Tufts University

Quality Tiered Health Plan PPO Option
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.

Tiered Provider Network: This plan assigns Providers to benefit tiers. You may pay different Cost-Sharing Amounts based on a Provider's assigned benefit tier. This plan updates the assigned benefit tier each year on January 1st*. You may pay different Cost-Sharing Amounts if your Provider is reassigned to a different benefit tier. For information on the tier levels of available Network Providers please consult www.tuftshealthplan.com/tuftsuniversity, and click on “Find a Quality Tiered Plan Provider”.

Important Note: There are many ways to measure the performance of a physician. We have created the Provider tiers for this plan at the physician group level--not on an individual provider basis. A physician’s tier does not guarantee the quality of care that you might receive from a specific physician or practice group, or a certain health outcome. You should always speak with your physician when making decisions about where to get care.

*Updates that move a Provider from a higher benefit tier to a lower benefit tier may be made at other times during the year.

With Administrative Services Provided by

TUFTS Health Plan

705 Mount Auburn Street
Watertown, MA 02472-1508
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**
705 Mount Auburn Street
Watertown, MA 02472-1508

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

**IMPORTANT PHONE NUMBERS:**

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

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

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

For questions related to subrogation, call Member Services at 1-844-516-5790. If you are uncertain which department can best address your questions, call Member Services.

**Member Services Department**
Call the Tufts Health Plan Member Services Department at 1-844-516-5790 for general questions, benefit questions, and information regarding eligibility for enrollment and billing.

**Behavioral Health Services**
If you need assistance finding a Provider or receiving information regarding behavioral health/substance use disorder benefits, please contact the Tufts Health Plan Behavioral Health Department at 1-800-208-9565.

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

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

- **Massachusetts Relay (MassRelay)**
  711

**IMPORTANT ADDRESSES:**

**Appeals and Grievances Department**
If you need to call Tufts Health Plan about a concern or appeal, contact Member Services at 1-844-516-5790. To submit your appeal or grievance in writing, send your letter to:

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

**Web site**
For more information about Tufts Health Plan and to learn more about the self-service options that are available to you, please see the Tufts Health Plan Web site at www.tuftshealthplan.com/tuftsuniversity.
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 ترجمة مجانية باللغة العربية، الرجاء الاتصال على رقم بطاقة الهوية الخاصة بك.
Chinese: 若需免费的中文版本，请拨打ID卡上的电话号码。
French: Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.
German: Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.
Greek: Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτα σας.
Haitian Creole: Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.
Italian: Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.
Japanese: 日本語の無料翻訳についてはIDカードに書いてある番号に電話してください。
Khmer (Cambodian): សូមទៅទំព័រទូរស័ព្ទសំណុំក្រុមជួរដ៏លឿននេះទៅទុកចុះជាមួយលោកអ្នក។
Korean: 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.
Laotian: ໃຫ້ຮុំលំហាត់ភាសាសាមរបស់អ្នកដោយសេចក្តីសេរីក្នុងការរៀបចំអំពីការប្រើប្រាស់តម្រូវការប្រុងប្រការ។
Navajo: Doo bááh ilini da Diné kʼechí áłnéehgo, hodiilih béešh be haniʼé beec néé hoʼolzingo nantíigii bíkáą.
Persian: اگر ترجمه رایگان برای زبان فارسی مورد نیاز دارید، با شماره تلفن، که بر روی کارت هویت شما مشخص شده است مکاتبه کنید.
Polish: Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.
Portuguese: Para tradução grátis para português, ligue para o número no seu cartão de identificação.
Russian: Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.
Spanish: Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.
Tagalog: Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.
Vietnamese: Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

Telecommunications Device for the Deaf (TDD)
711.

MassRelay
711.
**Plan Information**

**Plan Name**
Tufts University Quality Tiered Health Plan PPO

**Employer Address**
200 Boston Ave. Suite 1600
Medford, MA 02155

**Employer’s ID Number (EIN)**
04-2103634

**Plan Number**
48347-000

**Tufts Health Plan Effective Date**
This plan became effective as of January 1st, 2015.

**Description of Benefits Effective Date**
This Description of Benefits is effective January 1, 2018.

**Calendar Year**
January 1st – December 31st

**Plan Administrator and Agent for Service of Legal Process**
Vice President for Human Resources, Tufts University

**Type of Plan**
Medical and Pharmacy 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.

**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.

*Italicized words are defined in Appendix A.*
Preferred Provider Option Plan

Overview

Introduction
This booklet contains your Description of Benefits. It describes Tufts University employee health benefits 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 and you are responsible for any member cost share as outlined in this document. Italicized words are defined in the Glossary in Appendix A.

How the Plan works
The Group has contracted with Tufts Health Plan. Tufts Health Plan offers a preferred provider organization (“PPO”) and performs certain services for the Plan, such as claims processing and enrollment. Tufts Health Plan also offers you access to a network of preferred providers known as Network Providers.

Tufts Health Plan does not, however, insure the Plan benefits or determine your eligibility for benefits under the Plan. This is the Plan’s responsibility.

About the Network
Network Providers are hospitals, community-based physicians and other health care professionals who work out of their private offices throughout the Network Contracting Area.

These Providers enter into arrangements either with Tufts Health Plan directly or with a Provider network with whom Tufts Health Plan contracts. Network Providers, in turn, provide you with Covered Services. This means that Tufts Health Plan itself does not provide these services. Network Providers are independent contractors and are not, for any purposes, employees or agents of the Plan or Tufts Health Plan.

With Tufts Health Plan, each time you need health care services, you may choose to obtain your health care from either:
- a Network Provider. This is the In-Network Level of Benefits.
- any Non-Network Provider. This is the Out-of-Network Level of Benefits.
Preferred Provider Option Plan, continued

About the Network, continued

The Plan will determine the level of benefits you receive for your health care services:

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

  In addition, this plan is a tiered plan. This means that most Network Providers (PCPs, Specialists, and Hospitals) have been placed into two tiers based upon whether they pass our quality and cost thresholds. These tiers determine your costs for care at the In-Network Level of Benefits from that Provider.

  - For most Outpatient services, the Network Provider’s practice group, rather than the individual Provider, is placed into a tier based upon whether the group passes our quality and cost thresholds. Because a Provider may change his or her practice group affiliation during the year, the Provider’s tier may change.
    - Network Providers who pass our quality threshold and lower cost threshold are Tier 1 Providers, referred to as “TU Preferred” providers. You will pay the lowest Copayment if you obtain care from Tier 1 TU Preferred Providers.
    - Network Providers who pass our quality threshold and moderate cost threshold are Tier 2 Providers. You will pay higher Copayments for care from Tier 2 Providers than for care from Tier 1 TU Preferred Providers.
  - Care at a Limited Service Medical Clinic at the In-Network Level of Benefits is covered with a Tier 1 TU Preferred PCP Copayment.
  - Network Hospitals are also placed into tiers based on whether they pass our quality and cost thresholds.
    - Network Hospitals who pass our quality threshold and lower cost threshold are placed into Hospital Tier 1 TU Preferred, and are subject to the lowest Copayments.
    - Network Hospitals who pass our quality threshold and moderate cost threshold are placed into Hospital Tier 2 and are subject to higher Cost Sharing Amounts than those at Hospital Tier 1 TU Preferred.
  - You may receive some Outpatient services at the In-Network Level of Benefits, such as diagnostic imaging or Day Surgery, at free-standing facilities. Free-standing facilities are independent and are not affiliated with a hospital or hospital system. Covered Services at free-standing facilities at the In-Network Level of Benefits are covered with a lower Copayment than the same services provided at a hospital.
  - Please note that some Network Providers may be placed in Tier 2 because there was inadequate data to tier them or because the specialized range of services they provide were not subject to tiering.

For more information about the standards used for placing these Providers into tiers, please see the Web site at www.tuftshealthplan.com/tuftsuniversity or please call the Tufts University Dedicated line at 1-844-516-5790.

- **Out-of-Network Level of Benefits**: If your care is provided by a Non-Network Provider, you will be covered at the Out-of-Network Level of Benefits.
  - **Covered Services Outside of the 50 United States**: Emergency Care services provided to you outside of the 50 United States qualify as Covered Services. However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan. Once outside the 50 United States for more than 90 consecutive days, Emergency Care services are no longer covered.

For additional information about these levels of benefits and how to receive Covered Services, please see Chapter 1. If you have any questions, please call the Tufts Health Plan Member Services Department.

**PLEASE READ THIS DESCRIPTION OF BENEFITS CAREFULLY.**
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Italicized words are defined in Appendix A.  
To contact Member Services, call 1-844-516-5790, or see our Web site at www.tuftshealthplan.com/tuftsuniversity.
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Italicized words are defined in Appendix A.

To contact Member Services, call 1-844-516-5790, or see our Web site at www.tuftshealthplan.com/tuftsuniversity.
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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 specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

<table>
<thead>
<tr>
<th>COST SHARING AMOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Level of Benefits:</strong></td>
</tr>
<tr>
<td><strong>Outpatient Cost-Sharing Amounts</strong> at the In-Network Level of Benefits vary based upon whether they are provided by a Primary Care Physician (PCP) or another Network Provider, and whether they are provided by a Tier 1 PCP or Provider, or a Tier 2 PCP or Provider.</td>
</tr>
<tr>
<td><strong>Inpatient and Day Surgery Cost Sharing Amounts</strong> at the In-Network Level of Benefits vary based upon whether they are provided at a facility that passes our quality threshold and lower cost threshold (Hospital Tier 1), or passes our quality threshold and moderate cost threshold (Hospital Tier 2). In addition, certain care at the In-Network Level of Benefits received at a free-standing facility (a facility not affiliated with a hospital or hospital system) may be subject to lower Cost-Sharing Amounts. Please see the following Benefit Overview for specific information.</td>
</tr>
</tbody>
</table>

**Copayments** for care in an Emergency Room are not tiered. You pay a $100 Copayment per Emergency Room visit at any Emergency Room, regardless of network tier.

**Important Notes:**

- An Emergency Room Copayment may apply (either In-Network or Out-of-Network) if you register in an Emergency Room but leave that facility without receiving care.
- If Day Surgery services are received at the In-Network Level of Benefits, tiered Cost-Sharing Amounts for those services may apply.
- The In-Network Deductible will apply for certain types of office visits. Please see “Important Information about your In-Network Deductible” and the “Benefit Overview” table below for information about when a Deductible does and does not apply.
- The PCP Level applies at the In-Network Level of Benefit to care provided by your PCP, a behavioral health/ substance use disorder Provider, or an obstetrician/ gynecologist (“OB/GYN”), as well as for Outpatient routine eye care and visits to a Limited Service Medical Clinic.
- For certain Outpatient services at the In-Network Level of Benefit listed as “covered in full” in the table below, you may be charged Cost Sharing Amounts when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are covered in full. Please see the following Benefit Overview chart for more information. Also, please note that Cost Sharing Amounts for Urgent Care services vary depending on type of Provider (PCP vs. specialist), tier of Provider, and location in which services are rendered (for example, Emergency Room, Limited Service Medical Clinic, Urgent Care Center, and Provider’s office).

**Out-of-Network Level of Benefits:**

Except as described in the Covered Services table below in this section, the Plan pay 80% of the Reasonable Charge for all Covered Services provided in the 50 United States by a Non-Network Provider. The Member pays the remaining 20%. The Member is also responsible for any charges in excess of the Reasonable Charge.

*Italicized words are defined in Appendix A.*
Benefit Overview, continued
This table provides basic information about your benefits under this plan. Please see the table below and the “Benefit Limits” section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

<table>
<thead>
<tr>
<th>DEDUCTIBLES (IN-NETWORK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDUCTIBLES per calendar year:</td>
</tr>
<tr>
<td>Each of these Deductibles applies under this plan for separate Tiers of Covered Services. However, any amount you pay towards the Deductible at one tier will apply towards the Deductibles of the other tiers.</td>
</tr>
<tr>
<td>TIER 2 Deductible</td>
</tr>
<tr>
<td>Individual ........................................................................................................................................... $1,000.</td>
</tr>
<tr>
<td>Family (two or more Members) ........................................................................................................ $1,000 per Member; $2,000 per family.</td>
</tr>
</tbody>
</table>

IMPORTANT NOTES ABOUT YOUR DEDUCTIBLES
The benefit schedule later in this section tells you which benefits are subject to a Deductible and other Cost Sharing Amounts you pay under this plan.

Any amount that we count towards your Tier 2 Deductible counts toward all three of these Deductibles.

Under a family plan, any combination of enrolled Members in a family can contribute towards meeting the Family Deductible at each Tier. Once the Family Deductible is met during a calendar year at each Tier, the Plan begins to pay for Covered Services under that Tier for all enrolled Members in a family under the terms of this Description of Benefits. However:

OPTION 1:
- If any enrolled Member in a family meets the Individual Deductible before the Family Deductible is met at that Tier, then that Member has met his/her Deductible requirement, and the Plan begins to pay for his/her Covered Services under the terms of this Description of Benefits.

The following amounts do not count towards your Deductible at each Tier:
- Any amount you pay for services or supplies that are not Covered Services. This includes pediatric dental care, because coverage is not provided through Tufts Health Plan.
- Costs in excess of the Reasonable Charge.

Italicized words are defined in Appendix A.
Benefit Overview, continued

This table provides basic information about your benefits under this plan. Please see the table below and the “Benefit Limits” section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

<table>
<thead>
<tr>
<th>DEDUCTIBLE (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Deductible</strong></td>
</tr>
<tr>
<td>An Individual Deductible of $2,000 per calendar year applies to each Member for Covered Services received at the Out-of-Network Level of Benefits.</td>
</tr>
<tr>
<td><strong>Family Deductible</strong></td>
</tr>
<tr>
<td>A Family Deductible of $4,000 per calendar year applies for all enrolled Members of a family for Covered Services received at the Out-of-Network Level of Benefits.</td>
</tr>
<tr>
<td>Once the Family Deductible has been met during a calendar year, all enrolled Members in a family will thereafter have satisfied their Individual Deductibles for the remainder of that calendar year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUT-OF-POCKET MAXIMUM (In-Network Tier 1 Tufts University Preferred Provider and Tier 2 combined)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Out-of-Pocket Maximum</strong>                                                           $2,000.</td>
</tr>
<tr>
<td>An Individual Out-of-Pocket Maximum of $2,000 applies to each Member per calendar year for Covered Services received at the In-Network Level of Benefits.</td>
</tr>
<tr>
<td><strong>Family (two or more Members) Out-of-Pocket Maximum</strong>                                         $4,000.</td>
</tr>
<tr>
<td>A Family Out-of-Pocket Maximum of $4,000 applies per calendar year for all enrolled Members of a family for Covered Services received at the In-Network Level of Benefits.</td>
</tr>
<tr>
<td>All amounts any enrolled Members in a family pay toward their Individual Out-of-Pocket Maximums are applied toward the Family Out-of-Pocket Maximum.</td>
</tr>
<tr>
<td>Once the Family Out-of-Pocket Maximum has been met during a calendar year, all enrolled Members in a family will thereafter have satisfied their Individual Out-of-Pocket Maximums for the remainder of that calendar year.</td>
</tr>
<tr>
<td>The following amounts do not count towards your Out-of-Pocket Maximum:</td>
</tr>
<tr>
<td>- Any amount you pay for services, supplies, or medications that are not Covered Services. This includes pediatric dental care, because this coverage is not provided through Tufts Health Plan.</td>
</tr>
<tr>
<td>- Costs in excess of the Reasonable Charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUT-OF-POCKET MAXIMUM (Tier 3 Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Out-of-Pocket Maximum</strong>          $4,000 per calendar year.</td>
</tr>
<tr>
<td><strong>Family Out-of-Pocket Maximum</strong>              $8,000 per calendar year.</td>
</tr>
<tr>
<td>This Family Out-of-Pocket Maximum applies for all enrolled Members of a family.</td>
</tr>
<tr>
<td>All amounts any enrolled Members in a family pay toward their Individual Out-of-Pocket Maximums are applied toward the Family Out-of-Pocket Maximum.</td>
</tr>
<tr>
<td>Once the Family Out-of-Pocket Maximum has been met during a calendar year, all enrolled Members in a family will thereafter have satisfied their Individual Out-of-Pocket Maximums for the remainder of that calendar year.</td>
</tr>
</tbody>
</table>

Italicized words are defined in Appendix A.
Benefit Overview, continued
This table provides basic information about your benefits under this plan. Please see the table below and the “Benefit Limits” section for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

<table>
<thead>
<tr>
<th>INPATIENT NOTIFICATION PENALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must pay the <em>Inpatient Notification Penalty</em> listed below for failure to <em>Preregister</em> a hospitalization or hospital transfer in accordance with Chapter 1.</td>
</tr>
</tbody>
</table>

**In-Network Level of Benefits:**
There is no *Inpatient Notification Penalty* for a hospitalization or hospital transfer at the *In-Network Level of Benefits*. As long as your *Inpatient* procedure is provided by a *Network Provider*, you are not responsible for *Preregistering* the hospitalization or transfer. Your *Network Provider* will *Preregister* the procedure for you.

