this chapter.

Services must be prescribed by the treating physician or surgeon, and that *Provider* must certify that the services are *Medically Necessary* and are required because of the cleft lip or cleft palate.

Diabetic Monitoring Strips

The following diabetic monitoring strips for home use when ordered by a *Provider* in writing to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes:

- blood glucose monitoring strips;
- urine glucose strips;
- ketone strips.

Other Health Services, (continued)

Durable Medical Equipment

Equipment must meet the following definition of "*Durable Medical Equipment*".

Durable Medical Equipment is a device or instrument of a durable nature that:

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

In order to be eligible for coverage, the equipment must also be the most appropriate available amount, supply or level of service for the *Member* in question considering potential benefits and harms to that individual, as determined by *Tufts Health Plan*.

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

Note: Certain *Durable Medical Equipment* may require *Authorized Reviewer* approval.

Important Note: You may be responsible for paying towards the costs of *Durable Medical Equipment* covered under this *Plan*. To determine whether your *Durable Medical Equipment* is subject to a *Deductible*, *Coinsurance* or a benefit limit, please see the "Benefit Overview" and "Benefit Limits" sections at the front of this *Description of Benefits*.

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

Below are examples of commonly covered items (this list is not all-inclusive):

- the purchase of a manual or electric (non-hospital grade) breast pump or the rental of a hospital grade electric breast pump for pregnant or post-partum *Members*, when prescribed by a licensed *Provider* (Note: These breast pumps are covered in full);
- cranial helmets;
- the following equipment when used to diagnose or treat diabetes mellitus Type 1 (insulin-dependent diabetes), diabetes mellitus Type 2 (insulin or non-insulin dependent diabetes), or gestational diabetes:
  - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind,
  - therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease; and
  - visual magnifying aids;
- gradient stockings (up to three pairs every 365 days);
- oral appliances for the treatment of sleep apnea;
- oxygen concentrators (stationary and portable);
- prosthetic devices, except for arms, legs or breasts*;
  *Important Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Prosthetic Devices" benefit later in this chapter.
- scalp hair prostheses made specifically for an individual or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury (up to $350 per *Calendar Year*). (Note: Please see "Scalp hair prostheses or wigs for cancer or leukemia patients" later in this chapter);
- power/motorized wheelchairs;

Tufts HP 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 HP* to provide such equipment.

(continued on next page)

Other Health Services, (continued)

Durable Medical Equipment, continued

Below are examples of non-covered items (this list is not all-inclusive). Please call Member Services for all questions regarding coverage of *Durable Medical Equipment*:

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

Hearing aids

Coverage is provided for:

- hearing aids (one per ear per prescription change) for *Children* age 21 or younger.

Home health care (must be approved in advance by an *Authorized Reviewer*)
The *Plan* will cover the following services for *Members* who are homebound*:

- home visits by a *Tufts HP Provider*;
- 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;
  - the use of *Durable Medical Equipment;* (coverage is not subject to the limits described in the "*Durable Medical Equipment*" benefit in this chapter. and
  - the services of a part-time home health aide.

Sleep studies performed in the home are not covered under this "Home Health Care" benefit. Instead, these sleep studies are covered as described under "Diagnostic testing" earlier in this chapter.

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

Note: Home health care services for physical and occupational therapies following an injury or illness are only covered to the extent that those services are provided to restore function lost or impaired, as described under "Rehabilitative and *Habilitative* physical and occupational services" earlier in this chapter. However, those home health care services are not subject to the 60-day period for significant improvement requirement listed for "Rehabilitative and *Habilitative* physical and occupational services".

Hospice care services (must be approved by an *Authorized Reviewer*)
The *Plan* will cover the following services for *Members* who are terminally ill (having a life expectancy of 6 months or less):

- *Provider* services;
- nursing care provided by or supervised by a registered professional nurse, or any other licensed *Provider* offering these services within the scope of their license;
- social work services;
- volunteer services; and
- counseling services (including bereavement counseling services for the *Member's* family for up to one year following the *Member's* death).

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

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

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

Notes:

- Prior authorization and quantity limitations may apply.
- There are designated home infusion *Providers* for a select number of specialized pharmacy products and drug administration services. These *Providers* offer clinical management of drug therapies, nursing support, and care coordination to *Members* with acute and chronic conditions. Medications offered by these *Providers* include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. Please contact Member Services or see our website for more information on these medications and *Providers.*
- Intravenous Immunoglobulin (IVIg) therapy is covered for the treatment of Pediatric Autoimmune Neuropsychiatric Disorders and Pediatric Acute-Onset Neuropsychiatric Syndromes under this benefit.
- Coverage includes the components required to administer these medication, including but not limited to, hypodermic needles and syringes, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.

Medical supplies
The *Plan* covers the cost of certain types of medical supplies from an authorized vendor, including:

- ostomy, tracheostomy, catheter, and oxygen supplies, insulin pumps; and related supplies.

Notes:

- These medical supplies must be obtained from a vendor that has an agreement with *Tufts HP* to provide such supplies.
- Contact a Member Representative with coverage questions.
- Services may require the approval of an *Authorized Reviewer*.

Oral medications for the treatment of cancer (prior authorization by an *Authorized Reviewer* may be required)
Coverage is provided for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Prosthetic devices
Tufts HP covers the cost (including repairs) of breast prostheses and prosthetic arms and legs. Coverage is provided for the most appropriate *Medically Necessary* model. Prior approval by an *Authorized Reviewer* is required.

*Note: Breast prostheses require prior authorization, except when provided in connection with a mastectomy.

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

Note: Please also see "*Durable Medical Equipment*" earlier in this chapter.

Special Formulas (prior approval by an *Authorized Reviewer* may be required)
Included in this benefit are the following: special medical formulas; nonprescription enteral formulas; and low protein foods, when prescribed by a *Provider* for the treatments described below.

Low protein foods
When provided to treat inherited diseases of amino acids and organic acids. Services may require the approval of an *Authorized Reviewer*.

Nonprescription enteral formulas (prior approval by an *Authorized Reviewer* may be required)
Coverage is provided:

- for home use for treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.
- when *Medically Necessary*: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.

Special medical formulas (prior approval by an *Authorized Reviewer* may be required)
Coverage is provided for the treatment of:

- phenylketonuria (PKU), tyrosinemia, homocystinuria, maple syrup urine disease, propionic academia, and methylmalonic acidemia; or
- when *Medically Necessary*, to protect the unborn fetuses of women with PKU.

