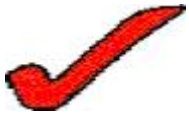
HMO
MASSACHUSETTS Large Group
EVIDENCE OF COVERAGE
Premium Formulary



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

TUFTS HEALTH PLAN
1 Wellness Way
Canton, MA 02021

EC-MASSHMO-002 Ed. 1-2024

47504_196

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.**

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

TUFTS HEALTH PLAN Address and Telephone Directory

TUFTS HEALTH PLAN
1 Wellness Way
Canton, Massachusetts 02021
Member Services Hours:
Monday through Thursday 8:00 a.m.-7:00 p.m. EST
Friday 8:00 a.m.-5:00 p.m. EST

IMPORTANT PHONE NUMBERS:

EMERGENCY Care
For routine care, you should always call your PRIMARY CARE PROVIDER (PCP) before seeking care. If you have an urgent medical need and cannot reach your PCP or your PCP's COVERING PROVIDER, you should seek care at the nearest EMERGENCY room.

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

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

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

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

Behavioral Health and Substance Use Disorder Services
If you need assistance locating a PROVIDER or finding information about your 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 our Member Services Department.

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

IMPORTANT ADDRESSES:

Fraud, Waste and Abuse
You may have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud or abuse, or if you have questions, please call Member Services, or email **fraudandabuse@point32health.org**. You can also call our confidential hotline any time at 877-824-7123 or send an anonymous letter to us at:

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

TUFTS HEALTH PLAN Address and Telephone Directory,

continued

Appeals and Grievances Department
If you need to call us about a concern or appeal, contact Member Services. To submit your appeal or grievance in writing, send your letter to the address below. Or you may fax it to us at 617-972-9509. You may also submit your appeal or grievance electronically via the secure online member portal.

Tufts Health Plan
Attn: Appeals and Grievances Department
P.O. Box 474
Canton, MA 02021

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

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

IMPORTANT WEBSITES:

Website
For more information about TUFTS HEALTH PLAN and to learn more about the self-service options that are available to you, please see the TUFTS HEALTH PLAN website at **www.tuftshealthplan.com**.

COVID-19 Resource Center

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

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

- the estimated or maximum ALLOWED COST for a proposed admission, procedure or service; and
- the estimated amount you will be responsible for paying for admissions, procedures, or services that are COVERED SERVICES (including COST SHARING AMOUNTS), based on information available to TUFTS HEALTH PLAN at the time the request is made.

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

Translating services for more than 200 languages

Interpreter and translator services related to administrative procedures are available to assist MEMBERS upon request.

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

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

Chinese 若需免費的中文版本，請撥打 ID 卡上的電話號碼。

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

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

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

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

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

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

Khmer (Cambodian) សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈໍາຕົວຂອງທ່ານ.

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

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

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

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

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

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

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

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

Telecommunications Device for the Deaf (TDD)

Call 711.

EVIDENCE OF COVERAGE

This booklet is your EVIDENCE OF COVERAGE for health benefits underwritten by Tufts Associated Health Maintenance Organization, Inc. (“TAHMO”). TUFTS HEALTH PLAN has entered into an agreement with Total Health Plan, Inc., to administer the health benefits and makes available a network of PROVIDERS. Both Tufts Associated Health Maintenance Organization, Inc. and Total Health Plan, Inc., are Massachusetts corporations doing business under the name of TUFTS HEALTH PLAN.

This booklet describes the benefits provided under the GROUP CONTRACT. It applies to persons covered under the GROUP CONTRACT. It replaces any EVIDENCE OF COVERAGES previously issued to you. Please read this booklet for an understanding of how this plan works.

CHANGES TO THIS EVIDENCE OF COVERAGE ("EOC")

From time-to-time, certain sections in this EOC may change. This may happen to comply with a state or federal regulation. Or, this may happen to reflect an enhancement to your PLAN during the year. To check to see whether this EOC has been amended, please go to **https://tuftshealthplan.com/member/employer-individual-or-family-plans/benefit-documents/2024-amendments**.

Introduction

Welcome to TUFTS HEALTH PLAN. We are pleased you have chosen us. We look forward to working with you to meet your health care needs. We are a health maintenance organization which arranges for your health care through a network of health care professionals and hospitals.