**Out-of-Network Level of Benefits:**
You must pay an *Inpatient Notification Penalty* of $300 for failure to *Preregister* a hospitalization or hospital transfer at the *Out-of-Network Level of Benefits* in accordance with Chapter 1. For more information, please see “*Inpatient Notification*” in Chapter 1.

*Note:* This *Inpatient Notification Penalty* cannot be used to meet the *Deductibles* or *Out-of-Pocket Maximums* described above.

<table>
<thead>
<tr>
<th>PRE-EXISTING CONDITION LIMITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your <em>Effective Date</em>.</td>
</tr>
</tbody>
</table>

**Important Note about your coverage under the Affordable Care Act (“ACA”):** Under the ACA, preventive care services -- including women’s preventive health services, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription -- are now covered in full at the *In-Network Level of Benefits*. These services are listed in the following Benefit Overview. For more information on what services are now covered in full, please see our Web site at [https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/](https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/).
### Benefit Overview, continued

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

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<tr>
<th>COVERED SERVICE</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td></td>
<td>Tier 2 In-Network Provider</td>
</tr>
<tr>
<td></td>
<td>Tier 3 Out-of-Network Level of Benefits</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td><strong>Emergency Room Copayment.</strong></td>
</tr>
<tr>
<td>Treatment in an Emergency Room</td>
<td>$100 Emergency Room Copayment.</td>
</tr>
<tr>
<td></td>
<td>(waived if admitted as an Inpatient or for Day Surgery)</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Observation services will take an Emergency Room Copayment.</td>
</tr>
<tr>
<td><strong>You should call Tufts Health Plan within 48 hours after Emergency Care is received.</strong></td>
<td>If admitted as an Inpatient after receiving Out-of-Network Emergency Care, you or someone acting for you must call Tufts Health Plan within 48 hours in order to be covered at the In-Network Level of Benefits. <strong>Note:</strong> A Day Surgery Cost-Sharing Amount may apply if Day Surgery services are received. <strong>The Cost Sharing Amount is based upon the setting in which you receive care. Please see “Day Surgery” in this Benefit Overview for more information.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
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</tr>
<tr>
<td></td>
<td>Tier 2 In-Network Provider</td>
</tr>
<tr>
<td></td>
<td>Tier 3 Out-of-Network Level of Benefits</td>
</tr>
<tr>
<td>Allergy injections</td>
<td>Covered in full.</td>
</tr>
<tr>
<td></td>
<td>Covered in full.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td>Allergy testing and</td>
<td>$15 Copayment applies per visit.</td>
</tr>
<tr>
<td>treatment</td>
<td>$25 Copayment applies per visit.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

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**Italicized words are defined in Appendix A.**
**Benefit Overview, continued**

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

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<tbody>
<tr>
<td><strong>Tier 1 TU Preferred Provider</strong></td>
<td><strong>Tier 2 In-Network Provider</strong></td>
</tr>
</tbody>
</table>
| **Autism spectrum disorders – diagnosis and treatment (AR)** | **Habilitative or rehabilitative care (including applied behavioral analysis):**<br>- When provided by a Paraprofessional: Covered in full.<br>- When provided by a Board-Certified Behavior Analyst (BCBA): $15 Copayment per visit.<br>- When provided by a licensed physical or occupational therapist: $15 Copayment per visit.<br>- When provided by a licensed speech-language therapist or audiologist: $15 Copayment per visit.<br><br>**Prescription medications:** Covered as described under “Prescription Drug Benefit”.<br><br>**Psychiatric and psychologic care:** Covered as described under “Behavioral Health and Substance Use Disorder Services”.<br> | **Habilitative or rehabilitative care (including applied behavioral analysis):**<br>- When provided by a Paraprofessional: Covered in full.<br>- When provided by a Board-Certified Behavior Analyst (BCBA): $15 Copayment per visit.<br>- When provided by a licensed physical or occupational therapist: $15 Copayment per visit.<br>- When provided by a licensed speech-language therapist or audiologist: $15 Copayment per visit.<br> | *Out-of-Network Deductible and Coinsurance.*
| **Cardiac rehabilitation services** | $15 Copayment per visit. | $15 Copayment per visit. | *Out-of-Network Deductible and Coinsurance.*

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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**Benefit Overview, continued**

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</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>See “Spinal manipulation”</td>
</tr>
<tr>
<td>Cleft lip and cleft palate treatment and services for <em>Children</em></td>
<td>See “Cleft lip and cleft palate treatment and services for <em>Children</em>” under “Other Health Services” later in this table.</td>
</tr>
<tr>
<td>Cytology examinations (Pap Smear)</td>
<td>• Routine annual cytology testing: Covered in full. • Diagnostic cytology examinations: Covered in full.</td>
</tr>
<tr>
<td>Diabetes self-management training and educational services</td>
<td>$15 Copayment per visit.</td>
</tr>
</tbody>
</table>

**(AR)** – These services may require approval by an *Authorized Reviewer* on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “*Authorized Reviewer Approval*” in Chapter 1 for more information.

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Italicized words are defined in Appendix A.
Benefit Overview, continued

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

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<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td>Outpatient Care, continued</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td></td>
</tr>
<tr>
<td>• General imaging (such as x-rays and ultrasounds)</td>
<td>General Imaging:</td>
</tr>
<tr>
<td></td>
<td>• When performed in a non-hospital setting, including at a free-standing imaging center*: Covered in full.</td>
</tr>
<tr>
<td></td>
<td>• When performed in a hospital setting on an Outpatient basis: Covered in full.</td>
</tr>
<tr>
<td></td>
<td>MRI/MRA, CT/CTA, PET, and nuclear cardiology</td>
</tr>
<tr>
<td></td>
<td>• When performed in a free-standing imaging center*: Covered in full.</td>
</tr>
<tr>
<td></td>
<td>• When performed in a hospital setting on an Outpatient basis or at any other Outpatient setting: $150 Copayment per visit.</td>
</tr>
<tr>
<td></td>
<td>Note: Diagnostic imaging will be covered in full when the imaging is required as part of an active treatment plan for a cancer diagnosis.</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

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**Benefit Overview, continued**

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

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<th>COVERED SERVICE</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic or preventive screening procedures (for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies)</td>
<td><strong>Screenings for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention:</strong> Covered in full.</td>
</tr>
<tr>
<td>(AR)</td>
<td></td>
</tr>
<tr>
<td><strong>Important Note:</strong> Certain procedures may be covered in full, as required for preventive care by the Affordable Care Act. To determine if your procedure is covered in full, please contact Member Services.</td>
<td><strong>Diagnostic colonoscopies, proctosigmoidoscopies and sigmoidoscopies (procedure only):</strong> Covered in full.</td>
</tr>
<tr>
<td></td>
<td><strong>Diagnostic colonoscopies, proctosigmoidoscopies and sigmoidoscopies (procedure accompanied by treatment/surgery- for example, polyp removal):</strong> Covered in full.</td>
</tr>
<tr>
<td></td>
<td><strong>Other diagnostic procedures (procedure only):</strong></td>
</tr>
<tr>
<td></td>
<td>• When performed in a non-hospital setting, including at a free-standing ambulatory surgery center*: Covered in full.</td>
</tr>
<tr>
<td></td>
<td>• When performed in a hospital setting on an Outpatient basis: Covered in full.</td>
</tr>
<tr>
<td></td>
<td><strong>Other diagnostic procedures, when accompanied by treatment/surgery:</strong></td>
</tr>
<tr>
<td></td>
<td>• When performed in a non-hospital setting, including at a free-standing ambulatory surgery center*: $150 Copayment.</td>
</tr>
<tr>
<td></td>
<td>• When performed in a hospital setting on an Outpatient basis: $150 Copayment per visit.</td>
</tr>
<tr>
<td></td>
<td>(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.</td>
</tr>
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<td></td>
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</tbody>
</table>
**Benefit Overview, continued**

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<tr>
<th>COVERED SERVICE</th>
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<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic testing (AR)</td>
<td></td>
<td>• When performed in a non-hospital setting, including at a free-standing laboratory*: Covered in full.</td>
<td>• When performed in a non-hospital setting, including at a free-standing laboratory*: Covered in full.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

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**Benefit Overview, continued**

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
</tr>
<tr>
<td>Family planning (procedures, services, and contraceptives)</td>
<td><strong>Office Visit:</strong> $15 Copayment per visit</td>
</tr>
<tr>
<td><strong>Day Surgery:</strong></td>
<td></td>
</tr>
<tr>
<td>• At a free-standing ambulatory surgery center*: $150 Copayment.</td>
<td></td>
</tr>
<tr>
<td>• Hospital: $150 Copayment.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Under the ACA, women’s preventive health services, including contraceptives and female sterilization procedures, are covered in full at covered in full at the In-Network Level of Benefits. To determine whether a specific family planning service is covered in full or subject to a Cost Sharing Amount, please see <a href="https://www.hrsa.gov/womensguidelines2016/index.html">https://www.hrsa.gov/womensguidelines2016/index.html</a> or <a href="https://www.uspreventiveservicestaskforce.org/Page/Name/uspsf">https://www.uspreventiveservicestaskforce.org/Page/Name/uspsf</a> f-a-and-b-recommendations, or call Member Services.</td>
<td></td>
</tr>
<tr>
<td>Human leukocyte antigen testing or histocompatibility locus antigen testing</td>
<td>Covered in full.</td>
</tr>
<tr>
<td></td>
<td>All other vaccines: Covered in full.</td>
</tr>
<tr>
<td>Infertility services (AR)</td>
<td>$15 Copayment per visit. Note: Approved Assisted Reproductive Technology services are covered in full.</td>
</tr>
</tbody>
</table>

*(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
</tr>
<tr>
<td>Laboratory tests (AR)</td>
<td>• When performed in a non-hospital setting: Covered in full.</td>
</tr>
<tr>
<td><strong>Note:</strong> In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full at the In-Network Level of Benefits.</td>
<td>• When performed in a hospital setting on an Outpatient basis: Covered in full.</td>
</tr>
<tr>
<td></td>
<td>• When performed in a non-hospital setting, including at a freestanding imaging center*: Covered in full.</td>
</tr>
<tr>
<td></td>
<td>• When performed in a hospital setting on an Outpatient basis: Covered in full.</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>Preventive nutritional counseling: Covered in full. All other nutritional counseling services: $15 Office Visit Copayment. <strong>Note:</strong> Nutritional counseling services are covered in full at the In-Network Level of Benefits 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.</td>
</tr>
</tbody>
</table>

(AAR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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<tbody>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits to diagnose and treat illness or injury, including consultations</td>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Tier 1 TU Preferred</strong></td>
<td><strong>Tier 2 In-Network</strong></td>
<td><strong>Tier 3 Out-of-Network</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>Provider</td>
<td>Level of Benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15 Copayment applies per visit.</td>
<td>$25 Copayment applies per visit.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> This includes visits at a Limited Service Medical Clinic.</td>
<td></td>
<td></td>
<td></td>
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</tbody>
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<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral health services (AR)</td>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Tier 1 TU Preferred</strong></td>
<td><strong>Tier 2 In-Network</strong></td>
<td><strong>Tier 3 Out-of-Network</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>Provider</td>
<td>Level of Benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office Visit:</td>
<td>Office Visit:</td>
<td>Emergency Care in an</td>
<td><strong>Emergency Room:</strong> $100</td>
</tr>
<tr>
<td></td>
<td>$15 Copayment applies per visit.</td>
<td>$25 Copayment applies per visit.</td>
<td>Emergency Room:</td>
<td>Copayment applies per visit.</td>
</tr>
</tbody>
</table>
| | **Day Surgery:** | **Day Surgery:** | All other services: | Out-of-
| | - At a free-standing ambulatory surgery center*: $150 | - Hospital: Deductible and then $500 | Network Deductible and | |
| | - Hospital: $150 | Copayment per admission. | Coinsurance. | |
| | Emergency Room: $100 | | **Emergency Room:** $100 | Copayment applies per visit. | |
| | Copayment applies per visit. | | Inpatient Services: | |
| | **Inpatient Services:** | | **Hospital:** Deductible | **Hospital:** $250 | |
| | - Hospital: $250 | | and then $500 | Copayment per admission. | |
| | Copayment per admission. | | Copayment per admission. | |

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

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Benefit Overview, continued

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

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery in a Provider’s office</td>
<td>$15 Copayment applies per visit.</td>
</tr>
<tr>
<td>Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions</td>
<td>$15 Copayment applies per visit.</td>
</tr>
</tbody>
</table>

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. In addition, 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.uspreventiveservicestaskforce.org/Page/Name/uspsf-a-and-b-recommendations/ for more information about which laboratory services are considered preventive.

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(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

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Italicized words are defined in Appendix A.
Benefit Overview, continued

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<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>Tier 1 TU Preferred Provider</th>
<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care for Members age 6 and older</td>
<td>Covered in full. Note: Any follow-up care determined to be <em>Medically Necessary</em> as a result of a routine physical exam or a routine annual gynecological exam is subject to an Office Visit Copayment. In addition, Member cost sharing will also apply to diagnostic tests or laboratory tests when they are ordered as part of a preventive services visit or routine annual gynecological exam. Please see “Diagnostic testing” and “Laboratory tests” for information on your Cost Sharing Amounts for these services, and see our website at <a href="https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/">https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</a> for more information about which laboratory services are considered preventive.</td>
<td>Covered in full.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

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### Benefit Overview, continued

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

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1 TU Preferred Provider</strong></td>
<td>$Tier 2 In-Network Provider</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>Respiratory therapy or pulmonary rehabilitation services</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Rehabilitative and Habilitative physical and occupational therapy services (BL)</strong></td>
<td><strong>Physical therapy: $15 Copayment applies per visit.</strong> Physical therapy: $15 Copayment applies per visit.</td>
</tr>
<tr>
<td><strong>Note:</strong> Visit limits do not apply to the treatment of autism spectrum disorders.</td>
<td><strong>Occupational therapy: $15 Copayment applies per visit.</strong> Occupational therapy: $15 Copayment applies per visit.</td>
</tr>
<tr>
<td>Therapy for speech, hearing and language disorders</td>
<td>$15 Copayment applies per visit.</td>
</tr>
<tr>
<td><strong>Note:</strong> 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).</td>
<td></td>
</tr>
<tr>
<td>Smoking cessation counseling services</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>Spinal manipulation (BL)</td>
<td>$15 Copayment applies per visit.</td>
</tr>
<tr>
<td>Urgent Care in an Urgent Care Center</td>
<td>$15 Copayment applies per visit.</td>
</tr>
</tbody>
</table>

**AR** – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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<thead>
<tr>
<th>COVERED SERVICE</th>
<th>Tier 1 TU Preferred Provider</th>
<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Care, continued</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vision care services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual routine eye examination</td>
<td>$15 Copayment applies per visit.</td>
<td>$15 Copayment applies per visit.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td>Other vision care services</td>
<td>Care provided by an optometrist (O.D.): $15 Copayment applies per visit.</td>
<td>Care provided by an optometrist (O.D.): $15 Copayment applies per visit.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Care provided by an ophthalmologist (M.D.): $15 Copayment per visit.</td>
<td>Care provided by an ophthalmologist (M.D.): $25 Copayment per visit.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>Tier 1 TU Preferred Provider</th>
<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Surgery (AR)</td>
<td>When performed in a free-standing ambulatory surgery center*: $150 Copayment.</td>
<td>When performed in a hospital setting on an Outpatient basis: Deductible and then $500 Copayment.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td></td>
<td>When performed in a hospital setting on an Outpatient basis: $150 Copayment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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**Benefit Overview, continued**