Exclusions from Benefits

List of exclusions

There is no coverage for the following services, supplies, and medications:

- A service, supply or medication which is not *Medically Necessary*.
- A service, supply or medication which is not a *Covered Service*.
- A service, supply or medication received outside the *Tufts HP Service Area*, except as described under "How the *Plan* Works" in Chapter 1.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- Custodial care.
- Services related to non-covered services.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.
  This exclusion does not apply to:
  - long-term antibiotic treatment of chronic Lyme disease when administered as described under "Injectable, infused or inhaled medications", earlier in this Chapter 3;
  - bone marrow transplants for breast cancer;
  - If the treatment is *Experimental or Investigative*, the *Plan* will not pay for any related treatments which are provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, Medications and other products which can be purchased over-the-counter
- Laboratory tests ordered by a *Member* (online or through the mail), even if performed at a licensed laboratory.
- The following exclusions apply to services provided by the relatives of a *Member*:
  - Services provided by a relative who is not a *Tufts Health Plan Provider,* whether or not the services are authorized by your *PCP*, are not covered.
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Tufts Health Plan Provider* and the services are authorized by your *PCP*, are not covered.
  - If you are a *Tufts Health Plan Provider*, you cannot provide or authorize services for yourself, be your own *PCP*, or be the *PCP*, of a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Please consult with your *Provider* to determine if he or she 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).
- Preventive dental care; periodontal treatment; orthodontia, even when it is an adjunct to other surgical or medical procedures; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under "Oral Health Services" and "Gender reassignment surgery and related services" benefits
- earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea, as described in Chapter 3), including those for TMJ disorders. TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies, are not covered. This exclusion does not apply to the treatment of cleft lip or cleft palate for *Children* under the age of 18, as described under "Cleft lip or cleft palate treatment and services for *Children*" earlier in this chapter.

Exclusions from Benefits, continued

- Surgical removal or extraction of teeth, except as provided under "Oral health services" earlier in this chapter.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under "Reconstructive surgery and procedures" earlier in this chapter.
- Rhinoplasty, except as provided under "Reconstructive surgery and procedures" and "Gender reassignment surgery and related services" benefits
  earlier in this chapter;
  Liposuction for cosmetic reasons except as provided under "Gender reassignment surgery and related services" benefit earlier in this chapter,; removal of tattoos; and brachioplasty:.
- Treatment of spider veins; removal or destruction of skin tags.

  Hair removal, (e.g., electrolysis, laser hair removal) except when *Medically Necessary* to treat an underlying skin condition or, when determined to be *Medically Necessary* under the "Gender reassignment surgery and related services" benefit described earlier in this chapter.
- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcisions performed in any setting other than a hospital, *Day Surgery*, or a *Provider's* office.
- Infertility services. for *Members* who do not meet the definition of infertility as described in the "*Outpatient* Care" section earlier in this chapter; experimental infertility procedures; reversal of voluntary sterilization; long-term (longer than 90 days) sperm or embryo cryopreservation unless the *Member* is in active infertility treatment; costs associated with donor recruitment and compensation; [sterilization]; infertility services which are necessary for conception as a result of voluntary sterilization[, planned gender reassignment surgery,]or following an unsuccessful reversal of a voluntary sterilization; and donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
- The costs of surrogacy, which means all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member.* These costs include, but are not limited to; (1) use of a donor egg and a gestational carrier; (2) costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos and (3) costs for maternity care if the surrogate is not a *Member.*

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

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

  Note: *Tufts HP* may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a *Member's* future fertility. Prior approval by an *Authorized Reviewer* is required.
- 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* is provided at a *Tufts HP* ART center, and the *Member* is the sole recipient of the donor's eggs.
- Pregnancy terminations.
- Treatments, medications, procedures, services and supplies related to: medical or
- Reversal of aby transgender health services, including all related drugs and procedures.
- Reversal of voluntary sterilization.
- Over-the-counter contraceptive agents.
- The purchase of an electric hospital-grade breast pump; donor breast milk.
- Human organ transplants, except as described earlier in this chapter.
- Services provided to a non-*Member*, except as described earlier in this chapter for:
  - organ donor charges under "Human organ transplants";
  - bereavement counseling services under "Hospice care services"; and
  - the costs of procurement and processing of donor sperm or eggs, under "Infertility services" (to the extent such costs are not covered by the donor's health coverage, if any).
- Acupuncture.
- Psychoanalysis.

Exclusions from Benefits, continued

- *Inpatient* and *Outpatient* weight loss programs and clinics, except as described earlier in this chapter.
- Biofeedback, except for the treatment of urinary incontinence; neuromuscular stimulators and related supplies.
- Hypnotherapy: relaxation therapies; massage therapies, except as described under "Rehabilitative and *Habilitative* physical and occupational therapy services" " earlier in this chapter; services by a personal trainer; exercise classes; cognitive rehabilitation programs or cognitive retraining programs, except as described earlier in this chapter. Also excluded are diagnostic services related to any of these procedures or programs.
- Multi-purpose general electronic devices including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electronic devices including USB devices and direct connect devices (e.g., speaker, microphone, cables, cameras, batteries, etc.). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet, and all related accessories.
- certain wearable devices (e.g. smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g. Fitbit, Biostamp, Embrace smartwatch, Smartmonitor smartwatch, Garmin Vivofit 4, Garmin Vivosmart 3, Samsung Galaxy Fit);
- All *Non-Conventional Medicine* services provided independently or together with conventional medicine, and all related testing, laboratory testing, services, supplies, procedures, and supplements associated with this type of medicine.
- We do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including, but not limited to: therapeutic schools; camps, wilderness or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound. We will provide coverage for *Medically Necessary Outpatient* or intermediate behavioral health services provided by licensed behavioral health *Providers* while the *Member* is in a tuition-based program, subject to plan rules, including network requirements or *Cost Sharing*.
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the "Note" below.

  Note: The following blood services and products are covered:
  - blood processing;
  - blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor disease), and von Willebrand disease (prior approval by an *Authorized Reviewer* is required);
  - intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an *Authorized Reviewer* is required).
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in this chapter. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities, behavioral problems, and services to treat speech, hearing and language disorders in a school-based setting.

Exclusions from Benefits, continued

- Eyeglasses, lenses or frames, except as described earlier in the Benefit Overview; refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described in the Benefit Overview, the *Plan* will not cover contact lenses or contact lens fittings.
- Private duty nursing (block or non-intermittent nursing).
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace. This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.

  Note: This exclusion also does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:
  - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
  - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, pedorthist,
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" earlier in this chapter.
- Travel expenses, including lodging related to receiving any covered medical service.
- Service or therapy animals and related supplies.

Chapter 4

When Coverage Ends

Overview

Reasons coverage ends

Coverage (including federal COBRA coverage) ends when any of the following occurs:

- you lose eligibility because you:
  - no longer meet the *Plan's* or *Tufts HP's* eligibility rules (including the requirement for minimum hours described in Chapter 1), or
  - are a *Subscriber* or a *Spouse* and you no longer live, work, or reside in the *Service Area**;
- you choose to drop coverage;
- you commit an act of physical or verbal abuse unrelated to your physical or behavioral health condition which poses a threat to:
  - any *Provider*,
  - any *Tufts HP Member*, or
  - *Tufts Health Plan* or any *Tufts HP* employee;
- you commit an act of misrepresentation or fraud; or
- the *Group's* contract with *Tufts HP* ends. (For more information, see "Termination of the *Group Contract*" later in this chapter.)

Note:

- *Children* are not required to maintain primary residence in the *Service Area*. However, care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only.

Benefits after termination

The *Plan* will not cover services you receive after your coverage ends even if:

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

Continuation

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

When a *Member* is No Longer Eligible

Loss of eligibility

Your coverage ends on the date you no longer meet the *Group's* eligibility rules.