PROVIDERS in the TUFTS HEALTH PLAN network are hospitals, physicians and other health care professionals working throughout the SERVICE AREA. TUFTS HEALTH PLAN does not provide health care services to MEMBERS. Our PROVIDERS provide health care services to MEMBERS. These PROVIDERS are independent contractors; and are not the employees or agents of TUFTS HEALTH PLAN for any purposes.

When you join TUFTS HEALTH PLAN, you need to choose a PRIMARY CARE PROVIDER (PCP) to manage your care. Your PCP is a PROVIDER who personally cares for your health needs. Your PCP refers you to a specialist within Our network when needed. For CHILDREN, you may designate a pediatrician as the PCP.

COVERED SERVICES Outside of the 50 United States

EMERGENCY services provided to you outside of the 50 United States qualify are covered. In addition, URGENT CARE services provided to you while traveling outside of the 50 United States are covered. However, any other service, supply, or medication provided to you outside of the 50 United States is not covered.

Overview

IMPORTANT NOTE:

- For OUTPATIENT care: When you receive services from your PCP, a behavioral health/substance use disorder PROVIDER, or an "Ob/Gyn" your COPAYMENT may be lower than for services from other PROVIDERS.
- For INPATIENT care or DAY SURGERY: Your COPAYMENT may be lower when you receive care at a COMMUNITY HOSPITAL than when you receive care at a TERTIARY HOSPITAL (see Appendix A for definitions of these facilities).

Your satisfaction is important to us. If you have questions, please call Member Services. We will be happy to help you.

Eligibility for Benefits
When you join TUFTS HEALTH PLAN, you agree to receive your care from TUFTS HEALTH PLAN PROVIDERS.

We cover 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.

TUFTS HEALTH PLAN does not:

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

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

IMPORTANT NOTE: If you live outside of Massachusetts, your benefits under this plan may also include benefits required by the laws of your state. For more information, call Member Services.

Benefit Overview

This table provides basic information about your benefits under this plan. Please see "Benefits Limits" and Chapter 3 for detailed explanations of COVERED SERVICES, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COPAYMENTS	
● **EMERGENCY Care:**	
● EMERGENCY room	$150.00 COPAYMENT applies per visit.
Notes: ● 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 COPAYMENT may apply if DAY SURGERY services are received.	
Other COVERED SERVICES: ● Office Visits:	
● Lower Office Visit COPAYMENT	$20.00 COPAYMENT applies per visit
Note: This COPAYMENT applies to covered OUTPATIENT care provided by your PCP, a behavioral health/ substance use disorder PROVIDER, and obstetrician/ gynecologist ("Ob/Gyn") services and visits to a LIMITED SERVICE MEDICAL CLINIC.	
● Higher Office Visit COPAYMENT:	$35.00 COPAYMENT applies per visit
Note: This COPAYMENT applies to vists for all covered OUTPATIENT care subject to an Office Visit COPAYMENT, except for care obtained from the PROVIDERS for the services listed above under Lower Office Visit COPAYMENT.	
● Visit to a FREE-STANDING URGENT CARE CENTER	$35.00 COPAYMENT
● INPATIENT Services	$500.00 COPAYMENT applies per admission
● DAY SURGERY	$500.00 COPAYMENT

Notes:

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

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

For certain diagnostic OUTPATIENT services, provided in conjunction with a preventive care visit, you may be charged an office visit COST SHARING AMOUNTS.

For certain OUTPATIENT and INPATIENT services, you may be billed both a facility fee and a separate physician fee for a single episode of care if the services are provided in a hospital setting or free-standing facility. If the COST SHARING AMOUNTS for the service includes a DEDUCTIBLE or COINSURANCE charge, that charge will apply to both fees. If the COST SHARING AMOUNT is a COPAYMENT charge, only a singular COPAYMENT will apply unless otherwise specified in the "Benefit Overview."