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<thead>
<tr>
<th>COVERED SERVICE</th>
<th>Tier 1 TU Preferred Provider</th>
<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>Covered in full.</td>
<td>Tier 2 Deductible and then $500 Coinsurance.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td>Bone marrow transplants, hematopoietic stem cell transplants, and human solid organ transplants (AR)</td>
<td>$250 Copayment.</td>
<td>Deductible and then $500 Copayment.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td>Cleft lip and cleft palate treatment and services for Children</td>
<td></td>
<td></td>
<td>See “Cleft lip and cleft palate treatment and services for Children” under “Other Health Services” later in this table.</td>
</tr>
<tr>
<td>Gender reassignment surgery and related services (AR)</td>
<td><strong>Inpatient care (including Inpatient surgical procedures):</strong> $250 Copayment.</td>
<td><strong>Inpatient care (including Inpatient surgical procedures):</strong> Deductible and then $500 Copayment.</td>
<td><strong>Note:</strong> In the event that certain Inpatient gender reassignment surgeries are not available in the Network Contracting Area or from any Network Provider, your Cost Sharing Amount for these Covered Services is Deductible and then $500 Copayment.</td>
</tr>
<tr>
<td></td>
<td><strong>Day Surgery:</strong></td>
<td><strong>Day Surgery:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When performed in a free-standing ambulatory surgery center*: $150 Copayment.</td>
<td>• When performed in a hospital setting on an Outpatient basis: $150 Copayment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When performed in a hospital setting on an Outpatient basis: $150 Copayment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient care related to gender reassignment surgery (including pre-operative and post-operative Outpatient care):</strong> Covered as described under “Office visits to diagnose and treat illness or injury”, above.</td>
<td><strong>Outpatient care related to gender reassignment surgery (including pre-operative and post-operative Outpatient care):</strong> Covered as described under “Office visits to diagnose and treat illness or injury”, above.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Behavioral health care services related to gender reassignment surgery (pre-operative and post-operative):</strong> Covered as described under “Behavioral health and substance use disorder services”, below.</td>
<td><strong>Behavioral health care services related to gender reassignment surgery (pre-operative and post-operative):</strong> Covered as described under “Behavioral health and substance use disorder services”, below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Prescription medications:</strong> Covered as described under the “Prescription Drug Benefit” in Chapter 3.</td>
<td><strong>Prescription medications:</strong> Covered as described under the “Prescription Drug Benefit” in Chapter 3.</td>
<td></td>
</tr>
</tbody>
</table>

(AL) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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Italicized words are defined in Appendix A.
Benefit Overview, continued

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

<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 TU Preferred Provider</td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital services (Acute care) /facility fees (AR)</td>
<td>$250 Copayment.</td>
</tr>
<tr>
<td>Patient care services provided pursuant to a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions</td>
<td>$250 Copayment.</td>
</tr>
<tr>
<td>Reconstructive surgery and procedures (AR)</td>
<td>$250 Copayment.</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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<thead>
<tr>
<th>COVERED SERVICE</th>
<th>Tier 1 TU Preferred Provider</th>
<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please note that routine laboratory tests associated with maternity care are covered in full the In-Network Level of Benefits, in accordance with the ACA. However, 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-routine maternity care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit: $15 Copayment applies per visit.</td>
<td>Office Visit: $25 Copayment applies per visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$250 Copayment.</td>
<td>Deductible and then $500 Copayment.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
</tbody>
</table>

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**Benefit Overview, continued**

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<table>
<thead>
<tr>
<th>COVERED SERVICE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 TU Preferred Provider</td>
<td>Tier 2 In-Network Provider</td>
</tr>
<tr>
<td><strong>Behavioral Health and Substance Use Disorder Services</strong></td>
<td></td>
</tr>
<tr>
<td>To contact the Tufts Health Plan Behavioral Health Department, call 1-800-208-9565.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient services (AR)</strong></td>
<td>$15 Copayment applies per office visit.</td>
</tr>
<tr>
<td>Medication assisted treatment, including methadone maintenance</td>
<td>$5 Office Visit Copayment when provided by a medication assisted treatment clinic.</td>
</tr>
<tr>
<td><strong>Inpatient services, including Medically Necessary treatment in a behavioral health residential treatment facility (AR)</strong></td>
<td>$250 Copayment.</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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Benefit Overview, continued

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<tr>
<th>COVERED SERVICE</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 TU Preferred Provider</td>
</tr>
</tbody>
</table>

Other Health Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Tier 1 TU Preferred Provider</th>
<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleft lip and cleft palate treatment and services for Children (AR)</td>
<td>Medical or facial surgery:</td>
<td>Medical or facial surgery:</td>
<td>Dental surgery or orthodontic treatment and management:</td>
</tr>
<tr>
<td></td>
<td>- Inpatient services: Covered as described under “Hospital services (acute care)” or Reconstructive Surgery and Procedures”.</td>
<td>- Inpatient services: Covered as described under “Hospital services (acute care)” or Reconstructive Surgery and Procedures”.</td>
<td>Covered in full.</td>
</tr>
<tr>
<td></td>
<td>- Day Surgery: Covered as described under “Day Surgery”.</td>
<td>- Day Surgery: Covered as described under “Day Surgery”.</td>
<td>Preventive and restorative dentistry: Covered in full.</td>
</tr>
<tr>
<td></td>
<td>Dental surgery or orthodontic treatment and management: Covered in full.</td>
<td>Dental surgery or orthodontic treatment and management: Covered in full.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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).</td>
<td>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).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speech therapy and audiology services: Covered as described under “Therapy for speech, hearing, and language disorders”.</td>
<td>Speech therapy and audiology services: Covered as described under “Therapy for speech, hearing, and language disorders”.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutrition services: Covered as described under “Nutritional counseling”.</td>
<td>Nutrition services: Covered as described under “Nutritional counseling”.</td>
<td></td>
</tr>
</tbody>
</table>

Terminology:

AR – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

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Benefit Overview, continued

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<tr>
<th>COVERED SERVICE</th>
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<th>Tier 1 TU Preferred Provider</th>
<th>Tier 2 In-Network Provider</th>
<th>Tier 3 Out-of-Network Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Health Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (AR)</td>
<td></td>
<td>The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
</tr>
<tr>
<td>Hearing aids (BL)</td>
<td>Hearing aids for <strong>Children age 21 and under:</strong> The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>Hearing aids for <strong>Children age 21 and under:</strong> The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Scalp hair prostheses or wigs for cancer or leukemia patients</td>
<td>The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
<td></td>
</tr>
<tr>
<td><strong>Special medical formulas</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Low protein foods</td>
<td>The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>The Plan pays 80%. You pay 20% Coinsurance.</td>
<td>Out-of-Network Deductible and Coinsurance.</td>
<td></td>
</tr>
</tbody>
</table>

*(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.*

*(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.*

*A free-standing ambulatory surgery center is a facility not affiliated with a hospital or a hospital system.*

**Italicized words are defined in Appendix A.**

To contact Member Services, call 1-844-516-5790, or see our Web site at [www.tuftshealthplan.com/tuftsuniversity](http://www.tuftshealthplan.com/tuftsuniversity).
Benefit Overview, continued

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

<table>
<thead>
<tr>
<th>Prescription Drug Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>For information about your Copayments for covered prescription drugs, see the “Prescription Drug Benefit” section in Chapter 3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fitness Reimbursement and Weight Management Reimbursement (BL)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness Reimbursement:</strong> A Fitness Reimbursement is available to members age 18 and older who are enrolled in a Tufts University Health Plan for at least 3 months during 2018. The subscriber and one other covered dependent qualify for a 3-month reimbursement per year on expenses for fitness center membership or 24 group exercise classes within a 12-week period. Your fitness expenses must meet the following criteria for the reimbursement: For fitness centers, you must be a member of the center for at least three months during 2018 before you qualify for the reimbursement. The center must offer cardio and strength-training machines and other programs for improved physical fitness. Eligible expenses do not include martial arts centers, gymnastics centers, country clubs, aerobics-only or pool-only centers, sports teams and leagues, social clubs and tennis clubs, personal trainers, sports coaches, or the purchase of personal or at-home exercise machines. Group exercise classes must take place in a studio or health club and include aerobics, cycling, yoga, Pilates, Zumba, and kickboxing. Eligible expenses do not include dance classes and classes held in a residential setting.</td>
</tr>
<tr>
<td><strong>Weight Management Reimbursement:</strong> A Weight Management Reimbursement is available to members age 13 and older. The subscriber and one other covered dependent qualify for a 12-week reimbursement each, per calendar year, paid to the subscriber. To be eligible, members must be enrolled in a Tufts University health plan for at least 3 months during 2018. Qualifying Weight Watchers programs include: Traditional Weight Watchers meetings and Weight Watchers At Work programs. Please note that the Weight Watchers Online and Weight Watchers At Home programs do not qualify. In addition, fees for individual nutrition counseling sessions, food, books, videos, scales, or other items do not qualify for the reimbursement. For more information about this benefit, including covered classes and the reimbursement process, please call Member Services at 1-844-516-5790. Member must file for both benefits by March 31 of the following year.</td>
</tr>
</tbody>
</table>

(AR) – These services may require approval by an Authorized Reviewer on both the In-Network and Out-of-Network Levels of Benefits. At the In-Network Level of Benefits, your Provider will obtain this approval for you. At the Out-of-Network Level of Benefits, you are responsible for obtaining this approval. Please see “Authorized Reviewer Approval” in Chapter 1 for more information.

(BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

Italicized words are defined in Appendix A.
Benefit Limits

Extended Care Services
The maximum benefit payable in each calendar year is 100 days (*In-Network and Out-of-Network Levels combined*).

Fitness Reimbursement
The subscriber and one other covered dependent qualify for $150 individual reimbursement with a maximum of $300 family per year on expenses for fitness center membership or 24 group exercise classes within a 12-week period. Your fitness expenses must meet the following criteria for the reimbursement: For fitness centers, you must be a member of the center and the Tufts University Health Plan for at least three months during 2018 before you qualify for the reimbursement. The center must offer cardio and strength-training machines and other programs for improved physical fitness. Eligible expenses do not include martial arts centers, gymnastics centers, country clubs, aerobics-only or pool-only centers, sports teams and leagues, social clubs and tennis clubs, personal trainers, sports coaches, or the purchase of personal or at-home exercise machines. Group exercise classes must take place in a studio or health club and include aerobics, cycling, yoga, Pilates, Zumba, and kickboxing. Eligible expenses do not include dance classes and classes held in a residential setting.

Weight Management Reimbursement
A Weight Management Reimbursement is available to members age 13 and older. The subscriber and one other covered dependent qualify for $150 individual reimbursement with a maximum of $300 per family, per calendar year, paid to the subscriber. To be eligible, members must be enrolled in a Tufts University health plan for at least 3 months during 2018. Qualifying Weight Watchers programs include: Traditional Weight Watchers meetings and Weight Watchers At Work programs. Please note that the Weight Watchers Online and Weight Watchers At Home programs do not qualify. In addition, fees for individual nutrition counseling sessions, food, books, videos, scales, or other items do not qualify for the reimbursement.

Hearing aids
Hearing aids for Children age 21 and under are covered up to $2,000 per ear every 36 months (*In-Network and Out-of-Network Levels of Benefits combined*). 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 2 evaluations and 30 visits (*In-Network and Out-of-Network Levels of Benefits combined*) per injury or illness.

The maximum benefit payable in each calendar year for Habilitative physical therapy services is 2 evaluations and 30 visits (*In-Network and Out-of-Network Levels of Benefits combined*).

The maximum benefit payable in each calendar year for rehabilitative occupational therapy services is 2 evaluations and 30 visits (*In-Network and Out-of-Network Levels of Benefits combined*) per injury or illness.

The maximum benefit payable in each calendar year for Habilitative occupational therapy services is 2 evaluations and 30 visits (*In-Network and Out-of-Network Levels of Benefits combined*).

**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.

Spinal manipulation
The maximum benefit payable in each calendar year is 20 visits per person (*In-Network and Out-of-Network Levels combined*).
Chapter 1

How Your Preferred Provider Option Plan Works

Eligibility for Benefits
When you need health care services, you may choose to obtain these services from either:
• a Network Provider (In-Network Level of Benefits); or
• a Non-Network Provider (Out-of-Network Level of Benefits).

The Plan will determine the level of benefits you receive for your health care services. The Plan covers only the services and supplies described as Covered Services in 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.

In-Network Level of Benefits

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

In-Network Level of Benefits
You pay a Copayment for certain Covered Services you receive at the In-Network Level of Benefits. For more information about your Member costs for medical services, see “Benefit Overview” at the front of this Description of Benefits.

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

(There are special rules for Inpatient behavioral health and Inpatient substance use disorder services. Those rules are described under “Inpatient Behavioral Health and Substance Use Disorder” later in this chapter.)

Important: This plan assigns Network Providers to benefit tiers. You may pay different Cost-Sharing Amounts based on a Network Provider’s benefit tier. This plan updates the assigned benefit tier each year on January 1st*. You may pay different Cost-Sharing Amounts at the In-Network Level of Benefits if your Network Provider is reassigned to a different benefit tier. Please consult the Directory of Health Care Providers www.tuftshealthplan.com/tuftsuniversity site for information on the tier levels of available Network Providers.

There are many ways to measure the performance of a physician. We have created the Network Provider tiers for this plan at the physician group level—not on an individual provider-basis. A physician’s tier does not guarantee the quality of care that you might receive from a specific physician or practice group, or a certain health outcome. You should always speak with your physician when making decisions about where to get care.
In-Network Level of Benefits, continued

Selecting a Provider
In order to receive coverage at the In-Network Level of Benefits, you must receive care from a Network Provider listed in the Directory of Health Care Providers www.tuftshealthplan.com/tuftsuniversity site. You should choose a Provider who is in a location convenient to you. If you have difficulty or need assistance in finding a Provider, please contact us at 1-844-516-5790.

Notes:

- Under certain circumstances required by law, if your Provider is not in the Tufts Health Plan network, you will be covered for a short period of time for services provided by that Provider. Member Services can give you more information. Please see “Continuity of Care” on page 36.

- For additional information about a Network Provider or specialist, the Massachusetts Board of Registration in Medicine provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (800) 377-0550 or www.mass.gov/massmedboard.

No Inpatient Notification by You
As long as your Inpatient hospitalization is provided by a Network Provider, you are not responsible for notifying Tufts Health Plan of the Inpatient hospitalization or transfer to another hospital. Your Network Provider will notify Tufts Health Plan of the Inpatient hospitalization or transfer for you. See “Inpatient Notification” in Chapter 1 for more information.

Canceling Appointments
If you have to cancel an appointment with any Network Provider, always give him or her as much notice as possible, but at least 24 hours. If the Network Provider’s office policy is to charge for missed appointments that were not canceled in advance, you will have to pay the charges. The Plan will not pay for missed appointments that you did not cancel in advance.

Changes to Provider network
Tufts Health Plan offers Members access to an extensive network of physicians, hospitals, and other Providers throughout the Network Contracting Area. Network Providers may change during the year.

This can happen for many reasons, including a Provider’s retirement, moving out of the Network Contracting Area, or failure to continue to meet credentialing standards. In addition, because Providers are independent contractors, this can also happen if the Provider does not reach an agreement on a network contract.

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

Out-of-Network Level of Benefits

Out-of-Network Level of Benefits
If your care is not provided by a Network Provider, you are entitled to coverage for Covered Services at the Out-of-Network Level of Benefits. You pay a Deductible and Coinsurance for certain Covered Services you receive at the Out-of-Network Level of Benefits. For more information about your Member costs for medical services, see “Benefit Overview” at the front of this Description of Benefits.

Please note that you must submit a claim form for each service that is provided by a Non-Network Provider. For information on filing claim forms, see Chapter 6.

Covered Services Not Available from a Network Provider
If a Covered Service is not available from a Network Provider, as determined by Tufts Health Plan, with Tufts Health Plan’s approval, you may go to a Non-Network Provider and receive Covered Services at the In-Network Level of Benefit. The Plan will pay up to the Reasonable Charge for these services. You will be responsible for any charges in excess of the Reasonable Charge (as well as any applicable Cost Sharing Amount). You may receive a bill for these services. If you receive a bill, please call Member Services or see “Bills from Providers” in Chapter 6 (Page 86) for more information about what to do if you receive a bill.

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

Italicized words are defined in Appendix A.
Out-of-Network Level of Benefits (continued)

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

Continuity of Care

If you are an existing Member
If your Provider is involuntarily disenrolled from Tufts Health Plan for reasons other than quality or fraud, you may continue to see your Provider for Covered Services at the In-Network Level of Benefits in the following circumstances:

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

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

- you are undergoing a course of treatment. In this instance, you may continue to see your Provider and receive Covered Services at the In-Network Level of Benefits from that Provider for up to 31 days from your Effective Date.
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your Provider and receive Covered Services at the In-Network Level of Benefits from that Provider through your first postpartum visit.
- you are terminally ill. In this instance, you may continue to see your Provider and receive Covered Services at the In-Network Level of Benefits from that Provider as long as necessary.