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

Dependent Coverage

An enrolled *Dependent's* coverage ends when the *Subscriber's* coverage ends or when the *Dependent* no longer meets the definition of *Dependent*, whichever occurs first.

If you no longer live, work, or reside in *Tufts HP's Service Area*

If you are a *Subscriber* or *Spouse* and you no longer live, work, or reside in the *Tufts HP Service Area*, coverage ends as of the date you no longer live, work, or reside there. Please note that *Children* are not required to live, work, or reside in the *Service Area.* However, care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only.

Before you no longer live, work, or reside in the *Service Area*, tell your *Group* or call a Member Representative to notify *Tufts HP* of the date you will no longer live, work, or reside there.

For more information about coverage available to you when you no longer live, work, or reside in the *Service Area*, contact a Member Representative.

When a *Member* is No Longer Eligible, continued

You choose to drop coverage

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

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

Your coverage may be terminated if you commit acts of physical or verbal abuse which:

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

Membership Termination for Misrepresentation or Fraud

Policy

Your coverage may be terminated for misrepresentation or fraud. If your coverage is terminated for misrepresentation or fraud, *Tufts HP* may not allow you to re-enroll for coverage with *Tufts HP* under any other plan (such as a non-group or an employer plan) or type of coverage (for example, coverage as a *Dependent* or *Spouse*).

Acts of misrepresentation or fraud

Examples of misrepresentation or fraud include:

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

Date of termination

The *Plan* will terminate coverage by sending a notice of termination to your last address as shown on the *Plan's* records. Termination will be retroactive to the *Effective Date*, unless the *Plan* determines that the termination shall be retroactive to the date of the misrepresentation or fraud or to such later date as the *Plan* designates in the notice of termination.

Payment of claims

The *Plan* will pay for all *Covered Services* you received between:

- your *Effective Date*; and
- your termination date, as chosen by the *Plan*. The *Plan* may retroactively terminate your coverage back to a date no earlier than your *Effective Date*.

The *Plan* may use any contributions to coverage you paid for a period after your termination date to pay for any *Covered Services* you received after your termination date.

If the contributions you paid are not enough to pay for that care, the *Plan*, at its option, may:

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

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

Termination of the *Group Contract*

End of *Tufts HP's* and *Group's* relationship

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

- *your Group's* contract with *Tufts HP* terminates;
- *your Group* fails to pay its obligation;
- *Tufts HP* stops operating; or
- *your Group* stops operating.

Chapter 5

Continuation of Coverage

Federal Continuation Coverage (COBRA)

Introduction
This topic contains an overview of continuation coverage under federal COBRA law. For more information, please contact *your Group* or the *Plan Administrator*.

Rules for federal COBRA continuation
Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), *you* may be eligible to continue coverage after *Group* coverage ends if:

- *you* were enrolled in the *Plan* through a *Group* which has 20 or more eligible employees; and
- *you* experience a qualifying event (see list below) which would cause *you* to lose coverage under *your Group*.

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

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

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

When federal COBRA coverage is effective
A *Member* who is eligible for federal COBRA continuation coverage is called a "qualified beneficiary". A qualified beneficiary must be given an election period of 60 days to choose whether to elect federal COBRA continuation coverage. This period is measured from the later of:

- the date the qualified beneficiary's coverage under the *Group Contract* ends (see the list of qualifying events described above); and
- the date the *Plan* provides the qualified beneficiary with a COBRA election notice.

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

Cost of Coverage
In most cases, *you* are responsible for payment of 102% of the cost of coverage for the federal COBRA continuation coverage. For more information, contact *your Group* or the *Plan Administrator*.

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

Federal Continuation Coverage (COBRA), continued

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

When coverage ends

Federal COBRA continuation coverage will end at the end of the maximum period of coverage, which in most cases is 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event. However, coverage may end earlier if:

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

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military services or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Under USERRA:

- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed services, and (1) you ensure that your employer receives advance written or verbal notice of your service; (2) you have five years or less of cumulative service in the uniformed services while with that particular employer; (3) you return to work or apply for reemployment in a timely manner after conclusion of service; and (4) you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service, or, in some cases, a comparable job.
- If you are a past or present member of the uniformed services, have applied for membership in the uniformed services, or are obligated to serve in the uniformed services, then an employer may not deny you initial employment, reemployment, retention in employment, promotion, or any benefit of employment because of this status. In addition an employer may not retaliate against any assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your *Dependents* for up to 24 months while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (for example, pre-existing condition exclusions) except for service-connected illnesses or injuries.
- Service members may be required to pay up 102% of the premium for the health plan coverage. If coverage is for less than 31 days, the service member is only required to pay the employee share, if any, for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

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

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

Coverage under an Individual Contract

If *you* live in Massachusetts:

If *your Group* 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 *Tufts Health Plan* Member Services or contact the Connector either by phone (1-877-MA-ENROLL) or on its website (**www.mahealthconnector.org**).

If *you* live outside Massachusetts:

If *your Group* 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 may be available to *you* in the state where *you* reside.

For more information

Please call the *Tufts HP* Member Services Department.

Chapter 6

Member Satisfaction

Overview

Introduction

This chapter contains information about:

- the *Member* Satisfaction Process, which addresses the *Member* Grievance Process and the Internal *Member* Appeals Process;
- concerns about quality of medical care;
- administrative concerns about *Tufts HP*;
- bills from *Providers*; and
- limitation on actions.

Address and telephone number

If you need to call *Tufts HP* about a grievance or appeal, contact a Member Services Representative at 1-800-462-0224. If you write to *Tufts HP*, send the letter to the Appeals and Grievances Department at the P.O. Box address below. Or you may fax it to us at 617-972-9509.

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

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

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Member Satisfaction Process

Process Summary

Tufts HP has a *Member* Satisfaction Process to address *your* concerns as expeditiously as possible. This process addresses:

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

All calls should be directed to *Tufts HP's* Member Services at 1-800-462-0224. Alternatively, *you* may mail *your* grievance or appeal to the P.O. Box address listed above.

Internal Inquiry

Call a *Tufts HP* Member Representative 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 Representative 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.

Member Grievance Process

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 Health Plan* Member Representative, who will document *your* concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect *your* concerns, *you* may want to put *your* grievance in writing and send it to the P.O. Box address provided at the beginning of this section. *Your* explanation should include:

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

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

Administrative Grievances

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

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

Clinical Grievances

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

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

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

Internal Member Appeals

Requests for coverage that was denied as specifically excluded in this *Description of Benefits* or for coverage that was denied based on medical necessity determinations are reviewed as appeals through the Internal Appeals Process. You may designate in writing someone to act on your behalf. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

You can submit a verbal appeal of a benefit coverage decision to a *Tufts HP* Member Representative, who will forward it to the Appeals and Grievances Department.

You can also mail a written appeal to the P.O. Box address listed previously. *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 and suffix;
- a detailed description of your request (including relevant dates, any applicable medical information and *Provider* names); and
- copies of any supporting documentation.