COST SHARING AMOUNTS for URGENT CARE services vary depending on:

- type of PROVIDER (PCP vs. Specialist);
- location where services are provided (for example, PROVIDER's office, LIMITED SERVICE MEDICAL CLINIC, FREE-STANDING URGENT CARE CENTER, mobile URGENT CARE unit, or EMERGENCY room); and
- any additional Diagnostic OUTPATIENT services provided during the visit. Such services including but are not limited to laboratory tests, x-rays, or DURABLE MEDICAL EQUIPMENT may be subject to separate COST SHARING AMOUNTS (see the "Benefit Overview"). For more information, please call Member Services.

OUT-OF-POCKET MAXIMUM

Individual OUT-OF-POCKET MAXIMUM : $3,000.00.

An Individual OUT-OF-POCKET MAXIMUM of $3,000.00 applies to each MEMBER per CONTRACT YEAR.

Family (two or more MEMBERS) OUT-OF-POCKET MAXIMUM: $3,000.00 per MEMBER and $6,000.00 per family each CONTRACT YEAR.

Any DEDUCTIBLE, COPAYMENT or COINSURANCE amount you pay for COVERED SERVICES under this plan counts towards your OUT-OF-POCKET MAXIMUM. Once you have satisfied your OUT-OF-POCKET MAXIMUM, you are no longer responsible for DEDUCTIBLES, COPAYMENTS or COINSURANCE.

Note: Under a family plan, any combination of enrolled MEMBERS in a family can contribute towards meeting the Family OUT-OF POCKET MAXIMUM. Once the Family OUT-OF POCKET MAXIMUM is met during a CONTRACT YEAR, we begin to pay for COVERED SERVICES for all enrolled MEMBERS in a family under the terms of this EVIDENCE OF COVERAGE. If any enrolled MEMBER in a family meets the Individual OUT-OF POCKET MAXIMUM before the Family OUT-OF POCKET MAXIMUM is met; then: (1) that MEMBER has met his/her OUT-OF POCKET MAXIMUM requirement; and (2) we will begin to pay for his/her COVERED SERVICES, subject to the terms of this EVIDENCE OF COVERAGE.

For more information about your OUT-OF POCKET MAXIMUM, see the definition of “OUT-OF POCKET MAXIMUM” in Appendix A.

Note:

The following amounts do not count towards your OUT-OF POCKET MAXIMUM:

- Any amount you pay for services, supplies, or medications that are not COVERED SERVICES.
- Costs in excess of the REASONABLE CHARGE.
- The premium you pay for this plan.

Important Note about your coverage under the Affordable Care Act ("ACA"): Under the ACA, preventive care services -- including women’s preventive health care services, preventive care visits, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription -- are now covered in full. These services are listed in the following “Benefit Overview”. For more information on what services are now covered in full, please see the website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services.**

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
EMERGENCY Care	
Treatment in an EMERGENCY room	$150.00 COPAYMENT per visit. (COPAYMENT waived if admitted as an INPATIENT or for DAY SURGERY)
Notes: ● Observation services will take an EMERGENCY room COST SHARING AMOUNT. ● A MEMBER should call TUFTS HEALTH PLAN within 48 hours after EMERGENCY care is received. If you are admitted as an INPATIENT, you or someone acting for you must call your PCP or TUFTS HEALTH PLAN within 48 hours. ● If you are admitted as an INPATIENT after receiving EMERGENCY care, please call TUFTS HEALTH PLAN in order to have your EMERGENCY room COPAYMENT waived. A DAY SURGERY COPAYMENT may apply if DAY SURGERY services are received.	
Acupuncture	$35.00 COPAYMENT.
Allergy Injections	$5.00 COPAYMENT per injection