Conditions for coverage of continued treatment
Tufts Health Plan may condition coverage of continued treatment upon the Provider’s agreement:

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

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

**Coverage at the Out-of-Network Level of Benefits**
If you wish to receive *Inpatient* or intermediate behavioral health or substance use disorder services at a *Provider* that is not a *Network Provider*, your coverage will be at the *Out-of-Network Level of Benefits*. Coverage at the *Out-of-Network Level of Benefits* means that you pay a *Deductible* and *Coinsurance* and are responsible notifying *Tufts Health Plan* of your admission. In order to receive care for *Inpatient* or intermediate behavioral health or substance use disorder services at the *Out-of-Network Level of Benefits*, you must receive prior authorization from an *Authorized Reviewer*. Please call the *Tufts Health Plan* Behavioral Health Department at 1-800-208-9565 for more information on how to receive this authorization.

**Emergency Admission to a non-Network Provider**
If you are admitted in an *Emergency* to a non- *Network Provider*, you will be covered at the *In-Network Level of Benefits* as long as you notify *Tufts Health Plan* within 48 hours of the admission. Once it is determined that transfer to a *Network Provider* is medically appropriate, you will be transferred to a *Network Provider*. If you choose not to accept the transfer and to remain at the non- *Network Provider*, then your coverage as of that time will revert to the *Out-of-Network Level of Benefits*.

**Emergency Care**

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

**Outpatient Care**
If you receive *Emergency* services but are not admitted as an *Inpatient*, you will be covered at the *In-Network Level of Benefits*. You will be required to pay a $100 *Copayment* for each *Emergency Room visit*.

If you receive *Emergency Covered Services* from a *Non-Network Provider*, the *Plan* will pay up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable *Copayment*). You may receive a bill for these services. If you receive a bill, please see "Bills from *Providers*" (Page 86) in Chapter 6 or call Member Services for more information about what to do if you receive a bill.

**Inpatient Care**
If you receive *Emergency* services and are admitted as an *Inpatient*, you or someone acting for you must notify *Tufts Health Plan* within 48 hours of seeking care in order to be covered at the *In-Network Level of Benefits*. (Notification from the attending physician satisfies this requirement.) Otherwise, coverage for these services will be provided at the *Out-of-Network Level of Benefits*.

Also, if you are admitted as an *Inpatient* to a hospital that is a *non-Network Provider* after receiving *Emergency Care*, an *Inpatient Copayment* will apply. In addition, you must notify *Tufts Health Plan* of the admission or you will be charged a *Notification Penalty*. *Inpatient Notification* guidelines are described later in this chapter.

Italicized words are defined in Appendix A.
Financial Arrangements between *Tufts Health Plan* and *Network Providers*

**Methods of payment to Network Providers**

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

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

You should feel free to talk to your *Provider* about how he or she is paid.

**Member Identification Card**

**Introduction**

*Tufts Health Plan* 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 Member Services.

**Identifying yourself as a *Tufts Health Plan* Member**

Your Member ID card is important because it identifies you as a *Tufts Health Plan* 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 Health Plan* Member.

**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.

*Italicized words are defined in Appendix A.*
Utilization Management

Utilization management

The purpose of the program is to control health care costs by evaluating whether health care services provided to Members are Medically Necessary and provided in the most appropriate and efficient manner. This program includes prospective, concurrent, and retrospective review of health care services.

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 the course of treatment as it occurs and to determine when that treatment is no longer Medically Necessary.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, retrospective review is used to more accurately determine the appropriateness of health care services provided to Members. Retrospective review is also referred to as "post-service review".

TIME FRAMES FOR TUFTS HEALTH PLAN TO REVIEW YOUR REQUEST FOR COVERAGE

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Time frame for Determinations*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective (Pre-service) review</td>
<td>15 days</td>
</tr>
<tr>
<td>Concurrent review</td>
<td>Determination is made prior to treatment being reduced or terminated to allow you to appeal the determination.</td>
</tr>
<tr>
<td>Retrospective (Post-service) review</td>
<td>31 days</td>
</tr>
<tr>
<td>Urgent care review</td>
<td>72 hours</td>
</tr>
</tbody>
</table>

*Time frames for determinations may be extended under certain circumstances.

See Appendix B for more details on determination procedures under the Department of Labor’s (DOL) Regulations.

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.

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

IMPORTANT NOTE: Members can call the following numbers to determine the status or outcome of utilization review decisions:
- Behavioral health and substance use disorder utilization review: 1-800-208-9565;
- All other utilization review decisions: 1-844-516-5790.

Care Management

Some Members with Severe Illnesses or Injuries may warrant care management intervention under a case management program. Under this program, use of the most appropriate and cost-effective treatment is encouraged, and the Member’s treatment and progress is supported.

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 Network Provider to discuss a treatment plan and establish prioritized goals. A Complex Care Manager may suggest alternative services or supplies available to the Member.

The Member’s treatment plan may be periodically reviewed. The Member and the Member’s Network Provider will be contacted if alternatives to the Member’s current treatment plan are identified 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.
Care Management, continued

Individual case management (ICM)
In certain circumstances, Tufts Health Plan 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 Health Plan may authorize certain coverage for alternative services and supplies that do not otherwise constitute Covered Services for that Member. This will occur only if Tufts Health Plan 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 treatment or supplies that the Member otherwise might have incurred during the current episode of illness;
- the Member and an Authorized Reviewer agree to the alternative treatment program; and
- the Member continues to show improvement in his or her condition, as determined periodically by an Authorized Reviewer.

Tufts Health Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the Member. If, at any time, these services and supplies fail to satisfy any of the conditions described above, Tufts Health Plan 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 authorize 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 require this approval are identified by (AR) in the “Benefit Overview”.

- If you receive these services from a Network Provider, the Provider is responsible for obtaining approval from an Authorized Reviewer.
- If your services are not provided by a Network Provider, you are responsible for obtaining prior approval from an Authorized Reviewer. If prior approval is not received, Tufts Health Plan will not cover those services and supplies. In addition, if you receive services that Tufts Health Plan determines are not Covered Services, you will be responsible for the cost of those services.

For more information about how to obtain this prior approval, please call Member Services.

If a request for coverage is denied, you have a right to appeal. Please see Chapter 6, “How to File a Claim and 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. |
**Inpatient Notification (formerly known as Preregistration)**

**Introduction**

*Inpatient Notification* is the process that makes *Tufts Health Plan* aware of all *Inpatient* admissions and transfers to another hospital. We will evaluate the anticipated hospital stay, your proposed medical care, verify medical necessity, and assess the need for a care management program after discharge or recommend an alternative treatment setting.

The *Inpatient Notification* to *Tufts Health Plan* by your *Provider* does not guarantee payment. The *Plan* is not obligated to pay claims for persons who fail to meet eligibility criteria, who receive care that is determined not to be *Medically Necessary*, or if the claim is not for a *Covered Service*.

**When Care is Provided by a Network Provider**

When a *Network Provider* is directing your care, he or she is responsible to notify *Tufts Health Plan* of your *Inpatient* admission or transfer. In this case, you do not need to notify us of the admission or transfer.

**When Care is Not Provided by a Network Provider**

When your care is *not* provided by a *Network Provider*, you are responsible to notify *Tufts Health Plan* of any *Inpatient* admission or transfer.

If you do not notify *Tufts Health Plan*, you will have to pay a *Notification Penalty* in addition to the *Deductible* and *Coinsurance*. (Please see “Benefit Overview” for the amount of the *Notification Penalty*. ) Please read carefully the following description of the *Inpatient Notification* process that you must complete when a *Network Provider* is not directing your care.

**Note:** If your *Group* does not have an *Inpatient Notification Penalty*, this provision does not apply to you. Please see “Benefit Overview” at the front of this *Description of Benefits* to determine if a *Notification Penalty* applies to you.

**How to Notify *Tufts Health Plan* of a Hospital Admission**

Call the Member Services number on your ID card to report your hospital admission. You, or someone acting on your behalf, will need to provide the following information:

- Patient name, address and phone number (work and home)
- Hospital name, address and phone number
- Member identification number (from your Member ID card)
- Employer
- Diagnosis and proposed procedure
- Proposed admission and discharge dates
- Admitting *Provider* name, address and phone number

*Italicized words are defined in Appendix A.*
Inpatient Notification (formerly known as Preregistration), continued

When to Notify Tufts Health Plan

For Elective Hospitalization or Transfers
Notification to Tufts Health Plan for elective hospitalizations or transfers must occur at least five (5) days prior to hospitalization. After you call Tufts Health Plan, we may consult with your Provider and will notify you or your Provider of the determination of the admission and the anticipated hospital stay or will recommend an alternative treatment setting.

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

For Deliveries
Notification to Tufts Health Plan for delivery of your newborn Child should occur within 31 days of your due date.

For A Newborn Child
- In cases where the newborn Child leaves the hospital with the mother after delivery, there is no need to notify Tufts Health Plan of that newborn Child’s hospital stay.
- In cases where the newborn Child remains in the hospital after the mother is discharged after delivery and the newborn Child’s care is not provided by a Network Provider, you must notify Tufts Health Plan immediately of your newborn Child’s hospital stay (In order to be covered for any Medically Necessary care, the newborn Child must be enrolled in the Plan within 31 days after birth. See Chapter 2 for more information. For a description of the Level of Benefits applicable to the newborn Child’s care, see Chapter 1.)

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

Changes to Hospital Admission Information
Notification of your hospital admission is valid only for the diagnosis, admission date and medical facility specified at the time of the notification. You must provide notification of any delays, changes or cancellations of your proposed admission. A separate notification to Tufts Health Plan must be obtained for a new admission date, readmission, hospitalization, or transfer or surgery for conditions other than those designated during the initial hospital admission.

If you do not provide notification of changes, you will be required to pay a Notification Penalty for that admission. See “Benefit Overview” at the front of this Description of Benefits for the amount of the Notification Penalty.

Extension of Hospitalization
All Inpatient hospitalizations are monitored. When it is Medically Necessary to extend hospitalization beyond the originally determined stay, Tufts Health Plan staff will request additional clinical information from your attending physician or hospital for additional Medically Necessary hospital days.

Note: If the review team, after conferring with your Provider, determines that Inpatient hospitalization is no longer Medically Necessary, you will be notified that any additional hospital days will not be covered and that you will be responsible to pay for all hospital and Provider charges if you choose to remain in the hospital beyond the discharge date.
Chapter 2

Eligibility, Enrollment, & Continuing Eligibility

Subscribers
You are eligible to enroll as a Subscriber when you are in the class of eligible employees established by the Plan, you live, work, or reside in the Network Contracting Area; and you are a benefits-eligible employee, scheduled to work a minimum of 90 days and scheduled to work the minimum number of hours per week as described below.

Dependents
Dependents are eligible under Family Coverage if they meet the definition of Dependent in Appendix A and live, work, or reside in the Network Contracting Area.

Notes:
- Children are not required to live, work, or reside in the Network Contracting Area. However, coverage outside of the Network Contracting Area is limited to the Out-of-Network Level of Benefits only.
- In some cases, other Dependents who live, work, or reside outside the Network Contracting Area can be eligible for coverage under this plan. Please see “If you do not live, work, or reside in the Network Contracting Area” below for more information.

If You Do Not Live, Work, or Reside In the Network Contracting Area
If you do not live, work, or reside in the Network Contracting Area, you can be covered only if:
- you are a Child;
- you are a Dependent subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced Spouse for whom Tufts Health Plan is required to provide coverage.

Note: Coverage outside of the Network Contracting Area is limited to the Out-of-Network Level of Benefits only.

Proof of Eligibility
Tufts Health Plan may ask you for proof of your and your Dependents’ eligibility or continuing eligibility. You must give Tufts Health Plan proof when asked. This may include proof of residence, marital status, birth or adoption of a Child, and legal responsibility for health care coverage.

Minimum Hours
In order to be eligible for coverage under the Plan, you must work a minimum of 17.5 hours per week.
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 31 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 31 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 are eligible under a state Medicaid plan or state children’s health insurance program (CHIP) and the Medicaid or CHIP coverage is terminated; or
- you or your Dependent become eligible for a premium assistance subsidy under a state Medicaid plan or CHIP.

Effective Date of coverage
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 are an Inpatient on your Effective Date, your coverage starts on the later of the Effective Date, or the date Tufts Health Plan is notified and given the chance to manage your care.

Italicized words are defined in Appendix A.
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 31 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; or
  - if your Group has an IRS qualified cafeteria plan, any other qualifying event under that plan.

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

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
</table>
| 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    | Complete a Qualified Status Change form or request a change as noted below:  
|      | - during your Group’s Open Enrollment Period, or  
|      | - within 31 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 or the date of your notification to the Tufts University Support Services, whichever is later.

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

Importance of enrolling newborn Children and Adoptive Children
You must enroll your newborn Child within 31 days after the Child’s birth for the Child to be covered from birth. Otherwise, you must wait until the next Open Enrollment Period to enroll the Child.

You must enroll your Adoptive Child within 31 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.

Italicized words are defined in Appendix A.
Qualified Domestic Partners

How to enroll a Qualified Domestic Partner
Your Group has elected coverage of Qualified Domestic Partners. In order to enroll a Qualified Domestic Partner, the Subscriber must provide to the Group:

- proof, acceptable to Tufts Health Plan and the Group, that the Subscriber and the Qualified Domestic Partner have shared a common residence for 12 prior consecutive months; and
- a completed and signed enrollment statement certifying that the relationship between the Subscriber and the Qualified Domestic Partner satisfies the criteria described in Appendix A.

A Subscriber may have only one Qualified Domestic Partner at a time. If the Qualified Domestic Partner’s coverage ends, the Subscriber may not enroll another Qualified Domestic Partner until the later of:

- 12 consecutive months following the date of termination of the first Qualified Domestic Partner’s coverage; and
- the date that the relationship between the Subscriber and a second Qualified Domestic Partner satisfies the criteria described in Appendix A.

Benefits available to a Spouse as described in this Description of Benefits are also available to a Qualified Domestic Partner, and benefits available to a Child as described in this Description of Benefits are also available to the child of a Qualified Domestic Partner, with the following exception: the continuation coverage described in Chapter 5 is not available to Qualified Domestic Partners or the children of Qualified Domestic Partners.

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.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>About 31 days before the Child no longer meets the definition of Dependent, please call the Tufts University Dedicated line at 1-844-516-5790 or go to our Web site at <a href="http://www.tuftshealthplan.com/tuftsuniversity">www.tuftshealthplan.com/tuftsuniversity</a> for instructions on Step 2 below.</td>
</tr>
<tr>
<td>2</td>
<td>Give proof, acceptable to Tufts Health Plan, of the Child’s disability.</td>
</tr>
</tbody>
</table>

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 Health Plan 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.

Italicized words are defined in Appendix A.
Continuing Eligibility for Dependents, continued

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.

Contact your Plan Administrator to report these changes within 31 days of the event.
Chapter 3

Covered Services

Covered Services

When health care services are Covered Services

Health care services 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 Web site at www.tuftshealthplan.com/tuftsuniversity or by calling Member Services;
- Emergency Care services provided to you outside of the 50 United States qualify as Covered Services. However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan. Once outside the 50 United States for more than 90 consecutive days, Emergency Care services are no longer covered.
- provided to treat an injury, illness, or pregnancy, except for preventive care; and
- approved by an Authorized Reviewer, in some cases.

Important Notes:

- **Authorized Reviewer approval**: All claims for services (whether or not the services were provided by a Network Provider) are subject to retrospective review by an Authorized Reviewer. Authorized Reviewers review claims to be sure that the claims are for Covered Services only. A Covered Service is one that is described in this chapter. The Plan will only pay claims that are for Covered Services.

- Certain services require the prior approval of an Authorized Reviewer at both the In-Network and Out-of-Network Levels of Benefits. Please see Chapter 1 for more information about how this prior approval is obtained at the In-Network Level of Benefits. If you wish to receive these services at the Out-of-Network Level of Benefits, you are responsible for obtaining prior approval from Tufts Health Plan. If prior approval is not received, Tufts Health Plan will not cover those services. Please contact Member Services, or, for behavioral health and substance use disorder services, the Tufts Health Plan Behavioral Health Department at 1-800-208-9565, for more information.

- **Inpatient Notification**: You must notify Tufts Health Plan of any Out-of-Network Inpatient admissions or hospital transfers. Please see “Inpatient Notification” in Chapter 1 for more information.

- At the In-Network Level of Benefits, for certain Outpatient services listed as “covered in full” below, you may be charged an Office Visit Copayment when these services are provided in conjunction with an office visit.

- For Outpatient care: When you receive services from a PCP, your Copayment may be lower than for services from other Providers.

- This plan assigns Network Providers to benefit tiers. You may pay different Cost-Sharing Amounts based on a Network Provider’s benefit tier. This plan updates the assigned benefit tier each year on January 1st*. You may pay different Cost-Sharing Amounts at the In-Network Level of Benefits if your Network Provider is reassigned to a different benefit tier. Please consult the Directory of Health Care Providers www.tuftshealthplan.com/tuftsuniversity site for information on the tier levels of available Network Providers.