Within forty-eight (48) hours of the receipt of your verbal or written appeal, you will be sent an acknowledgment of receipt, and a request for authorization for the release of medical and treatment information. The authorization for release of medical and treatment information gives permission to collect documents from your medical record related to your appeal. Your name will remain anonymous to your *Group* unless you explicitly request that your name remain in the case file. However, if your *Group* requests your name, we must provide it.

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 similar specialty as typically manages the medical condition, procedure, or treatment under review. The medical director and/ or practitioner will not have previously reviewed your case.

With respect to appeals for prospective or concurrent urgent care services, *Tufts HP* will conduct a full and fair review of the appeal and will send you a notice of the determination.

For non-emergent appeals not involving medical necessity of services, *Tufts HP* will make a recommendation based upon this review and will forward the recommendation to your *Group* along with the appeal information. Your group, fiduciary of the *Plan*, makes the final decision about these appeals.

For non-urgent appeals involving the medical necessity of services obtained from *Tufts HP Providers* or any *Provider* located in Massachusetts, New Hampshire or Rhode Island, a *Tufts HP* medical director will make a recommendation based upon this review and will forward this recommendation to your *Group* along with the appeal information. Your *Group*, fiduciary of the *Plan*, makes the final decisions about medical necessity.

For appeals involving the medical necessity of services obtained from health care providers not contracted with *Tufts HP* and that are not located in Massachusetts, New Hampshire, or Rhode Island, *Tufts HP* will conduct a full and fair review of the appeal and will send you a notice of the determination.

You will have access to any medical information and records relevant to your appeal that are in the possession and control of *Tufts HP* or its designee. The time limits of this process may be waived or extended by mutual written agreement between you or your authorized representative and *Tufts HP*.

In the event that you do not sign and return the authorization for the release of medical and treatment information within thirty (30) calendar days of the day you requested a review of your case, a resolution of the appeal may be made without the review of some or all of your medical records.

You will be notified in writing of the decision on your appeal, within no more than thirty (30) calendar days of the receipt of your appeal. The time limits may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and *Tufts HP.* The decision letter will include the specific reasons for the decision and references to the pertinent plan provisions on which the decision is based.

Tufts HP maintains records of each inquiry made by a *Member* or by that *Member's* authorized representative.

Expedited 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* physician, *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 appeal, it will be reviewed by a Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner in a same or similar specialty that typically manages the medical condition, procedure or treatment under review. The 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 no later than seventy-two (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 appeals involving medical necessity determinations (adverse determinations) and benefit reviews where medical judgment was used, if you do not agree with the Appeals decision, you or your authorized representative have the right to request an independent, external review of our Appeals decision. Appeals for coverage of services specifically excluded in your *Description of Benefits* and payment disputes are not eligible for external review.

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

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
1 Wellness Way
Canton, MA 02021

(fax) 617-972-9509

In some cases, *Members* may have the right to an expedited 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.

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* within no more than 45 days after receipt of the request for standard external review. For expedited external review, the independent review organization will provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request.

If *you* have questions

If *you* have questions or need help submitting a grievance or an appeal, please call a *Tufts HP* Member Representative for assistance.

Bills from *Providers*

Medical Expenses

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

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

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

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

Please note: *You* must contact *Tufts Health Plan* regarding *your* bill(s) or send *your* bill(s) to *Tufts HP* within twelve months from the date of service. If *you* do not, the bill cannot be considered for payment. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer. Reimbursements will be sent to the *Subscriber* at the address *Tufts HP* has on file.

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

The *Plan* reserves the right to be reimbursed by the *Member* for payments made in error.

IMPORTANT NOTE:
Certain Services *you* receive from non-*Tufts HP Providers* at an *In-Network* setting may be reimbursable. Some examples of these types of non-*Tufts HP Providers* include:

- radiologists, pathologists, and anesthesiologists who work in *Tufts HP Hospitals*; and
- *Emergency* room specialists.

Limitation on Actions

You cannot file a lawsuit against *Tufts HP* for failing to pay or arrange for or administer *Covered Services* unless *you* have completed the *Tufts HP Member* Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if *you* want to file a lawsuit because *you* were denied coverage under this *Group Contract, you* must first complete the *Tufts Health Plan Member* Satisfaction Process, and then file *your* lawsuit within two years after the date *you* were first sent a notice of the denial. Going through the *Tufts Health Plan Member* Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date *you* were first denied coverage.

Chapter 7

Other Plan Provisions

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 representative or administrator of your estate, your decedents, your heirs, your descendants, your beneficiaries, minors, and incompetent or disabled persons. These provisions will apply to all claims arising from your illness or injury, including, but not limited to, wrongful death, survival, or survivorship claims brought on your, your estate's or your heirs' behalf, regardless of whether medical expenses were or could be claimed. "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 (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, workers compensation coverage, automobile medical payments 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 from 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 interests 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 representing 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 benefits 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 judgment 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 is 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 representative's 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 prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all 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 litigation 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 its 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

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the *Plan* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits from the *Plan*, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the *Plan* may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the *Plan* incurs in successful attempts to recover amounts the *Plan* is entitled to under this section.

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
Benefits for otherwise covered services may be excluded when you have received a recovery from another source relating to an illness or injury for which benefits would normally be provided. However, the amount of any covered services excluded under this section will not exceed the amount of your recovery.

Coordination of Benefits

Application and Purpose

The coordination of benefits (COB) program applies when you are also covered by other plans for hospital, medical, dental or other health care expenses. These plans include personal injury insurance and medical benefits provisions of motor vehicle policies; group and non-group insurance contracts, health maintenance organization contracts (HMO), closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); student health insurance policies; medical care component of long-term care contracts, such as skilled nursing care; and Medicare or any other federal government plan, as permitted by law. The COB program prevents duplication of payments for the same health care services. *Tufts HP* will coordinate all benefits described in this *Description of Benefits* with other plans for the *Plan*, consistent with applicable law. (if any) or *Tufts Health Plan* COB processing guidelines.

How COB works

The *Plan* will coordinate benefits by determining: (a) which plan has the primary obligation to provide benefits to you (the primary plan); and (b) which plan has the secondary obligation to provide benefits (the secondary plan). These determinations will be made according to the following rules:

(1) No COB Rule

A plan that does not contain COB rules that are consistent with the *Plan's* COB rules is always the primary plan.

(2) COB Rule

When all plans which cover you have COB rules consistent with the *Plan's* COB rules, the rules listed below apply. Each plan determines the order of benefits using the first of the following rules that applies:

- **Employee/Dependent Rule**

  The plan which covers the person as an employee, retiree, or *Subscriber* is primary to the plan which covers the person as a *Dependent*.

  Exception: If the person is a Medicare beneficiary and, under the Medicare Secondary Payer rules, Medicare is primary over the plan covering the person as an employee, retiree, or *Subscriber* and Medicare is secondary to the plan covering the person as *Dependent*, then the order is reversed and the plan covering the person as a *Dependent* is primary and the plan covering the person as an employee, retiree, or *Subscriber* is secondary.

- **Birthday Rule**

  If two or more plans cover a *Dependent Child* whose parents are not separated or divorced, the primary plan is that of the parent whose birth date (month and day only) occurs earlier in the calendar year. If both parents have the same birth date, the primary plan is that of the parent whose coverage has been in effect for the longest period of time.