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Allergy testing and treatment	Covered in full
Ambulance services **(AR)**	Covered in full
Notes: ● Ground, sea, and air ambulance transportation for EMERGENCY care are COVERED SERVICES. ● Non-EMERGENCY ambulance transportation is covered only when an AUTHORIZED REVIEWER determines in advance that such services are MEDICALLY NECESSARY.	
Autism spectrum disorders - diagnosis and treatment **(AR)**	**HABILITATIVE or rehabilitative care (including applied behavioral analysis):** ● When provided by a PARAPROFESSIONAL: $20.00 COPAYMENT per visit. ● When provided by a BOARD-CERTIFIED BEHAVIORAL ANALYST (BCBA): $20.00 COPAYMENT per visit. ● When provided by a licensed physical or occupational therapist: $35.00 COPAYMENT per visit. ● When provided by a licensed speech-language therapist or audiologist: $35.00 COPAYMENT per visit. **Prescription medications:** Covered as described under "Prescription Drug Benefit" in Chapter 3. **Psychiatric and psychological care**: Covered as described under “Behavioral Health/Substance Use Disorder Services”. **Therapeutic care:** Covered as described under “MEDICALLY NECESSARY diagnosis and treatment of speech, hearing and language disorders” and “Physical and occupational therapy services”.
Behavioral Health and Substance Use Disorder Services	
To contact the TUFTS HEALTH PLAN Behavioral Health Department, call 1-800-208-9565.	
OUTPATIENT services*	Individual session - $20.00 COPAYMENT per visit. Group session - $20.00 COPAYMENT per visit.
Medication assisted treatment, including methadone maintenance	Covered in full per visit when provided by a medication assisted treatment clinic.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
INPATIENT services **(AR)** **Note:** Prior approval by an AUTHORIZED REVIEWER is not required for INPATIENT psychiatric services. Please see Chapter 3 for more information about these services.	**Facility Services:** $500.00 COPAYMENT per admission. **Professional Services:** Covered in full.
MEDICALLY NECESSARY treatment in a behavioral health residential treatment facility **(AR)**	Covered in full per admission.
Intermediate care, including behavioral health services for children and adolescents **(AR)** **Note:** Prior approval by an AUTHORIZED REVIEWER is only required for certain behavioral health services for children and adolescents. Please see Chapter 3 for more information about these services.	Covered in full.
Behavioral health wellness examination	Covered in full.
Emergency services programs	**Community Crisis Stabilization:** Covered in full. **Mobile Crisis Intervention:** Covered in full.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Cardiac rehabilitation services	$20.00 COPAYMENT per visit for care received from your PCP. $35.00 COPAYMENT per visit for care received from any other TUFTS HEALTH PLAN PROVIDER.
Chemotherapy administration **Note:** For information about your coverage for the medications used in chemotherapy, please see “Injectable, infused or inhaled medications” later in this “Benefit Overview”.	Covered in full
Chiropractic care See "Spinal manipulation".	
Cleft lip and cleft palate treatment and services for CHILDREN **(AR)**	**Medical or facial surgery:** Covered as INPATIENT services described under “Hospital INPATIENT services (Acute care)” or “Surgery -- Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment.” **DAY SURGERY:** Covered as described under “DAY SURGERY.” **Oral surgery:** Covered as described under “Oral Health Services”. **Dental surgery or orthodontic treatment and management:** Covered in full. **Preventive and restorative dentistry:** Covered in full. (see “Cleft lip and cleft palate treatment and services for CHILDREN” in Chapter 3 for more information). **Speech therapy and audiology services:** Covered as described under “MEDICALLY NECESSARY diagnosis and treatment of speech, hearing and language disorders”. **Nutrition services:** Covered as described under “Nutritional counseling”.
Colonoscopies See “Diagnostic or preventive screening procedures”	
DAY SURGERY **(AR)**	**Facility Services:** $500.00 COPAYMENT **Physician, surgical & medical services:** Covered in full.
Diabetes self-management training and educational service	$20.00 COPAYMENT per visit for care received from your PCP. $35.00 per visit for care received from any other TUFTS HEALTH PLAN PROVIDER.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Diagnostic Imaging ● General imaging (such as x-rays and ultrasounds); and ● MRI / MRA, CT/CTA, PET and nuclear cardiology **(AR)**	**General imaging:** Covered in full **MRI/MRA, CT/CTA, PET, and nuclear cardiology:** Covered in full
Diagnostic or preventive screening procedures (for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies) **(AR)**	**Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention:** Covered in full. **Diagnostic procedure only (for example, colonoscopies associated with symptoms):** Covered in full **Diagnostic procedure accompanied by treatment/surgery (for example, polyp removal)**: $500.00 COPAYMENT
Diagnostic testing **(AR)**	Covered in full
DURABLE MEDICAL EQUIPMENT **(AR)**	30% COINSURANCE
Early intervention services for a DEPENDENT CHILD	Covered in full