**Important Note**: There are many ways to measure the performance of a physician. We have created the Network Provider tiers for this plan at the physician group level—**not on an individual provider-basis**. A physician’s tier does not guarantee the quality of care that you might receive from a specific physician or practice group, or a certain health outcome. You should always speak with your physician when making decisions about where to get care.

*To contact Member Services, call 1-844-516-5790, or see our Web site at www.tuftshealthplan.com/tuftsuniversity.
**Covered Services**, continued

**YOUR BENEFIT AMOUNTS:**
The table below includes references to the amounts you must pay for *Covered Services* under this plan (for example, *Copayments* and *Deductibles*). Please see “Benefit Overview” at the front of this *Description of Benefits* for the actual amounts you must pay for:

- Deductibles
- Emergency Room Copayments
- Office Visit Copayments
- Coinsurance
- Out-of-Pocket Maximums

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**Emergency Care**
In an *Emergency*, you should call 911 for emergency medical assistance (or the local number for emergency medical services) and seek care at the nearest emergency facility.

**Notes:**
- The Emergency Room *Copayment* is waived if the Emergency Room visit results in immediate hospitalization or *Day Surgery*.
- If you receive *Emergency Covered Services* from a Non-Network *Provider*, the *Plan* will pay the *Provider* up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge*, (as well as any applicable Cost Sharing Amount). You may receive a bill for these services. If you receive a bill, please see “Bills from *Providers*” in Chapter 6 (page 86) or call Member Services for more information about what to do if you receive a bill.
- An Emergency Room *Cost Sharing Amount* 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.
- A *Member* may obtain *Covered Services* for an *Emergency*, including local pre-hospital emergency medical service systems, whenever he or she has an *Emergency* which in the judgment of a prudent layperson would require pre-hospital emergency medical services. Please note that *Tufts Health Plan* will provide coverage of *Emergency services* from any *Provider*.
- *Emergency services* will be covered from all *Providers* at the cost-level of the lowest *In-Network* cost-sharing tier. This is the case regardless of the tier in which we have classified the *Provider* providing such *Emergency services* within the network. This includes any *Deductible* that may apply to an *Inpatient* hospital admission, if you are seeking *Emergency services* and are subsequently admitted.

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**Outpatient care**

**Allergy testing and treatment**
Allergy testing (including antigens) and treatment, and allergy injections.
**Covered Services**, continued

**Outpatient care**, continued

**Autism spectrum disorders – diagnosis and treatment**

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*:

- *Habilitation* 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;
- 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 *Habilitation* physical or occupational therapy” benefit do not apply to coverage for autism spectrum disorders.
- prescription drugs, covered under your “Prescription Drug Benefit”, described later in this chapter;
- psychiatric and psychological care, covered under your “Behavioral Health and Substance Use Disorder services” benefit, described later in this chapter;
- therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, or social workers), covered under your “Physical and occupational therapy services” and “Therapy for speech, hearing and language disorders”, described later in this chapter.

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

**Note**: Services may require the prior approval of an Authorized Reviewer at both the **In-Network** and **Out-of-Network Levels of Benefits**. Please call Member Services and see “Important Notes” on the first page of this chapter for more information about when you are responsible for obtaining this approval.

**Cardiac rehabilitation services**

Coverage is provided for the cost of *Outpatient* treatment of documented cardiovascular disease that is 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**

**Chiropractic care**

See “Spinal manipulation”

**Cytology examinations**

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

*Italicized words are defined in Appendix A.*
Covered Services, continued

Outpatient care, continued

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 at the In-Network Level of Benefits when provided by a Network
  Provider who is a certified diabetes health care provider.
- Medical nutrition therapy provided under this benefit is not subject to any visit limit such as that described in
  the “Nutritional counseling” benefit later in this chapter.

Diagnostic imaging
Including general imaging (such as x-rays and ultrasounds), and MRI/MRA, CT/CTA, and PET tests, and nuclear
cardiology.

Important Note: MRI/MRA, CT/CTA, PET, and nuclear cardiology may require the prior approval of an Authorized
Reviewer at both the In-Network and Out-of-Network Levels of Benefits. Please contact Member Services for more
information.

Diagnostic or preventive screening procedures
Including, but not limited to, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies.

Important Note: These procedures may require the prior approval of an Authorized Reviewer at both the In-
Network and Out-of-Network Levels of Benefits. See “Important Notes” on the first page of this chapter for more
information about when you are responsible for obtaining this approval.

Diagnostic testing
Examples include, but are not limited to, ambulatory EKG testing, sleep studies and diagnostic audiological testing.
Prior approval by an Authorized Reviewer may be required at both the In-Network and Out-of-Network Levels of
Benefits. Please call Member Services with questions about specific tests.

Early intervention services
Services provided by early intervention programs. Medically Necessary early intervention services include, but are
not limited to, occupational therapy, physical therapy, speech therapy, nursing care, and psychological counseling.
These services are covered for Members from birth until their third birthday.
Covered Services, continued

Outpatient care, continued

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

- Procedures
  - sterilization; and
  - pregnancy terminations.

- Services
  - medical examinations;
  - consultations;
  - birth control counseling; and
  - genetic counseling.

- Contraceptives
  - cervical caps;
  - Intrauterine devices (IUDs);
  - implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants);
  - Depo-Provera and its generic equivalent; and
  - any other Medically Necessary contraceptive device that has been approved by the United States Food and Drug Administration*.

*Note: Please note that the Plan covers certain contraceptives, such as oral contraceptives, over-the-counter female contraceptives, and diaphragms, under a Prescription Drug Benefit. If these contraceptives are covered under that benefit, they are not covered here. In addition, please note that contraceptives and female sterilization procedures are covered in full at the In-Network Level of Benefits. To determine whether a specific family planning service is covered in full or subject to a Cost Sharing Amount, please see https://www.hrsa.gov/womensguidelines2016/index.html and https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Hemodialysis
Includes Outpatient hemodialysis (including home hemodialysis) and Outpatient peritoneal dialysis (including home peritoneal dialysis).

Human leukocyte antigen (HLA) 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.

Immunizations and vaccinations
Except as otherwise excluded herein.
Covered Services, continued

Outpatient care, continued

Infertility services

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

| 
| Oral and injectable drug therapies used in the treatment of infertility associated with the Covered Services below 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. |

Infertility services include:

(I.) the following services and supplies provided in connection with an infertility evaluation:

- diagnostic procedures and tests; and
- procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.

(II.) the following procedures when approved in advance by an Authorized Reviewer (see “Important Notes” on the first page of this chapter for more information):

- artificial insemination (intrauterine or intracervical);
- cryopreservation of eggs (less than 90 days); and
- procurement and processing of eggs or inseminated eggs or banking of inseminated eggs when associated with active infertility treatment.

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

(III.) the following Assisted Reproductive Technology (“ART”) procedures when approved in advance by an Authorized Reviewer **:

- I.V.F. (in-vitro fertilization and embryo transfer);
- D.O. (donor oocyte);
- F.E.T. (frozen embryo transfer);
- G.I.F.T. (gamete intra-fallopian transfer);
- assisted hatching;
- Z.I.F.T. (zygote intra-fallopian transfer); and

**Note: Artificial insemination and the ART procedures described above will only be considered Covered Services for Members with infertility:

- who meet Tufts Health Plan’s eligibility requirements, which are based on the Member’s medical history;
- who meet the eligibility requirements of Tufts Health Plan’s contracting infertility services providers;
- when approved in advance by an Authorized Reviewer at both the In-Network and Out-of-Network Levels of Benefits (see “Important Notes” on the first page of this chapter for more information about when you are responsible for obtaining this approval); and
- with respect to the procurement and processing of donor sperm, eggs, or inseminated eggs, or the banking of donor sperm or inseminated eggs, to the extent such costs are not covered by the donor’s health care coverage, if any.

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

Outpatient care, continued

Laboratory tests
Including, but not limited to, blood tests, urinalysis, throat cultures, glycosylated hemoglobin (HbA1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles. **Important:** Laboratory tests must be ordered by a licensed Provider, and must be performed at a licensed laboratory. Some laboratory tests (e.g., genetic testing) may require the approval of an Authorized Reviewer at both the In-Network and Out-of-Network Levels of Benefits. Please see the “Important Notes” on the first page of this chapter and contact Member Services for more information.) In addition, in compliance with the ACA, laboratory tests associated with routine preventive care are covered in full at the In-Network Level of Benefits.

Lead screenings

Mammograms
Provided at the following intervals:
- one baseline at 35-39 years of age,
- one every year at age 40 and older,
- when otherwise Medically Necessary.

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 at the In-Network Level of Benefits.

Note: Weight loss programs and clinics are not covered.

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

Oral health services
The following oral health services are covered:
- **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:** All Non-Emergency oral health services performed in an Inpatient or Day Surgery setting must be approved in advance by an Authorized Reviewer and meet Medical Necessity guidelines in order to be covered. For more information or to review the Medical Necessity guidelines, please call Member Services or see our Web site at www.tuftshealthplan.com/tuftsuniversity

- Hospital, physician, and surgical charges are covered for the following conditions:
  - Surgical treatment of skeletal jaw deformities;
  - Surgical treatment of cleft lip or cleft palate for Children under the age of 18; or
  - Surgical treatment for Temporomandibular Joint Disorder (TMJ).
Covered Services, continued

Outpatient care, continued

Oral health services, continued

- Non-Emergency Care, continued
  - The costs of Inpatient services and Day Surgery for certain additional oral health services are covered in certain specific instances. For these services (see chart below) to be covered, the following clinical criteria must be met:
    - the Member cannot safely and effectively receive oral health services in an office setting because of a specific and serious non-dental organic impairment (for example, hemophilia), AND
    - the Member requires these services in order to maintain his/her health (and the services are not cosmetic or Experimental).

<table>
<thead>
<tr>
<th>If you meet the criteria above and require these services...</th>
<th>THEN you are covered for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical removal of impacted teeth when embedded in bone.</td>
<td>Hospital, physician, and surgical charges.</td>
</tr>
<tr>
<td>Extraction of 7 or more permanent teeth during one visit.</td>
<td>Hospital, physician, and surgical charges.</td>
</tr>
<tr>
<td>Surgical removal of unerupted teeth when embedded in bone.</td>
<td>Hospital, physician, and surgical charges.</td>
</tr>
<tr>
<td>Any other non-covered dental procedure that meets the above criteria.</td>
<td>Hospital charges only.</td>
</tr>
</tbody>
</table>

Please go to our website at www.tuftshealthplan.com/medicalnecessityguidelines to view the complete guidelines for determining Medical Necessity for these services, entitled “Dental Procedures Requiring Hospitalization”. You may also call Member Services for additional information.

Outpatient surgery in a Provider’s office

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.
Covered Services, continued

Outpatient care, continued

Preventive 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 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 at the In-Network Level of Benefits. Member cost-sharing will also apply at the In-Network Level of Benefits to diagnostic tests or diagnostic laboratory tests when 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.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ for more information about which laboratory services are considered preventive.

Preventive care for Members age 6 and older

- routine physical examinations, including appropriate immunizations and lab tests as recommended by a Provider;
- hearing exams and screenings for Members under age 18; and
- routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be Medically Necessary as a result of that exam.

Note: Any follow-up care determined to be Medically Necessary as a result of a routine physical exam or a routine annual gynecological exam is subject to an Office Visit Copayment at the In-Network Level of Benefits. Member cost-sharing will also apply at the In-Network Level of Benefits to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine physical exam or routine annual gynecological 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.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ for more information about which laboratory services are considered preventive.

Radiation therapy

Respiratory therapy or pulmonary rehabilitation services

Italicized words are defined in Appendix A.
Covered Services, continued

Outpatient care, continued

Rehabilitative and Habilitative physical and occupational therapy services
Rehabilitative physical and occupational therapy services, including cognitive rehabilitation or cognitive retraining, are covered. These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or illness and 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 physical therapist; and
- in compliance with Tufts Health Plan’s Medical Necessity guidelines, and, if applicable, prior authorization 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.

Therapy for speech, hearing and language disorders
Diagnosis and treatment when Medically Necessary. Please note that 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).

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.

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 Patient Protection and Affordable Care Act.

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

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

Note: Coverage is provided up to the maximum benefit listed in “Benefit Overview” at the front of this Description of Benefits. You pay all subsequent charges in that calendar year.

Urgent Care in an Urgent Care Center
Covered Services, continued

Outpatient care, continued

Vision care services
- **Annual routine eye examination.** Coverage is provided for one routine eye examination every calendar year. **Note:** You must receive routine eye examinations from a Provider in the EyeMed Vision Care network in order to obtain coverage for these services at the In-Network Level of Benefits. Please go to www.tuftshealthplan.com/tuftsuniversity or contact Member Services for more information.
- **Other vision care services.** Coverage is provided for eye examinations and necessary treatment of a medical condition. **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.

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:** Prior approval by an Authorized Reviewer is required for certain Day Surgeries at both the In-Network and Out-of-Network Levels of Benefits. Call Member Services and see "Important Notes" on the first page of this chapter for more information about which Day Surgeries require this approval and about when you are responsible for obtaining this approval.

Inpatient care

Bone marrow transplants, hematopoietic stem cell transplants, and human solid organ transplants
**Authorized Reviewer** approval is required before you receive a bone marrow transplant, hematopoietic stem cell transplant, or a solid organ transplant (regardless of whether the procedure is provided by a Network Provider or a Non-Network Provider). Call the Tufts Health Plan Member Services Department for more information. Coverage is provided for the cost of:
- Bone marrow transplants for Members diagnosed with breast cancer that has progressed to metastatic disease; and
- Hematopoietic stem cell transplants and human solid organ transplants which are generally accepted in the medical community for Members who are the stem cell or solid organ recipients. When the recipient is a Member, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:
  - evaluation and preparation of the donor; and
  - surgical intervention and recovery services when those services relate directly to donating the stem cells or solid organ to the Member.

Notes:
- 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 up to 10 searches for donors not related by blood. Additional donor search expenses for unrelated donors must be approved by an Authorized Reviewer.
- Prior approval by an Authorized Reviewer is required at both the In-Network and Out-of-Network Levels of Benefits. See “Important Notes” on the first page of this chapter for more information about when you are responsible for obtaining this approval.
- The Plan covers a Member’s human leukocyte antigen (HLA) testing. See “Outpatient care” earlier in this chapter for more information.
Covered Services, continued

Inpatient care, continued

Extended care services
Extended care services are Skilled nursing, rehabilitation or chronic disease hospital services which are provided in a Medicare-certified:
- skilled nursing facility;
- rehabilitation hospital; or
- chronic hospital.

Custodial Care is excluded from coverage.

Important Note: Prior approval by an Authorized Reviewer is required at both the In-Network and Out-of-Network Levels of Benefits. See the “Important Notes” on the first page of this chapter and call the Tufts Health Plan Member Services Department for more information.

Gender reassignment surgery and related services
(Prior authorization is required for these services at both the In-Network and Out-of-Network Levels of Benefits) Coverage is provided for gender reassignment surgery, and pre-operative and post-operative services related to the surgery, prescription drugs and behavioral health care services for Members undergoing the gender reassignment process. Covered Services include:
- Inpatient services, including female to male or male to female gender reassignment surgery and related surgical procedures. This includes certain associated cosmetic procedures for feminization or masculinization not otherwise covered under this plan. For information about which procedures are covered, call Member Services.
- Day Surgery for surgical procedures related to the female to male or male to female gender reassignment surgery. This includes certain associated cosmetic procedures for feminization or masculinization not otherwise covered under this plan. For information about which procedures are covered, call Member Services. These services are covered as described under “Day Surgery” earlier in this chapter.
- Outpatient medical care (pre-operative or post-operative) related to the 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 Abuse Services”, later in this chapter.
- Prescription medications required as part of the gender reassignment process. These medications are covered as described under the “Prescription Drug Benefit”, later in this chapter.

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

Inpatient care, continued

Hospital services (Acute care)
- anesthesia;
- diagnostic tests and lab services;
- drugs;
- dialysis;
- intensive care/coronary care;
- nursing care;
- physical, occupational, speech, and respiratory therapies;
- radiation therapy;
- semi-private room (private room when Medically Necessary);
- surgery*; and
- Provider's services while hospitalized.

*Important Note: Prior approval by an Authorized Reviewer is required for certain Inpatient surgeries at both the In-Network and Out-of-Network Levels of Benefits. Please contact Member Services for more information about which Inpatient surgeries require this approval and about when you are responsible for obtaining this approval.

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.
- 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
  - prosthesis* 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 autoimmune disease or infection.