- ***Children* of Separated/Divorced Parents Rule**

  There may be a court decree which states that one of the parents is responsible for the health care expenses or insurance of the *Child*. If so, and the plan of the parent obligated to pay or provide benefits has actual knowledge of the terms of the court decree, that plan is primary only as of the time that that plan has such actual knowledge. If there is a court decree making both parents responsible for the health care expenses or insurance of the *Child*, the "Birthday Rule" applies. If there is a court decree granting joint custody, without stating that one of the parents is responsible for the health care expenses of the *Child*, the "Birthday Rule" applies.

  If two or more plans cover a *Dependent Child* whose parents are separated or divorced, and there is not a court decree addressing the responsibility for the health care expenses or insurance for the *Child*, the order of payment is:

  - The plan of the parent with custody of the *Child.*
  - The plan of the *Spouse* of the parent with custody of the *Child*.
  - The plan of the parent not having custody of the *Child*.
  - The plan of the *Spouse* of the parent not having custody of the *Child*.

- **Non-Parent**
  For a *Dependent Child* covered under more than one plan of individuals who are not the parents of the *Child*, the order of benefits shall be determined, as applicable, as if those individuals were the parents of the *Child*.

- **Person Covered as a *Child* and Spouse Rule**
  For a person covered under one plan as a dependent child and another plan as a dependent spouse, the plan that has covered the person longer is primary.

- **Active/Inactive Rule**
  The plan which covers an employee (or an employee's enrolled *Dependent*) who is neither laid off nor retired is primary to a plan which covers that person (or that person's enrolled *Dependent*) as a laid-off or retired employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- **COBRA Rule**
  The plan which covers the person pursuant to COBRA or a state continuation coverage law is secondary to a plan covering the person as an employee, retiree, or *Subscriber* (or that person's enrolled *Dependent*). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- **Longer/Shorter Rule**
  If none of the above rules determines which plan is primary, the plan which has covered a person longer is primary. A person's length of coverage is measured from the person's first date of coverage under the plan. Two successive plans are treated as one if the covered person is eligible under the second plan within 24 hours after coverage under the first plan ended. The start of a new plan does not include a change in the amount or scope of benefits, a change in the entity that pays or administers benefits, or a change in the type of plan (such as, from a single employer plan to a multiple employer plan).

This *Plan* always pays secondary to:

- Any medical payment (MedPay), personal injury protection (PIP), or Non-Fault coverage under any automobile policy available to you.
- Any plan or program which is required by law.

All *Subscribers* should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

Secondary Benefits

In determining the amount to be paid by the secondary plan on a claim, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of the other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total allowable expense for that claim.

Medicare

When a person has Medicare, the *Plan* pays primary over Medicare when required to do so by federal law. In all other cases, the plan is secondary to Medicare and will only pay claims after Medicare. If you are eligible for Medicare due to age, disability, or ESRD, but do not have it because you failed to apply for it or you dropped it, the *Plan* will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The *Plan* will not pay any amounts that would have been paid by Medicare if you had properly applied for it. This applies to both Parts A and B of Medicare. If you enter into a private contract with a provider who has opted out of Medicare, the *Plan* will also estimate Medicare benefits and pay secondary benefits only. Call *Tufts HP's* Liability and Recovery Department at 1-888-880-8699, x. 21098 for more information on Medicare COB.

Coordination of Benefits, continued

Right to receive and release necessary information

When you enroll, you must include information on your member application about other health coverage you have. After you enroll, you must notify *Tufts HP* of new coverage termination of other coverage, or if you are enrolled in any high deductible health plan with a health savings account (HSA). *Tufts HP* may ask for and give out information needed to coordinate benefits.

You agree to provide information about other coverage and cooperate with the *Plan's* COB program.

You hereby assign to the *Plan* benefits which they may be entitled to receive because a party other than the *Plan* may be responsible for all, or a portion of, the cost of health care services paid or to be paid by the *Plan*.

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, contact the *Tufts HP* Liability and Recovery Department at 1-888-880-8699, x. 21098. You can also call a Member Representative and have your call transferred to the *Tufts HP* Liability and Recovery Department.

Medicare Eligibility

Medicare eligibility

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

Tufts HP will pay benefits **before** Medicare:

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

Tufts HP will pay benefits **after** Medicare:

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

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

Use and Disclosure of Medical Information

For information about how *Tufts HP* uses and discloses your medical information, please contact a Member Representative. Information is also available on our website.

For information about how your employer uses and discloses your medical information, please contact your employer.

Relationships between *Tufts HP* and *Providers*

Tufts HP and *Providers*

Tufts HP is an administrator of health care services. *Tufts HP* does not provide health care services. *Tufts HP* has agreements with *Providers* practicing in their private offices throughout the *Tufts HP Service Area*. These *Providers* are independent. They are not *Tufts HP* employees, agents or representatives. *Providers* are not authorized to modify the *Plan*, change this *Description of Benefits*, or assume or create any obligation for the *Plan* or *Tufts HP*.

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

Circumstances Beyond *Tufts Health Plan's* Reasonable Control

Circumstances beyond *Tufts HP's* reasonable control

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

Group Contract

Acceptance of the terms of the *Plan*

By causing your member application to be submitted to your *Group* employees apply for coverage under the *Plan* and agree, on behalf of themselves and their enrolled *Dependents*, to all the terms and conditions of the *Plan*, including this *Description of Benefits*.

Payments

The *Plan* under which *you* are covered is a self-funded plan. This means that *your Group* is responsible for funding *Covered Services* for *Members* in accordance with the terms of the *Plan*. Under an administrative services agreement between *your Group* and *Tufts HP*, *Tufts HP* processes claims, disburses *Plan* funds and provides other *Covered Services* only when the *Group* has forwarded adequate funds to *Tufts HP* to pay for *Covered Services*. This is the case even if *your Group* has charged *you* (for example, by withholding from *your* paycheck) for some or all of the cost of coverage under the *Plan*. If *your Group* fails to provide adequate funds for claims payment, *Tufts HP* has no responsibility to pay claims.

Revisions to the *Plan* and this *Description of Benefits*

The *Group* may revise the *Plan* and this *Description of Benefits* in accordance with the terms of the *Plan*. Revisions do not require the consent of *Members*. Notice of *Tufts HP* revisions will be sent to the *Group* and will include the effective date of the revision. The *Group or Plan Administrator* is responsible for notifying the *Members* of revisions. *Tufts HP* is not responsible if the *Group* does not so notify *Members*. Any revisions will apply to all *Members* covered under the *Plan* on the effective date of the revision.

Notice

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

Notice to *Tufts HP*: *Members* should address all correspondence to:
Tufts Health Plan, Member Services, P.O. Box 9166, Watertown, MA 02472-9166.

Enforcement of terms

Tufts HP may choose to waive certain terms of the *Group Contract*, if applicable, including the *Description of Benefits*. This does not mean that *Tufts HP* gives up its rights to enforce those terms in the future.

Appendix A

Glossary of Terms

Terms and Definitions

Adoptive Child

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

- is legally adopted by the *Subscriber*; or
- is placed for adoption with the *Subscriber*. This means that the *Subscriber* has assumed a legal obligation

for the total or partial support of a *Child* in anticipation of adoption. If the legal obligation ceases, the *Child* is no longer considered placed for adoption.

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

Allowed Cost or Allowed Amount

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

Annual Coverage Limitations

Annual dollar or time limitations on *Covered Services*.

Authorized Review

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

Authorized Reviewer

An *Authorized Reviewer* reviews and approves certain services and supplies to Members. He or she is *Tufts HP's* Chief Medical Officer (or equivalent), or someone that person names.

Behavioral Health Disorders

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

Benefit Year

The 12-month period of time in which benefit limits, *Out-of-Pocket Maximums*, and *Coinsurance* are calculated.

Board-Certified Behavior Analyst (BCBA)

A *Board-Certified Behavior Analyst (BCBA)* meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A *BCBA* professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for *Members* with diagnoses of autism spectrum disorders. *BCBAs* may supervise the work of Board-Certified Assistant Behavior Analysts and other *Paraprofessionals* who implement behavior analytic interventions.

Child

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

- The *Subscriber's* or *Spouse's* natural child, stepchild, or *Adoptive Child*; or
- the *Child* of an enrolled child; or
- any other *Child* for whom the *Subscriber* has legal guardianship.

Coinsurance

The percentage of costs you must pay for certain *Covered Services*. For services provided by a non-*Tufts HP Provider*, your share is a percentage of the *Reasonable Charge* for those services. For services provided by a *Tufts HP Provider*, your share is a percentage of:

- the applicable *Tufts HP* fee schedule amount for those services; or
- the *Tufts HP Provider's* actual charges for those services, whichever is less.

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

Copayment

Fees you pay for *Covered Services*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. *Copayments* are included in the *Out-of-Pocket Maximum*. See "Benefit Overview" at the front of this *Description of Benefits* for more information.

Cost Sharing Amount

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

Covered Services

The services and supplies that the *Plan* will cover.
They must be:

- described in Chapter 3 (subject to the "Exclusions from Benefits" section in Chapter 3);
- *Medically Necessary*; and
- provided or authorized by your *PCP* and in some cases, approved by an *Authorized Reviewer*.

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

Covering Provider

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

Custodial Care

- Care provided primarily to assist in the activities of daily living, 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; or
- adult and pediatric day care.

  Note: *Custodial Care* is not a covered benefit under the *Plan*.

Day Surgery

Any surgical procedure(s) provided to a *Member* at a facility licensed by the state to perform surgery, and with an expected departure the same day, or in some instances, within twenty-four hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care."

Deductible

For each *Calendar Year*, the amount paid by the *Member* for certain *Covered Services* before any payments are made under this *Description of Benefits*. (Any amount paid by the *Member* for a *Covered Service* rendered during the last 3 months of a *Calendar Year* shall not be carried forward to the next *Calendar Year's Deductible*. *Copayments* do not count toward the *Deductible*.

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

See "Benefit Overview" at the front of this *Description of Benefits* for more information.

Dependent

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

Description of Benefits

This document, and any future amendments, which describes the EXCLUSIVE PROVIDER OPTION plan you have selected under the *Plan*.

Designated Facility

A facility licensed to treat *Behavioral Health Disorders* and/or substance use disorders (alcohol and drug). This facility has an agreement with *Tufts HP* to provide *Inpatient* or partial hospitalization services to *Members* assigned to the facility.

Developmental

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

Directory of Health Care Providers

A list of *Tufts HP Select Network PCPs* and their affiliated *Tufts HP Select Network Hospitals* and certain other *Tufts HP Select Network* Providers

Note: This list is updated from time to time to show changes in *Providers* affiliated with *Tufts HP Select Network*. For information about the *Providers* listed in the *Directory of Health Care Providers*, you can call *Tufts HP* Member Services or check *Tufts HP's* website.

Disabled Dependent

The *Subscriber's Child* who:

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

Durable Medical Equipment

Devices or instruments of a durable nature that:

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

Effective Date

The date, according to the *Plan's* records, when you became a *Member* and began receiving *Covered Services* administered by *Tufts HP*.

Emergency

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

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

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

Experimental or Investigative

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

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

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

Family Coverage

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

Free-Standing Urgent Care Center

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

Group

The employer who sponsors the *Plan*, contracts with *Tufts HP* for the provision of certain services and the availability of a preferred provider network to the *Plan*, and who is responsible for funding all *Covered Services* under the *Plan* and described in this *Description of Benefits*.

A *Group* subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the plan sponsor under ERISA. The *Group* is your agent and is not *Tufts HP's* agent.

Group Contract

The agreement between *Tufts HP* and the *Group* under which *Tufts HP* agrees to provide certain administrative services and the *Group* agrees to pay *Tufts HP* for these services. The *Group Contract* includes this *Description of Benefits* and any amendments.

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.

Individual Coverage

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 the day.

Limited Service Medical Clinic

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

Medically Necessary

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

- is the most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual;
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- for services and interventions not in widespread use, is based on scientific evidence.

In determining coverage for *Medically Necessary* services, *Tufts HP* uses Medical Necessity Guidelines which are:

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

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

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

Member

A *Subscriber* or *Dependent* who is covered under the *Plan* and therefore entitled to all benefits in accordance with the *Plan*. Also referred to as "you".

Non-Conventional Medicine

A group of diverse medicine and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the *Tufts Health Plan* definition of *Medical Necessity*, and are not covered. *Providers* of these non-covered services may be contracting or non-contracting traditional medical providers. These services may be offered in connection with a traditional office visit. Providers of *Non-Conventional Medicine* services often request payment up front because health insurance typically does not cover these services.

Common terminology used to refer to these types of services include, but are not limited to, “alternative medicine”, “complementary medicine”, integrative medicine”, “functional health medicine”, and may be described as treating “the whole person”, the “entire individual” or the “inner self”, and may refer to re-balancing hormones or finding underlying causes that lead to bodily dysfunction. Examples of *Non-Conventional Medicine* and related services include, but are not limited to:

- holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields);
- manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi);
- mind-body medicine (e.g., hypnotherapy, meditation, stress management);
- whole medicine systems (e.g., naturopathy, homeopathy);
- biologically based practices (e.g., herbal medicine, dietary supplements, probiotics); and
- other related practices when provided in connection with *Non-Conventional Medicine* services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).

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

Open Enrollment Period
If applicable to the *Plan*, the period of time each year when eligible employees are allowed to apply for or change coverage under the *Plan*.

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

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

Out-of-Pocket Maximum
The maximum amount of money paid by a *Member* during a *Calendar Year* for certain *Covered Services*. The *Out-of-Pocket Maximum* consists of *Copayments* and *Coinsurance*. It does not include:

- any amount you pay for prescription drugs prior to January 1, 2015; or
- costs for health care services that are not *Covered Services* under the *Group Contract*.

Once you have met your *Out-of-Pocket Maximum* in a *Calendar Year*, you no longer pay for *Copayments* and *Coinsurance* in that *Calendar Year*.

See "Benefit Overview" at the front of this Description of Benefits for detailed information about your *Out-of-Pocket Maximum*.