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

Notes:
- Cosmetic surgery is not covered.
- Except as described above in connection with a mastectomy or the treatment of cleft lip and cleft palate for Children under age 18, Authorized Reviewer approval is required before you receive any reconstructive surgery or procedure (regardless of whether the procedure is provided by a Network Provider or a Non-Network Provider). See “Important Notes” on the first page of this chapter for more information about when you are responsible for obtaining this approval.
 Covered Services, continued

Maternity care – Routine and Non-Routine (Outpatient and Inpatient)

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

Notes:
- Providers may collect Copayments in a variety of ways for this coverage (for example, at the time of your first visit, at the end of your pregnancy, or in installments). Please check with your Provider.
- Routine prenatal tests are covered in full at the In-Network Level of Benefits, in accordance with the ACA. Member cost-sharing will apply at the In-Network Level of Benefits to diagnostic tests or diagnostic laboratory tests when 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.

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

(For information about notifying Tufts Health Plan for a newborn Child, see Chapter 1.)
Covered Services, continued

Maternity care – Routine and Non-Routine (Outpatient and Inpatient), continued

<table>
<thead>
<tr>
<th>IMPORTANT NOTE - Benefits for Newborn Children at Time of Delivery:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Member’s Delivery is Performed by a Network Provider</strong></td>
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<tr>
<td>If a mother is a Member whose delivery was performed by a Network Provider, the Plan will cover Medically Necessary care as follows:</td>
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<tr>
<td><strong>When newborn Child is enrolled:</strong> If the newborn Child is enrolled under the Plan as described under “Adding Dependents” in Chapter 2, the Plan will cover:</td>
</tr>
<tr>
<td>- Routine Nursery Care at the In-Network Level of Benefits; and</td>
</tr>
<tr>
<td>- Medically Necessary care other than Routine Nursery Care: (1) at the In-Network Level of Benefits, if that care is provided by a Network Provider, and (2) at the Out-of-Network Level of Benefits, if that care is not provided by a Network Provider (Inpatient Notification is required).</td>
</tr>
<tr>
<td><strong>When newborn Child is not enrolled:</strong> If the newborn Child is not enrolled under the Plan as described under “Adding Dependents” in Chapter 2, the Plan will cover Routine Nursery Care at the In-Network Level of Benefits; and (2) will not cover care other than Routine Nursery Care.</td>
</tr>
<tr>
<td><strong>2. Non-Member’s Delivery</strong></td>
</tr>
<tr>
<td>Applicable law requires a newborn Child’s Routine Nursery Care to be covered under the maternity coverage benefits of the mother’s health plan. If the mother is not a Member under the Plan and has no other maternity coverage benefits, the Plan will cover Medically Necessary care that the newborn Child may require (either Routine Nursery Care or other care) if that newborn Child is enrolled under the Plan.</td>
</tr>
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</tr>
<tr>
<td>- Routine Nursery Care (1) at the In-Network Level of Benefits, if that care is provided by a Network Provider, and (2) at the Out-of-Network Level of Benefits, if that care is not provided by a Network Provider, (Inpatient Notification is required); and</td>
</tr>
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<td>- Medically Necessary care other than Routine Nursery Care (1) at the In-Network Level of Benefits, if that care is provided by a Network Provider, and (2) at the Out-of-Network Level of Benefits, if that care is not provided by a Network Provider (Inpatient Notification is required).</td>
</tr>
<tr>
<td><strong>When newborn Child is not enrolled:</strong> If the newborn Child is not enrolled under the Plan as described under “Adding Dependents” in Chapter 2, the Plan will not pay for any care for the newborn Child.</td>
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</table>
**Covered Services, continued**

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

Behavioral health and substance use disorder services include the following *Outpatient, Inpatient* and Intermediate care services:

**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 *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.
- Psychopharmacological services and neuropsychological assessment services are covered as “Office visits to diagnose and treat illness or injury” as described earlier in this chapter.
- Prior approval by a *Tufts Health Plan Behavioral Health Authorized Reviewer* is required for psychological testing and neuropsychological assessment services at both the In-Network and Out-of-Network Levels of Benefits. Please contact the *Tufts Health Plan Behavioral Health Department* at 1-800-208-9565 for more information on how to obtain this authorization.

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

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

  Intermediate behavioral health and substance use disorder services. These services 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.

**Notes:**

- *Inpatient* and intermediate behavioral health and substance use disorder services must be obtained at a *Network Provider* in order to be covered at the *In-Network Level of Benefits*. See “*Inpatient* Behavioral Health and Substance Use Disorder Services” in Chapter 1 for more information.

- You must receive authorization from an *Authorized Reviewer* for *Inpatient* and intermediate behavioral health and substance use disorder services at the *Out-of-Network Level of Benefits*. Please contact the *Tufts Health Plan Behavioral Health Department* at 1-800-208-9565 for more information on how to receive this authorization.
Covered Services, continued

Other Health Services

Ambulance services

- Ground, sea, and helicopter ambulance transportation for Emergency Care.

- Airplane ambulance transportation (e.g., Medflight) when approved by an Authorized Reviewer*.

- Non-emergency, Medically Necessary ambulance transportation between covered facilities (approval by an Authorized Reviewer may be required).

- Non-emergency ambulance transportation for Medically Necessary care when the medical condition of the Member prevents safe transportation by any other means. Approval by an Authorized Reviewer may be required*.

*Approval by an Authorized Reviewer may be required for these benefits at both the In-Network and Out-of-Network Levels of Benefits. See "Important Notes" on the first page of this chapter for more information about when you are responsible for obtaining this approval.

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 (Prior approval by an Authorized Reviewer is required at both the In-Network and Out-of-Network Levels of Benefits, except as specified below)

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

- **Medical and facial surgery**: Covered as described under “Day Surgery”, “Hospital services (acute care)”, and “Reconstructive surgery and procedures” earlier in this chapter. This includes surgical management and follow-up care by plastic surgeons.

- **Oral surgery**: Covered as described under “Oral health services” earlier in this chapter. This includes surgical management and follow-up care by oral surgeons.

- **Dental surgery or orthodontic treatment and management**: Prior authorization is not required for these services if they are obtained at the In-Network Level of Benefits.

- **Preventive and restorative dentistry**: to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy. Prior authorization is not required for these services at the In-Network Level of Benefits.

- **Speech therapy and audiology services**: Covered as described under “Therapy for speech, hearing and language disorders” earlier in this chapter.

- **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.
Covered Services, continued

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. This prior approval is required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See “Important Notes” on the first page of this chapter for more information about when you are responsible for obtaining this approval.

**Important Note:** You may be responsible for paying towards the cost of *Durable Medical Equipment* covered under this plan. To determine whether your *Durable Medical Equipment* benefit is subject to a *Coinsurance*, please see the “Benefit Overview” sections at the front of this Description of Benefits.

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

Examples of 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 physician (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 per calendar year);
- insulin pumps;
- 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. (*Note:* Please see “Scalp hair prostheses or wigs for cancer or leukemia patients” later in this chapter for more information about prostheses and wigs for these patients);
- power/motorized wheelchairs.

*Tufts Health Plan* will decide whether to rent or purchase *Durable Medical Equipment* for use by the Member. At the *In-Network Level of Benefits*, this equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with *Tufts Health Plan* to provide such equipment. Certain equipment is subject to recovery when no longer *Medically Necessary* or upon termination of coverage, whichever is earlier.

(continued on next page)
Covered Services, continued

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;
- bed-related items, including bed trays, bed pans, bed rails, bed cradles, over-the-bed tables, and bed wedges;
- car seats;
- car/van modifications;
- comfort or convenience devices;
- dentures;
- ear plugs;
- exercise equipment and saunas;
- externally powered exoskeleton assistive devices and orthoses;
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts, or stair climbers;
- foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease;
- heating pads, hot water bottles, and paraffin bath units;
- 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.
- breast prostheses and prosthetic arms and legs. For more information about these covered devices, see “Prosthetic Devices” later in this chapter.
- Wheelchair trays

Hearing aids

Coverage is provided for:

- hearing aids (one per ear per prescription change) for Children age 21 or younger. Coverage is provided up to $2,000 per ear every 36 months (In-Network and Out-of-Network Levels of Benefits combined). This includes both the amount the Plan pays and the Member’s Cost Sharing Amount. Cap applies to the hearing aid device only, and does not apply to any hearing aid evaluations, fitting, adjustments, and supplies.
Covered Services, continued

Other Health Services, continued

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

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

*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 requirement 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 Therapy services” earlier in this chapter. However, those home health care services are not subject to the 60-day period for significant improvement requirement for rehabilitative services listed under “Rehabilitative and Habilitative Physical and Occupational Therapy services” or the benefit limit listed under “Benefit Limits” earlier in this Description of Benefits.

Hospice care services
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;
- 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.
**Covered Services**, continued

**Other Health Services**, continued

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

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

**Medical supplies**
The Plan covers the cost of certain types of medical supplies, including ostomy, tracheostomy, and catheter supplies.

Contact Member Services with coverage questions.

**Prosthetic devices**
*Tufts Health Plan* 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. Please see the first page of this chapter for more information about when you are responsible for obtaining this approval *

*Important Note:* Prior approval by an Authorized Reviewer is not required for breast prostheses provided in connection with a mastectomy.

**Scalp hair prostheses or wigs for cancer or leukemia patients**
Coverage is provided for 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 see “Durable Medical Equipment” earlier in this chapter.


**Covered Services**, continued

**Other Health Services**, continued

**Special medical formulas**

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 given to treat inherited diseases of amino acids and organic acids.

**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.

**Important Note:** Prior approval by an Authorized Reviewer may be required at both the In-Network and Out-of-Network Levels of Benefits. See “Important Notes” on the first page of this chapter for more information about when you are responsible for obtaining this approval.

**Special medical formulas (prior approval by an Authorized Reviewer may be required):**

Coverage is provided

- For the treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, and methylmalonic acidemia; or
- When Medically Necessary, to protect the unborn fetuses of women with PKU.

**Important Note:** Prior approval by an Authorized Reviewer may be required at both the In-Network and Out-of-Network Levels of Benefits. See “Important Notes” on the first page of this chapter for more information about when you are responsible for obtaining this approval.

Italicized words are defined in Appendix A.
**Covered Services**, continued

**Prescription Drug Benefit**

**Introduction**
This section describes the prescription drug benefit. The following topics are included in this section to explain your prescription drug coverage:
- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- *Tufts Health Plan* Pharmacy Management Programs
- Filling Your Prescription

**How Prescription Drugs Are Covered**
Prescription drugs will be considered *Covered Services* only if they comply with the “*Tufts Health Plan* Pharmacy Management Programs” section described below and are:
- listed below under “What is Covered”;
- provided to treat an injury, illness, or pregnancy;
- approved by the United States Food and Drug Administration (FDA); and
- *Medically Necessary.*

For a current list of covered drugs, please go to *Tufts Health Plan’s* Web site at [www.tuftshealthplan.com/tuftsuniversity](http://www.tuftshealthplan.com/tuftsuniversity), or call Member Services. For a list of non-covered drugs, please call Member Services.

The “Prescription Drug Coverage Table” below describes your prescription drug benefit amounts.
- Tier-1 drugs have the lowest level *Cost Sharing Amount.*
- Tier-2 drugs have the middle level *Cost Sharing Amount.*
- Tier-3 drugs have the highest level *Cost Sharing Amount.*

**Note:**
- Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells are covered in full when filled at a *Tufts Health Plan* designated pharmacy. These medications are not subject to any prescription drug deductible, if one applies to your plan.
- Smoking cessation agents (both prescription and generic over-the-counter agents when prescribed by a *Provider*) are covered in full.
- Certain drugs on our formulary are designated as part of our low cost drug program. Your retail pharmacy *Copayments* for these low cost drugs are $5 for up to a 30-day supply, and $10 for a 31-90 day supply. Please see the website at [www.tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy](http://www.tuftshealthplan.com/member/pharmacy/commercial-plans-pharmacy) or call Member Services for more information.
- Most generic drugs are covered on Tier 1 or Tier 2.
## Covered Services, continued

### Prescription Drug Benefit, continued

<table>
<thead>
<tr>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRUGS OBTAINED AT A RETAIL PHARMACY:</strong></td>
<td><strong>Tier-1 drugs:</strong> $10 for up to a 30-day supply $20 for a 31-60 day supply $30 for a 61-90 day supply <strong>Tier-2 drugs:</strong> $25 for up to a 30-day supply $50 for a 31-60 day supply $75 for a 61-90 day supply <strong>Tier-3 drugs:</strong> $50 for up to a 30-day supply $100 for a 31-60 day supply $150 for a 61-90 day supply</td>
</tr>
<tr>
<td>Covered prescription drugs (including both acute and maintenance drugs)</td>
<td><strong>Important Note:</strong> If you choose to obtain a covered prescription drug at a retail pharmacy which is not a Tufts Health Plan network pharmacy, you will be required to pay for the entire cost of the drug up front. You will then need to contact Tufts Health Plan in order to be reimbursed. You will be responsible only for the Member Cost Sharing Amount listed above.</td>
</tr>
<tr>
<td><strong>DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY:</strong></td>
<td><strong>Tier-1 drugs:</strong> $20 for up to a 90-day supply <strong>Tier-2 drugs:</strong> $50 for up to a 90-day supply <strong>Tier-3 drugs:</strong> $150 for up to a 90-day supply</td>
</tr>
<tr>
<td>Most maintenance medications, when mailed to you through a Tufts Health Plan designated mail services pharmacy.</td>
<td><strong>Note:</strong> • If you fill your prescription in a state that allows you to request a brand-name drug even though your Provider authorizes the generic equivalent, you will pay the applicable Tier Cost Sharing Amount plus the difference in cost between the brand-name drug and the generic drug. • If the cost of a drug is less than the minimum Cost Sharing Amount, you pay only for the cost of the drug.</td>
</tr>
</tbody>
</table>

*Italicized words are defined in Appendix A.*

To contact Member Services, call 1-844-516-5790, or see our Web site at [www.tuftshealthplan.com/tuftsuniversity](http://www.tuftshealthplan.com/tuftsuniversity).
Covered Services, continued

Prescription Drug Benefit, continued

**Value Based Benefit Program:** The Value Based Benefit Program is designed to encourage Members to take prescribed maintenance medications used to treat certain conditions, by offering these medications at no Copayment. Medications include those used in the treatment of asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (high blood pressure and high cholesterol), depression, diabetes and heart failure. If you would like to know if a prescription medication you take for these conditions is covered under the Value Based Benefit Program, please contact Member Services.

**Maintenance Choice Program:** Under the Maintenance Choice program, you can choose where to obtain maintenance medications for chronic conditions (i.e., hypertension, diabetes or asthma). You may obtain a 30-day supply of maintenance medication from any retail pharmacy, or a 90-day supply from either the CVS/Caremark mail order pharmacy, or from a CVS/pharmacy. The Copayments for a 90-day supply of these medications from the mail order or CVS/pharmacy provide cost savings over obtaining three 30-day supplies from retail pharmacies. If you do choose to obtain your maintenance medications through a retail pharmacy, you will be able to get the initial 30-day prescription and then one 30-day refill at that pharmacy. After one refill of a 30-day supply at a retail pharmacy, you must choose to obtain a 90-day supply either from the retail pharmacy or from the CVS/Caremark mail order pharmacy. The copayment for a 90-day supply at a retail pharmacy will be the same as the copayment for obtaining the medications through the CVS/Caremark mail order pharmacy. If you fill less than a 90-day supply of the maintenance medication, you will be responsible for the full cost of the drug.
**Covered Services**, continued

**Prescription Drug Benefit**, continued

**What is Covered**

The Plan covers the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under “What is Not Covered” (see “Important Notes” below).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Contraceptives, including oral contraceptives, diaphragms, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives (e.g., female condoms or contraceptive spermicides) when prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription, are covered in full.
  
  *Note: This Prescription Drug Benefit only describes coverage for oral contraceptives, diaphragms, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives when prescribed by a licensed Provider and dispensed at a pharmacy pursuant to a prescription. See “Family planning” earlier in this chapter for information about other contraceptive drugs and devices that qualify as Covered Services.*
- Fluoride for Children.
- Injectables and biological serum included on the list of covered drugs on the Tufts Health Plan Web site. Medically Necessary hypodermic needles and syringes required to inject these medications are also covered. For more information, call Member Services or see our Web site at www.tuftshealthplan.com/tuftsuniversity.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the Commissioner of Insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law and is FDA-approved. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call Member Services.
- Over-the-counter drugs included in the list of covered drugs on the formulary applicable to your plan when prescribed by a Provider. You may find the formulary on our website or you can call Member Services for more information. Certain medications used for bowel preparation in colonoscopy procedures are covered in full for Members age 50 through 74. For more information, please call Member Services or see the formulary on our Web site at www.tuftshealthplan.com.