Paraprofessional
As it pertains to the treatment of autism and autism spectrum disorders, a *Paraprofessional* is an individual who performs applied behavioral analysis (ABA) services under the supervision of a *Board-Certified Behavior Analyst (BCBA)*.

Plan
The employee health benefits plan established and maintained by the *Group*. This *Description of Benefits* only describes one health benefits option under the *Plan*. For a description of other health benefit options under the *Plan*, see *your Plan Administrator*.

Plan Administrator
The person(s) or entity designated by the *Plan* as the *Plan Administrator* or, if not so designated, the *Group*. *Tufts HP* is not the *Plan Administrator*.

Primary Care Provider (PCP)
The *Tufts HP* physician, physician assistant, or nurse practitioner you have chosen from the *Tufts HP Directory of Health Care Providers* who has an agreement with *Tufts HP* to provide primary care and to coordinate, arrange, and authorize the provision of *Covered Services*.

Provider
A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, *Limited Service Medical Clinics*), *Free-Standing Urgent Care Centers*, physicians, doctors of osteopathy, physician assistants, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed behavioral health counselors, licensed independent clinical social workers, licensed marriage and family therapists, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and behavioral health nursing, Licensed Alcohol and Drug Counselor licensed speech-language pathologists, and licensed audiologists.

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

Provider Organization
A *Provider Organization* is comprised of doctors and other health care *Providers* who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care.

Reasonable Charge
The lesser of the:
- amount charged; or
- amount that we determine to be reasonable, based on 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 provided to a well newborn *Child* immediately following birth until discharge from the hospital.

Service Area
The *Service Area* is the geographical area within which we have developed a network of *Providers* to afford Members with adequate access to *Covered Services*. The *Service Area* is comprised of Barnstable, Bristol, Essex, Franklin, Hampshire, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties in Massachusetts, and additional *Providers* in New Hampshire and Rhode Island. Notes:

- This plan offers a limited network of *Providers* in the *Service Area*.
- For a list of cities and towns in the *Service Area* for this plan, you can call the Member Services Department or check our website.

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

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

Subscriber
The person who:
- is an employee of the *Group*; and
- enrolls in *Tufts Health Plan* on behalf of himself or herself and any *Dependents*.

Tufts Health Plan or Tufts HP

Total Health Plan, Inc. ("THP"), a Massachusetts corporation d/b/a *Tufts Health Plan*. *THP* enters into arrangements with *Groups* or payors underwriting health benefit plans to make available a network of preferred providers and to provide certain services to the health benefit plans including, but not limited to, processing claims for benefits and enrollment. *THP* is not the *Plan Administrator* and does not insure the *Plan*. Also referred to as "*Tufts HP*".

Tufts HP Hospital

A hospital which 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 *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees.

Tufts HP Provider

A *Provider* with which *Tufts Health Plan* has an agreement to provide *Covered Services* to *Members*. *Providers* are not *Tufts Health Plan's* employees, agents or representatives.

Urgent Care

Care provided when your health is not in serious danger, but you need immediate 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, sudden extreme anxiety, a cut that needs stitches but is not actively bleeding, or symptoms of a urinary tract infection.

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*.

You, Your

This term has the following meaning when used in this *Description of Benefits*, regardless of whether or not it is italicized: the *Member*.

Appendix B - ERISA Information and other State and Federal Notices

ERISA RIGHTS

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

ERISA provides that all plan participants shall be entitled to:

- receive information about their plan and benefits;
- continue group health plan coverage; and
- prudent actions by plan fiduciaries.

Receiving Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

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

Continuing Group Health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

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

Prudent Actions by Plan Fiduciaries

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

ERISA RIGHTS, continued

Enforcing Your Rights

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

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

Assistance with Your Questions

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

PROCESSING OF CLAIMS FOR PLAN BENEFITS

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

Who can submit a claim?

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

How do I designate an Authorized Claimant?

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

Types of claims

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

Urgent care claim: An "urgent care claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your provider's determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested. For urgent care claims, Tufts HP will respond to you within 72 hours after receipt of the claim. If Tufts HP determines that additional information is needed to review your claim, we will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hours after that time to provide the requested information. Tufts HP will evaluate your claim within 48 hours after the earlier of our receipt of the requested information, or the end of the extension period given to you to provide the requested information.

Types of claims, continued

Concurrent care decision: A "concurrent care decision" is a determination relating to the continuation/reduction of an ongoing course of treatment. If Tufts HP has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment to be provided over a period of time or number of treatments , Tufts HP will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the decision and obtain a determination before the treatment is reduced or terminated. If you request to extend an ongoing course of treatment that involves urgent care, Tufts HP will respond to you within 24 hours after receipt of the request (provided that you make the request at least 24 hours prior to the expiration of the ongoing course of treatment). If you reach the end of a pre-approved course of treatment before requesting additional services, the "pre-service" or "post-service" time limits will apply.

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

Post-service claim: A "post-service claim" is a claim for payment for a particular service after the service has been provided. For post-service claims, Tufts HP will respond to you within 30 days after receipt of the claim. If Tufts HP determines that an extension is necessary due to matters beyond our control, we will notify you within 30 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a post-service claim, but do not submit enough information for Tufts HP to make a determination, we will notify you within 30 days and describe the information that you need to provide to Tufts HP. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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

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

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

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

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

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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

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

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

- Qualifying Exigency Leave: Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. Effective October 28, 2009, deployment to a foreign country was added as a requirement for exigency leave.
- Military Caregiver Leave: An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. The employee is entitled to a combined total of 26 weeks of all types of FMLA leave in the single 12-month period. Effective March 8, 2013, the definition of "covered service member" was expanded to include certain veterans.

In order to be eligible, the employee must have worked for his or her employer for a total of 12 months and worked at least 1,250 hours over the previous 12 months.

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance contributions while on leave. In some instances, the employer may recover contributions it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

An employee should contact his or her employer for details about FMLA and to make payment arrangements, if applicable. Additional information is also available from the U.S. Department of Labor: (1-866-487-9243, TTY: 1-877-899-5627 or **http://www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf.**

PATIENT PROTECTION DISCLOSURE

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

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

You do not need prior 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.

TUFTS HEALTH PLAN'S NOTICE OF PRIVACY PRACTICES

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

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

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

How We Obtain PHI

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

How We Use and Disclose Your PHI

We use and disclose PHI in a number of ways to carry out our responsibilities as a managed care plan. The following describes the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

- **Treatment:** We may use and disclose your PHI to health care providers to help them treat you. For example, our care managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from a hospital.
- **Payment Purposes:** We use and disclose your PHI for payment purposes, such as paying doctors and hospitals for covered services. Payment purposes also include activities such as: determining eligibility for benefits; reviewing services for medical necessity; performing utilization review; obtaining premiums; coordinating benefits; subrogation; and collection activities.
- **Health Care Operations:** We use and disclose your PHI for health care operations. For example, this includes coordinating/managing care; assessing and improving the quality of health care services; reviewing the qualifications and performance of providers; reviewing health plan performance; conducting medical reviews; and resolving grievances. It also includes business activities such as: underwriting; rating; placing or replacing coverage; determining coverage policies; business planning; obtaining reinsurance; arranging for legal and auditing services (including fraud and abuse detection programs); and obtaining accreditations and licenses. We do not use or disclose PHI that is genetic information for underwriting purposes.
- **Health and Wellness Information:** We may use your PHI to contact you with information about: appointment reminders; treatment alternatives; therapies; health care providers; settings of care; or other health-related benefits, services and products that may be of interest to you. For example, we might send you information about smoking cessation programs, or we might send a mailing to subscribers approaching Medicare eligible age with materials describing our senior products and an application form.
- **Organizations That Assist Us:** In connection with treatment, payment and health care operations, we may share your PHI with our affiliates and third party "business associates" that perform activities for us or on our behalf, for example, our pharmacy benefit manager. We will obtain assurances from our business associates that they will appropriately safeguard your information. The following corporate affiliates of Tufts Health Plan designate themselves as a single affiliated covered entity and may share your information among them: Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, CarePartners of Connecticut, Inc., Tufts Associated Health Plans, Inc. group health plans, Harvard Pilgrim Health Care, Inc., Harvard Pilgrim Health Care of New England, Inc., HPHC Insurance Company, Inc., and Harvard Pilgrim Group Health Plan.

How We Use and Disclose Your PHI – continued

- **Plan Sponsors:** If you are enrolled in Tufts Health Plan through your current or former place of work, you are enrolled in a group health plan. We may disclose PHI to the group health plan's plan sponsor – usually your employer – for plan administration purposes. A plan sponsor of an insured health benefit plan must certify that it will protect the PHI in accordance with law.
- **Public Health and Safety; Health Oversight:** We may disclose your PHI: to a public health authority for public health activities, such as responding to public health investigations; when authorized by law, to appropriate authorities, if we reasonably believe you are a victim of abuse, neglect or domestic violence; when we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to your or others' health or safety; or to health oversight agencies for certain activities such as: audits; disciplinary actions; and licensure activity.
- **Legal Process; Law Enforcement; Specialized Government Activities:** We may disclose your PHI in the course of legal proceedings; in certain cases, in response to a subpoena, discovery request or other lawful process; to law enforcement officials for such purposes as responding to a warrant or subpoena; or for specialized governmental activities such as national security.
- **Research; Death; Organ Donation:** We may disclose your PHI to researchers, provided that certain established measures are taken to protect your privacy. We may disclose PHI, in certain instances, to coroners, medical examiners and in connection with organ donation.
- **Workers' Compensation:** We may disclose your PHI when authorized by workers' compensation laws.
- **Family and Friends:** We may disclose PHI to a family member, relative, or friend – or anyone else you identify – as follows: (i) when you are present prior to the use of disclosure and you agree; or (ii) when you are not present (or you are incapacitated or in an emergency situation) if, in the exercise of our professional judgment and in our experience with common practice, we determine that the disclosure is in your best interests. In these cases, we will only disclose the PHI that is directly relevant to the person's involvement in your health care or payment related to your health care.
- **Personal Representatives:** Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or health care benefits. For example, an individual named in a durable power of attorney or a parent or guardian of an unemancipated minor are personal representatives.
- **Communications:** We will communicate information containing PHI to the address or telephone number we have on record for the subscriber of your health benefits plan. Also, we may mail information containing your PHI to the subscriber. For example, communication regarding member requests for reimbursement may be addressed to the subscriber. We will not make separate mailings for enrolled dependents at different addresses, unless we are requested to do so and agree to the request. See below "Right to Receive Confidential Communications: for more information on how to make such a request.
- **Required by Law:** We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

If one of the above reasons does not apply, we will not use or disclose your PHI without your written permission ("authorization"). You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may later change your mind and revoke your authorization in writing. However, your written revocation will not affect actions we've already taken in reliance on your authorization. Where state or other federal laws offer you greater privacy protections, we will follow those more stringent requirements. For example, under certain circumstances, records that contain information about: alcohol abuse treatment; drug abuse prevention or treatment; AIDS-related testing or treatment; or certain privileged communications, may not be disclosed without your written authorization. In addition, when applicable, we must have your written authorization before using or disclosing medical or treatment information for a member appeal. See below "Who to Contact for Questions or Complaints" if you would like more information.

How We Protect PHI Within Our Organization

Tufts Health Plan protects oral, written and electronic PHI throughout our organization. We do not sell PHI to anyone. We have many internal policies and procedures designed to control and protect the internal security of your PHI. These policies and procedures address, for example, use of PHI by our employees. In addition, we train all employees about these policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws.

Your Individual Rights

The following is a summary of your rights with respect to your PHI:

- **Right of Access to PHI:** You have the right to inspect and get a copy of most PHI Tufts Health Plan has about you, or a summary explanation of PHI if agreed to in advance by you. Requests must be made in writing and reasonably describe the information you would like to inspect or copy. If your PHI is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable cost-based fee for paper or electronic copies as established by state or federal law. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice of denial describing the basis of our denial. You may request that we send a copy of your PHI directly to another person that you designate. Your request must be in writing, signed by you, and clearly identify the person and the address where the PHI should be sent.
- **Right to Request Restrictions:** You have the right to ask that we restrict uses or disclosures of your PHI to carry out treatment, payment and health care operations, and disclosures to family members or friends. We will consider the request. However, we are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made verbally or in writing to Tufts Health Plan.
- **Right to Receive Confidential Communications:** You have the right to ask us to send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the subscriber's address. We will accommodate your request if: you state that disclosure of your PHI through our usual means could endanger you; your request is reasonable; it specifies the alternative means or location; and it contains information as to how payment, if any, will be handled. Requests may be made verbally or in writing to Tufts Health Plan.
- **Right to Amend PHI:** You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to Tufts Health Plan and must include a reason to support the requested amendment.
- **Right to Receive an Accounting of Disclosures:** You have the right to a written accounting of the disclosures of your PHI that we made in the last six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to: (i) disclosures we made for treatment, payment or health care operations; (ii) disclosures made to you or people you have designated; (iii) disclosures you or your personal representative have authorized; (iv) disclosures made before April 14, 2003; and (v) certain other disclosures, such as disclosures for national security purposes. IF you request an accounting more than once in a 12-month period, we may charge you a reasonable fee. All requests for an accounting of disclosures must be made in writing to Tufts Health Plan.
- **Right to authorize other use and disclosure:** You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- **Right to receive a privacy breach notice:** You have the right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.
- **Right to this Notice:** You have a right to receive a paper copy of this Notice from us upon request.

Your Individual Rights – continued

- **How to Exercise Your Rights:** To exercise any of the individual rights described above or for more information, please call a Member Services Representative at 1-800-462-0224 (TDD: 711) or write to:

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

Effective Date of Notice

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

Changes to this Notice of Privacy Practices

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

Who to Contact for Questions or Complaints

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

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

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

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

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

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

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

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

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

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

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

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

ANTI-DISCRIMINATION NOTICE

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

Tufts Health Plan:

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

If you need these services, contact Member Services.

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

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

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

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

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

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

tuftshealthplan.com | 800.462.0224