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

*Italicized words are defined in Appendix A.*

To contact Member Services, call 1-844-516-5790, or see our Web site at www.tuftshealthplan.com/tuftsuniversity.
Covered Services, continued

Prescription Drug Benefit, continued

What is Not Covered
The Plan does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the “What is Covered” section above).
- Drugs that are part of our “Non-Covered Drugs with Suggested Alternatives” pharmacy management program unless they are approved for coverage for you through the medical review process. See “Pharmacy Management Programs” and “Important Notes” later in this chapter.
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, and fluoride for Children).
- Topical and oral fluorides for adults.
- Medications for the treatment of idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etionorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent (these are covered under your Outpatient care benefit earlier in this chapter),
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Products that are FDA approved as devices, including therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under Preventive health care earlier in this chapter.
- Over-the-counter smoking cessation agents
- Drugs for asymptomatic onchomycosis, except for Members with diabetes, vascular compromise, or immune deficiency status.
- Acne medications unless Medically Necessary.
- Compounded medications, if no active ingredients require a prescription by law. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may also not be covered. For more information, call Member Services or check our Web site at www.tuftshealthplan.com/tuftsuniversity.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check our Web site at www.tuftshealthplan.com/tuftsuniversity.
- Prescription medications when packaged with non-prescription products.
- Oral non-sedating antihistamines.
- Over-the-counter medications if not included on the list of covered drugs on our website.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
Covered Services, continued

Prescription Drug Benefit, continued

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

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

Prior Authorization Program:
Tufts Health Plan restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing Provider to obtain prior approval from Tufts Health Plan for such drugs.

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

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

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

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

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

IMPORTANT NOTES:

- If your Provider feels it is Medically Necessary for you to take medications that are restricted under any of the “Tufts Health Plan Pharmacy Management Programs” described above, he or she may submit a request for coverage. We will review the request and provides you with notification or our coverage determination within 72 (seventy-two) hours after receiving the request. Tufts Health Plan will approve the request if it meets the guidelines for coverage. For more information, call Member Services.

- If a request is made to cover medications that are part of the “New-to-Market Drug Evaluation Process” program or the “Non-Covered Drugs with Suggested Alternatives” program, and that request is approved by Tufts Health Plan, the medications will generally be covered on the highest tier (e.g., Tier 3 on a 3-tier formulary, Tier 7 on a 4-tier formulary), with some exceptions. Please call Member Services for more information about on which tier your medication is covered.

- The Tufts Health Plan Web site has a list of covered drugs with their tiers. Tufts Health Plan may change a drug’s tier during the year. For example, if a brand drug’s patent expires, Tufts Health Plan may change the drug’s status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) moving the brand drug to our list of non-covered drugs when a generic alternative becomes available.

- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check our Web site at www.tuftshealthplan.com/tuftsuniversity, or call Member Services.

Italicized words are defined in Appendix A.
Covered Services, continued

Prescription Drug Benefit, continued

Filling Your Prescription

Where to Fill Prescriptions:
You can fill your prescriptions at any pharmacy; however, Tufts Health Plan designated pharmacies will only charge you the Member Cost Sharing Amount at the time you fill your prescription. If you choose to fill your prescription at a non-Tufts Health Plan designated pharmacy, you will be responsible for paying the entire cost of the medication up front. Please see the “Prescription Drug Coverage Table” earlier in this chapter for more information. Tufts Health Plan designated pharmacies include:

- for the majority of prescriptions, many of the pharmacies in Massachusetts, New Hampshire, and Rhode Island, and additional pharmacies nationwide; and
- for a select number of drug products, a small number of designated specialty pharmacy providers. (For more information about Tufts Health Plan’s designated specialty pharmacy program, see “Tufts Health Plan Pharmacy Management Programs” earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the Tufts Health Plan Member Services Department.

How to Fill Prescriptions:

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

Important: If you are filling a prescription at a non-Tufts Health Plan designated pharmacy, please call the Member Services Department for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:
If you are required to take a maintenance medication, Tufts Health Plan offers you two choices for filling your prescription:

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

*The following may not be available to you through a Tufts Health Plan designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of Tufts Health Plan’s Quantity Limitations program; or
- medications that are part of Tufts Health Plan’s Designated Specialty Pharmacy program.

NOTE: Your Cost Sharing Amounts for covered prescription drugs are shown in the “Prescription Drug Coverage Table” earlier in this section.
Exclusions from Benefits

There is no coverage for the following services, supplies, or 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 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.
- A service, supply, or medication that is obtained outside of the 50 United States. The only exceptions to this rule are for **Emergency care services**, and for **Urgent Care services** provided to you while you are traveling, which qualify as **Covered Services** when provided outside of the 50 United States is excluded under this plan. Once outside the 50 United States for more than 90 consecutive days, emergency care services are no longer covered.
- **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;
  - bone marrow transplants for breast cancer;
  - patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions; or
  - off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS, if you have a Prescription Drug Benefit which meet the requirements of applicable law.

  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, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter. 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 **Provider** are not covered;
    - Services provided by an immediate family member (by blood or marriage), even if the relative is a **Provider**, are not covered.
    - If you are a **Provider**, you cannot provide or authorize services for yourself or 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. Refer to the **Directory of Health Care Providers** to determine if your **Provider** charges such a fee.

  - Charges incurred when the **Member**, for his or her convenience, chooses to remain an **Inpatient** beyond the discharge hour.

  - Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated).

*Italicized words are defined in Appendix A.*

To contact Member Services, call 1-844-516-5790, or see our Web site at [www.tuftshealthplan.com/tuftsuniversity](http://www.tuftshealthplan.com/tuftsuniversity).
Exclusions from Benefits, continued

- Facility charges or related services if the procedure being performed is not a Covered Service, except as provided under “Oral health services” earlier in this chapter.
- Preventive dental care; periodontal treatment; orthodontia, even when it is an adjunct to other medical and surgical 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” or as part of the gender reassignment process, as described 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, and 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.
- 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” and “Gender reassignment surgery and related services” earlier in this chapter.
- Rhinoplasty, except as provided under “Reconstructive surgery and procedures” and “Gender reassignment surgery and related services” earlier in this chapter; the removal of tattoos; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.
- Hair removal (e.g., electrolysis, laser hair removal), except when Medically Necessary to treat an underlying skin condition or for skin preparation for transgender genital surgery that has been approved by an Authorized Reviewer.
- 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; the costs of surrogacy*: 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; Infertility services which are necessary for conception as a result of voluntary sterilization; 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 means: (1) all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile Member. These costs include, but are not limited to: costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a Member.

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

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

Note: Tufts Health Plan may authorize short-term (less than 90 days) cryopreservation of sperm, oocytes or embryos for certain medical conditions that may impact a Member’s future fertility. Prior approval 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 and the Member is the sole recipient of the donor’s eggs.
- Reversal of gender reassignment surgery.
- Reversal of voluntary sterilization.
- Over-the-counter contraceptive agents, except as described in the “Prescription Drug Benefit” earlier in this chapter.

Italicized words are defined in Appendix A.
Exclusions from Benefits, continued

- 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"; or
  - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or the banking of sperm or inseminated eggs under "Infertility services" (to the extent such costs are not covered by the donor's health care coverage, if any).

- Acupuncture.
- Psychoanalysis; long term residential behavioral treatment.
- 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 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.

- 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.

- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; educational, vocational or recreational settings; daycare or preschool settings; Outward Bound, wilderness, camp or ranch programs), even if performed or provided by a licensed Provider (including, but not limited to, behavioral health professionals, nutritionists, nurses, or physicians). Examples of services provided in a non-conventional setting that are excluded from coverage include, but are not limited to, psychotherapy, ABA services and nutritional counseling.

- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the "Note" below.

  Note: The following blood services and products are covered:
  - blood processing;
  - blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (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.
Exclusions from Benefits, continued

- 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.

- Eyeglasses, lenses or frames, except as described earlier in this chapter; refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described earlier in this chapter, the Plan will not pay for contact lenses or contact lens fittings.

- Hearing aids, except as described earlier in this chapter.

- Private duty nursing (block or non-intermittent nursing).

- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for Members diagnosed with diabetes.

  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, or 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.

- Lodging related to receiving any medical service, including lodging related to gender reassignment surgery or related services.
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 Health Plan’s eligibility rules, including the requirement for minimum hours described in Chapter 2;
- you are a Subscriber or a Spouse and you no longer live, work, or reside in the Network Contracting 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 Health Plan Member, or Tufts Health Plan or any Tufts Health Plan employee;
- you commit an act of misrepresentation or fraud; or
- your Group’s contract with Tufts Health Plan ends. (For more information, see “Termination of the Group Contract” later in this chapter.)

*Note: Children are not required to live, work, or reside in the Network Contracting Area. However, coverage outside of the Network Contracting Area is limited to the Out-of-Network Level of Benefits only. In addition, there are a few other exceptions in which Dependents are still eligible for coverage under this plan even if they do not live, work, or reside in the Network Contracting Area. Please see “If you do not live, work, or reside in the Network Contracting Area” in Chapter 2 for more information.

Benefits after termination
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 requires medical care after your coverage ends.

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

When a Member is No Longer Eligible

Loss of eligibility
Your coverage ends on the date you no longer meet your Group’s 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. Coverage of any Child of an enrolled Dependent Child ends when the enrolled Dependent Child’s coverage ends.

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 31 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
Coverage may be terminated if you commit acts of physical or verbal abuse which are unrelated to your physical or behavioral health condition; and pose a threat to any Provider, any Tufts Health Plan Member, or Tufts Health Plan or any Tufts Health Plan employee.

Membership Termination for Misrepresentation or Fraud

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

Acts of misrepresentation or fraud
Examples of misrepresentation or fraud include:
- false or misleading information on your 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;
- 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 Health Plan’s and Group’s relationship
Coverage will terminate if the relationship between your Group and Tufts Health Plan ends for any reason, including:
- your Group’s contract with Tufts Health Plan terminates;
- your Group fails to pay its obligation;
- Tufts Health Plan stops operating; or
- your Group stops operating.

Italicized words are defined in Appendix A. 
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. (See “Important Note” in the “Duration of Coverage” table below for information about when you may be responsible for payment of more than 102% of the cost of COBRA coverage.) For more information, contact your Group or the Plan Administrator.

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

<table>
<thead>
<tr>
<th>Qualifying Event(s)</th>
<th>Qualified Beneficiaries</th>
<th>Maximum Period of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Termination of Subscriber’s employment for any reason other than gross misconduct.</td>
<td>Subscriber, Spouse, and Dependent Children</td>
<td>18 months*</td>
</tr>
<tr>
<td>• Reduction in the Subscriber’s work hours.</td>
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<tr>
<td>Subscriber’s divorce, legal separation, entitlement to Medicare, or death.</td>
<td>Spouse and Dependent Children</td>
<td>36 months</td>
</tr>
<tr>
<td>Subscriber’s or Spouse’s enrolled Dependent ceases to be a Dependent Child.</td>
<td>Dependent Child</td>
<td>36 months</td>
</tr>
</tbody>
</table>

*Important Note: If a qualified beneficiary is determined under the federal Social Security Act to have been disabled within the first 60 days of federal COBRA continuation coverage for these qualifying events, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA coverage for up to an additional 11 months. You may be responsible for the payment of up to 150% of the cost of COBRA coverage for this additional period of up to 11 months.

When coverage ends
Federal COBRA continuation coverage will end at the end of the maximum period of coverage, 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 service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Under USERRA:

- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed 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 exclusion) except for service-connected illnesses or injuries.

- Service members may be required to pay up to 102% of the premium for the health plan coverage. If coverage is for less than 31 days, the service member is only required to pay the employee share, if any, for such coverage.

- USERRA coverage runs concurrently with COBRA and other state continuation coverage.

- The U.S. Department of Labor, Veterans’ Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site 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 Web site (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 Health Plan Member Services Department.

Italicized words are defined in Appendix A.
Chapter 6

How to File a Claim and Member Satisfaction

How to File a Claim

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

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

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

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

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

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

To Obtain Claim Forms
Claim forms are available by calling the Tufts Health Plan Member Services Department.

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

Tufts Health Plan
Claims Department
P.O. Box 9185
Watertown, MA 02471-9185

Separate claim forms should be submitted for each family member.

Pharmacy Expenses
If you obtain a prescription at a non-designated or out-of-network pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting Member Services or through our Web site at www.tuftshealthplan.com/tuftsuniversity.
**Member Satisfaction Process**

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

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

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

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

All calls should be directed to the Tufts University Dedicated line at 1-844-516-5790. Alternatively, you may submit your grievance or appeal at the address listed above.

**Internal Inquiry**

Call a *Tufts Health Plan* Member Specialist 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 Services Coordinator that you are not satisfied with the response you have received from *Tufts Health Plan*, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

**Grievances**

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

It is important that you contact *Tufts Health Plan* 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 Specialist, who will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

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

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

**Administrative Grievances**

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

Administrative Grievance Timeline
- If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- Tufts Health Plan will review your grievance and will send you a letter regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and Tufts Health Plan.

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

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

Tufts Health Plan 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 time frame is extended.
Member Satisfaction Process, continued

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 Health Plan Member Services Coordinator, who will forward it to the Appeals and Grievances Department. You may also submit your appeal in person at the address listed at the beginning of this chapter. Alternatively, you can submit a written appeal to the address listed above. Tufts Health Plan 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 concern; and
- copies of any supporting documentation.

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

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

The Tufts Health Plan Benefits Committee will review appeals concerning specific exclusions and make determinations. The Tufts Health Plan Appeals Committee will make utilization management (medical necessity) decisions. If your appeal involves an adverse determination (medical necessity determination), it will be reviewed by a medical director and/or a practitioner in the same or 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.

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

The Appeals and Grievances Analyst will notify you in writing of Tufts Health Plan’s decision on your appeal, within no more than thirty (30) calendar days of the receipt of your appeal. 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 Health Plan maintains records of each inquiry made by a Member or by that Member’s authorized representative.
**Member Satisfaction Process, continued**

**Expedited Appeals**

*Tufts Health Plan* recognizes that there are urgent circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard appeals process. *Tufts Health Plan* 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 the 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 2 business days, but no later than 72 hours (whichever is less) after *Tufts Health Plan’s* receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.

**External Review**

For certain types of claims, you or your authorized representative have the right to request an independent, external review of our Appeals decision. Should you choose to do so, send your request within four months of your receipt of written notice of the denial of your appeal to:

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

In some cases, *Members* may have the right to an expedited 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 Health Plan* Member Services Coordinator for assistance.
Bills from Providers
Occasionally, you may receive a bill from a Non-Network Provider for Covered Services. Before paying the bill, contact the Tufts Health Plan 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 Health Plan web site or by contacting the Tufts Health Plan 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 bills to Tufts Health Plan 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.

If you receive Covered Services from a Non-Network Provider, you will be reimbursed up to the Reasonable Charge for the services.

IMPORTANT NOTE:
Certain services you receive from non-Network Providers at an in-network setting may be reimbursable. Some examples of these types of Providers include:

- radiologists, pathologists, and anesthesiologists who work in Network Hospitals; and
- Emergency Room specialists.

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

Limitation on Actions
You cannot file a lawsuit against Tufts Health Plan for failing to pay or arrange for or administer Covered Services unless you have completed the Tufts Health Plan 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 you’re 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 available to you due to an injury, illness, or condition for which the Plan has paid medical claims (including, but not limited to, any disability award or settlement, premises or homeowners’ medical payments coverage, premises or homeowners’ insurance coverage, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no fault automobile coverage or any first party insurance coverage).

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

No disbursement of any settlement proceeds or other recovery funds 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 interest are fully satisfied.
Subrogation and Right of Recovery, continued

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 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.
Subrogation and Right of Recovery, continued

Cooperation
You agree to cooperate fully with the Plan’s efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the Plan or its 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 information requested by the Plan, Tufts Health Plan or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury protection. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits, or the institution of court proceedings against you.

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

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

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

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.

Italicized words are defined in Appendix A.
Subrogation and Right of Recovery, continued

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

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

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

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

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 Health Plan will coordinate all benefits described in this Description of Benefits with other plans for the Plan, consistent with applicable law.

How COB works
The Plan will coordinate benefits by determining (a) which plan has the primary obligation to provide benefits to you when you make a claim (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:

- **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.

- **COB Rule**
  When all plans which cover you have COB rules consistent with the Plan’s COB rules, the rules listed below apply:

  - **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 a 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 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.

Italicized words are defined in Appendix A.
Coordination of Benefits, continued

How COB works, continued

- **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 the employee’s enrolled Dependent) who is neither laid off nor retired is primary to a plan that 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 determine which plan is primary, the plan which has covered a person longer is primary.

This Plan always pays secondary to:

- Any medical payment, 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.

**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 Medicare 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 Health Plan’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 Health Plan of new coverage or termination of other coverage. Tufts Health Plan may ask for and give out information needed to coordinate benefits.

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

You hereby assign to the Plan benefits which you 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 it made that are greater than payments it should have made under the COB program. The Plan will recover only overpayments it actually made.

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

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

The Plan 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.

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

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

Use and Disclosure of Medical Information
For information about how Tufts Health Plan uses and discloses your medical information, please contact a Member Services Coordinator. Information is also available on the Tufts Health Plan Web site at www.tuftshealthplan.com.

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

Italicized words are defined in Appendix A.
Relationships between *Tufts Health Plan* and *Providers*

*Tufts Health Plan* is an administrator of health care services. *Tufts Health Plan* does not provide health care services. *Tufts Health Plan* has agreements with *Providers* practicing in their private offices throughout the Network Contracting Area. These *Providers* are independent. They are not *Tufts Health Plan* employees, agents or representatives. *Providers* are not authorized to:

- modify the *Plan*; or  
- change this *Description of Benefits*; or  
- assume or create any obligation for the *Plan* or *Tufts Health Plan*.

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

Circumstances Beyond *Tufts Health Plan*’s Reasonable Control

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

**Group Contract**

Acceptance of the terms of the *Plan*

By completing the member application form, 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 the *Group* and *Tufts Health Plan*, *Tufts Health Plan* processes claims, disburses *Plan* funds and provides other *Covered Services* only when the *Group* has forwarded adequate funds to *Tufts Health Plan* to pay for *Covered Services*. This is the case even if the *Group* has charged you (for example, by withholding from your paycheck) for some or all of the cost of coverage under the *Plan*. If the *Group* fails to provide adequate funds for claims payment, *Tufts Health Plan* 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 Health Plan* 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 Health Plan* 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 Health Plan* sends a notice to you, it will be sent to your last address on file with *Tufts Health Plan*.

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

- *Tufts Health Plan*  
  Member Services  
  P.O. Box 9166  
  Watertown, MA 02471-9166

Enforcement of terms

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

Italicized words are defined in Appendix A.
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.

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

Authorized Reviewer
Authorized Reviewers review and approve certain services and supplies to Members. They are:

- Tufts Health Plan’s Chief Medical Officer (or equivalent); or
- someone he or she 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.

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. BCBA may supervise the work of Board-Certified Assistant Behavior Analysts and other Paraprofessionals who implement behavior analytic interventions.

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

Child
The following individuals covered until the last day of the month in which the Child’s 26th birthday occurs:

- The Subscriber’s or Spouse’s natural child, stepchild, or Adoptive Child; or
- any other Child for whom the Subscriber has legal guardianship.
Terms and Definitions, continued

Coinsurance
The Member’s share of costs for Covered Services.

- For services provided by a Network Provider, the Member’s share is a percentage of
  - the applicable Network fee schedule amount for those services; or
  - the Network Provider’s charges, whichever is less.

For services provided by a Non-Network Provider, the Member pays a share of Reasonable Charges. The Member is responsible for costs in excess of the Reasonable Charge.

Note: The Member's share percentage is based on the Tufts Health Plan 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.

See “Benefit Overview” at the front of this Description of Benefits for more information.

Copayment
The Member’s payment for certain Covered Services provided by a Network Provider. The Member pays Copayments to the Provider at the time services are rendered, unless the Provider arranges otherwise. Copayments are not included in the Deductible or Coinsurance.

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

Covered Service
The services and supplies for which the Plan will pay. They must be:
- described in Chapter 3 of this Description of Benefits (subject to the "Exclusions from Benefits" section in Chapter 3);
- Medically Necessary; and
- in some cases, approved by an Authorized Reviewer.

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

Note: Covered Services 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
A Provider designated by a Tufts Health Plan Provider to provide or authorize services to Members in the Tufts Health Plan Provider’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.

In cases of behavioral health care or substance use disorder care, Inpatient care or intermediate care provided primarily:
- for maintaining the Member’s or anyone else’s safety; or
- for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute hospital level of care or intermediate care.

Note: Custodial Care is not covered by the Plan.

Italicized words are defined in this Appendix A.
Terms and Definitions, continued

Day Surgery
Any surgical procedure(s) provided to a Member at a facility licensed by the state to perform surgery, and with an expected departure the same day, 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. Copayments do not count toward the Deductible. See “Benefit Overview” at the front of this Description of Benefits for more information.

Note: The amount credited towards the Member’s Deductible is based on the Network 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, Qualified Domestic Partner, Child, or Disabled Dependent.

Description of Benefits
This document, and any future amendments, which describes the Preferred Provider Option you have selected under the Plan.

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 separate booklet which lists Network physicians and their affiliated Network Hospital(s) and certain other Network Providers.

This directory is updated from time to time to reflect changes in Network Providers. For information about the Providers listed in the Directory of Health Care Providers, call Member Services or check Tufts Health Plan’s Web site at www.tuftshealthplan.com/tuftsuniversity.

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 the last day of the month in which the Child’s 26th birthday occurs; or has been covered by other group health coverage since the disability began.

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

Effective Date
The date, according to the Plan’s records, when you became a Member and were first eligible to receive Covered Services administered by Tufts Health Plan.

Emergency
An illness or medical condition, whether physical behavior, related to behavioral health or substance use disorders, or behavioral health, that manifests itself by symptoms of sufficient severity, including severe pain, that in 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.

Italicized words are defined in this Appendix A.
Terms and Definitions, continued

Group
The employer who sponsors the Plan, contracts with Tufts Health Plan for the provision of certain services and the availability of Network Providers 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 Health Plan’s agent.

Group Contract
The agreement between Tufts Health Plan and the Group under which Tufts Health Plan agrees to provide certain administrative services, and the Group agrees to pay Tufts Health Plan 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.

Hospital Tier 1 or 2
Inpatient hospital stays, Day Surgery admissions, and certain Covered Services at Network Hospitals are grouped into the following two tiers. The Cost Sharing Amount you pay for Covered Services at the In-Network Level of Benefits during an Inpatient or Day Surgery admission, or for certain Covered Services provided on an Outpatient basis will depend on which of these tiers applies to the facility in which you receive care:
- Hospital Tier 1: This tier applies to a Network Hospital that passes our quality threshold and lower cost threshold.
- Hospital Tier 2: This tier applies to a Network Hospital that passes our quality threshold and moderate cost threshold.

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

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

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

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

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

Italicized words are defined in this Appendix A.
**Terms and Definitions, continued**

**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 Health Plan* uses Clinical Coverage Guidelines which are:

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

**Member**
An employee or *Dependent* who is covered under the *Plan* and therefore entitled to all benefits in accordance with the *Plan*. Also referred to as “you”.

**Network Contracting Area**
The geographic area within which *Tufts Health Plan* has developed or arranged for a network of *Providers* to afford *Members* with adequate access to *Covered Services*.

*Note:* For information about *Providers* in the *Network Contracting Area*, call *Tufts Health Plan* Member Services or check *Tufts Health Plan*’s Web site at [www.tuftshealthplan.com/tuftsuniversity](http://www.tuftshealthplan.com/tuftsuniversity).

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

*Network Hospitals* are subject to change.

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

*Italicized words are defined in this Appendix A.*
Terms and Definitions, continued

Non-Conventional Medicine
A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the 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 conjunction with a traditional office visit. Providers of Non-Conventional Medicine services often request payment up front because health insurance typically does not cover these services.

Common terminology used to refer to these types of services include, but are not limited to, “alternative medicine”, “complementary medicine”, “integrative medicine”, “functional health medicine”, and may be described as treating “the whole person”, “the entire individual”, or “the inner self”, and may refer to re-balancing hormones or finding underlying causes that lead to bodily dysfunction. Examples of Non-Conventional Medicine and related services include, but are not limited to:
- holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields);
- manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi);
- mind-body medicine (e.g., hypnotherapy, meditation, stress management);
- whole medicine systems (e.g., naturopathy, homeopathy);
- biologically based practices (e.g., herbal medicine, dietary supplements, probiotics); and
- other related practices when provided in connection with Non-Conventional Medicine services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).

Non-Network Provider
A Provider who does not have an agreement either with Tufts Health Plan directly or with a provider network with which Tufts Health Plan has a contract to provide Covered Services to Members.

Notification Penalty (formerly known as “Preregistration Penalty”)
The amount a Member will be required to pay if he or she does not follow the Inpatient Notification guidelines described in Chapter 1. The Notification Penalty does not count toward Coinsurance, Deductibles, or the Out-of-Pocket Maximum. The Notification Penalty is shown in “Benefit Overview” at the front of this Description of Benefits.

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 an Inpatient basis. This includes services provided in a Provider’s office; a Day Surgery or ambulatory care unit; and an Emergency Room or Outpatient clinic.

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

Out-of-Network Level of Benefits
The level of benefits that a Member receives when care is not provided by a Network Provider. See “Benefit Overview” at the front of this Description of Benefits for more information.
Terms and Definitions, continued

Out-of-Pocket Maximum
The maximum amount of money paid by a Member during a calendar year for Covered Services. The Out-of-Pocket Maximum consists of Copayments, the Deductible and Coinsurance. It does not include the Notification Penalty, costs in excess of the Reasonable Charge for Covered Services received at the Out-of-Network Level of Benefits, or costs for health care services that are not Covered Services under the Plan.

Note: Once you have met your Out-of-Pocket Maximum in a calendar year, you continue to pay for any costs in excess of the Reasonable Charge.

See “Benefit Overview” at the front of this Description of Benefits for more information.

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 Health Plan is not the Plan Administrator.

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

Provider
A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, limited service medical clinics (if available), urgent care centers (if available), 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, and licensed psychiatric nurses who are certified as clinical specialists in psychiatric and behavioral health nursing, Licensed Alcohol and Drug Counselors I; 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.
Terms and Definitions, continued

Qualified Domestic Partner
An unmarried Subscriber's individual partner of the same or opposite sex who:

- is at least 18 years of age;
- is not married;
- is not related to the Subscriber by blood; and
- meets the eligibility criteria described in Chapter 2.

The Subscriber and the Qualified Domestic Partner must:

- share a mutually exclusive and enduring relationship;
- have shared a common residence for 12 prior consecutive months and intend to do so indefinitely;
- be financially interdependent;
- be jointly responsible for their common welfare; and
- be committed to a life partnership with each other.

Note: Roommates who do not satisfy the above criteria, parents, and siblings of the Subscriber cannot qualify as Domestic Partners.

Reasonable Charge
The lesser of the:

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

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

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

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

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

Spouse also includes the spousal equivalent of the Subscriber who is the registered Qualified Domestic Partner, civil union partner, or other similar legally recognized partner of the Subscriber who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Subscriber
The person who is employed by the Group for at least the minimum number of hours specified in Chapter 2 and enrolls in Tufts Health Plan and signs the member application form on behalf of himself or herself and any Dependents.
Terms and Definitions, continued

Tier 2 Deductible
The Deductible you pay for certain Covered Services at the In-Network Level of Benefits will fall into one of the two tiers listed below. Those services include Inpatient hospital care, Day Surgery provided in a hospital surgical day care unit or admission at a Network Hospital, and Outpatient hospital services. The Deductible you pay for these services will depend on the tier that applies to the Provider from whom you receive care:

- Tier 2 Deductible: This amount applies to certain Covered Services obtained at the In-Network Level of Benefits from a Network Hospital who passes our quality threshold and moderate cost threshold.

Tier 1 or 2 PCP
A Primary Care Provider will fall into one of the following two tiers. The Cost Sharing Amount you pay for Covered Services obtained from a PCP will depend on which of these tiers applies to him or her:

- Tier 1 PCP: A Primary Care Provider who passes our quality threshold and our lower cost threshold.
- Tier 2 PCP: A Primary Care Provider who passes our quality threshold and our moderate cost threshold.

Tier 1 or 2 Provider
A Network Provider who is a specialist (either adult or pediatric) will fall into one of the following two tiers. The Cost Sharing Amount you pay for Covered Services obtained at the In-Network Level of Benefits from this type of Network Provider will depend on which of these tiers applies to him or her:

- Tier 1 Provider: A Network Provider who is a specialist (either adult or pediatric) and passes our quality threshold and our lower cost threshold.
- Tier 2 Provider: A Network Provider who is a specialist (either adult or pediatric) and passes our quality threshold and our moderate cost threshold.

Tufts Health Plan
Tufts Benefit Administrators, Inc., a Massachusetts corporation d/b/a Tufts Health Plan. Tufts Health Plan enters into arrangements with Groups or payors underwriting health benefit plans to make available a network of Providers and to provide certain administrative services to the health benefit plans including, but not limited to, processing claims for benefits. Tufts Health Plan is not the Plan Administrator and does not insure the Plan. Also referred to as “we”, “us” and “our”.

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

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

Urgent Care Center
A medical facility (or clinic or medical practitioner office) that provides treatment for Urgent Care services (see definition of Urgent Care). An 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. An 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. An 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. To find an Urgent Care Center in the Tufts Health Plan network, please visit the website at www.tuftshealthplan.com/tuftsuniversity, and click on “Find a Doctor”.

You, Your
This term has the following meaning in this Description of Benefits, regardless of whether it is capitalized: 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, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuing Group Health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

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

Prudent Actions by Plan Fiduciaries

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

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day 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.

Italicized words are defined in Appendix A.
ERISA RIGHTS, continued

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 publications hotline of 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 Services Coordinator at 1-800-423-8080 for the specifics on how to appoint an authorized claimant.

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

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 our 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 Health Plan will respond to you within 72 hours after receipt of the claim. If Tufts Health Plan 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 Health Plan will evaluate your claim within 48 hours after the earlier of our receipt of the requested information, or the end of the extension period given to you to provide the requested information.

Concurrent care decision: A “concurrent care decision” is a determination relating to the continuation/reduction of an ongoing course of treatment. If Tufts Health Plan has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, Tufts Health Plan 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 Health Plan will respond to you within 24 hours after receipt of the request (provided that you make the request at least 24
Types of claims, continued

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” and “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 Health Plan will respond to you within 15 days after receipt of the claim. If Tufts Health Plan 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 Health Plan to make a determination, we will notify you within 15 days and describe the information that you need to provide to Tufts Health Plan. 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 Health Plan will respond to you within 30 days after receipt of the claim. If Tufts Health Plan 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 Health Plan to make a determination, we will notify you within 30 days and describe the information that you need to provide to Tufts Health Plan. 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. For information on precertification, 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 single 12-month period to care for the service member. The employee is entitled to a combined total of 26 weeks for all types of FMLA leave in the single 12-month period. Effective March 8, 2013, the definition of “covered service member” was expanded to include certain veterans.

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

A covered employer is required to maintain group health insurance coverage for an employee on FMLA leave whenever such insurance was provided before the leave was taken and on the same terms as if the employee had continued to work. If applicable, arrangements will need to be made for employees to pay their share of health insurance 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 www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf.
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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 insured health benefit plans (including HMO plans; Tufts Health Plan Medicare Preferred plans; and insured POS and PPO plans. It also applies to all members of health plans insured by Tufts Insurance Company (a Tufts Health Plan affiliate). 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.
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 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 your 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.
NOTICE OF PRIVACY PRACTICES, continued

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 on request.
NOTICE OF PRIVACY PRACTICES, continued

Your Individual Rights – continued

- **How to Exercise Your Rights**: To exercise any of the individual rights described above or for more information, please call the Tufts University Dedicated line at 1-844-516-5790 (TDD: 1-800-815-8580) or write to:

  Compliance Department
  Tufts Health Plan
  705 Mount Auburn Street
  Watertown, MA 02472-1508

Effective Date of Notice

This Notice takes effect August 1, 2013. 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 for the new Notice. Whenever we make an important change, we will publish the updated Notice on our Web site at [www.tuftshealthplan.com](http://www.tuftshealthplan.com). In addition, we will use one of our periodic mailings to inform subscribers about the updated Notice.

Who to Contact for Questions or Complaints

If you would like more information or a paper copy of this Notice, please contact a Member Services Coordinator at the number listed above. You can also download a copy from our Web site at [www.tuftshealthplan.com](http://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
  Compliance Department
  Tufts Health Plan
  705 Mount Auburn Street
  Watertown, MA 02472-1508

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., Total Health Plan, Inc., Tufts Benefit Administrators, Inc., and Tufts Insurance Company do business as Tufts Health Plan. Tufts Health Plan is a registered trademark of Tufts Associated Health Maintenance Organization, Inc.

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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 http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html.

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 Tufts Health Plan at 800.462.0224.

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

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
705 Mount Auburn St. Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, TTY number — 800.439.2370 or 711
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

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

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

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


tuftshealthplan.com | 800.462.0224