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Extended care **(AR) (BL)**	Covered in full
Family planning - procedures, services and contraceptives **Notes:** ● Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full. To determine whether a specific family planning service is covered in full or subject to a COST SHARING AMOUNT, please see **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-service** or call Member Services. ● Please note that pregnancy terminations and related care are covered in full. Please see Chapter 3 for additional information or contact Member Services.	**Office Visit**: $20.00 COPAYMENT per visit for care received from your PCP. $35.00 per visit for care received from any other TUFTS HEALTH PLAN PROVIDER. **DAY SURGERY***: $500.00 COPAYMENT
Hearing aids **(BL)**	**Hearing aids for CHILDREN age 21 and under:** 30% COINSURANCE
Hemodialysis **(AR)**	Covered in full.
Home health care **(AR)**	Covered in full
Hospice care **(AR)**	Covered in full
Hospital INPATIENT services (Acute care) **(AR)**	**Facility Services:** $500.00 COPAYMENT per admission. **Physician, surgical & medical services:** Covered in full.
House calls **(AR)**	Please see "House calls" in Chapter 3 for information about your COST SHARING AMOUNTS under this benefit.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Human leukocyte antigen (HLA) testing **(AR)**	Covered in full
Immunizations and vaccinations	Covered in full.
Infertility services **(AR)**	**Office Visit**: $20.00 COPAYMENT per visit for care received from your PCP. $35.00 per visit for care received from any other TUFTS HEALTH PLAN PROVIDER. **Note:** Approved Assisted Reproductive Technology services are $500.00 COPAYMENT
Injectable, infused, or inhaled medications **(AR)**	Covered in full
Laboratory tests **(AR)** **Note:** In compliance with the ACA, laboratory tests performed as part of preventive care are covered in full.	Covered in full
Lead screenings	Covered in full.
Mammograms	**Routine mammograms:** Covered in full. **Diagnostic mammograms:** Covered in full

Maternity Care	**OUTPATIENT:**
	● Routine: Covered in full.
	● Non-Routine:
	  ● Office Visit: $20.00 COPAYMENT per visit for care received from your PCP.
	  ● $35.00 per visit for care received from any other TUFTS HEALTH PLAN PROVIDERS.
	All other services: $500.00 COPAYMENT

	INPATIENT care: $500.00 COPAYMENT per admission.
Notes: ● Routine laboratory tests associated with maternity care are covered in full, in accordance with the ACA. ● MEMBER COST SHARING will apply to diagnostic tests or diagnostic laboratory tests when they are ordered during a routine maternity care visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services.	
Medical supplies **(AR)**	Covered in full

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
MEDICALLY NECESSARY diagnosis and treatment of speech, hearing, and language disorders **(AR)** **Note:** COST SHARING AMOUNTS for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).	$35.00 COPAYMENT per visit.
Nutritional counseling **Note:** Nutritional counseling services are covered in full when they are provided as preventive services, as defined by the U.S. Preventive Services Task Force. Please see “Nutritional Counseling” in Chapter 3 for more information.	**Preventive nutritional counseling:** Covered in full. **All other nutritional counseling services:** $20.00 COPAYMENT per visit for care received from your PCP. $35.00 COPAYMENT per visit for care received from any other TUFTS HEALTH PLAN PROVIDER.
Office visits to diagnose and treat illness and injury **Note:** Psychiatric collaborative care services are covered under this benefit. Please see Chapter 3 for more information about these services.	$20.00 COPAYMENT per visit for care received from your PCP. $35.00 COPAYMENT per visit for care received from any other TUFTS HEALTH PLAN PROVIDER.
Oral health services **(AR)**	**Office Visit:** Please see “Surgery – in a PROVIDER’s office" **EMERGENCY room**: $150.00 COPAYMENT per visit. **INPATIENT SERVICES:** $500.00 COPAYMENT per admission. **DAY SURGERY***: $500.00 COPAYMENT

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Pap Smears	**Routine pap screenings:** Covered in full. **Diagnostic pap examinations:** Covered in full
Patient care services provided as part of a qualified clinical trial for the treatment of cancer or other life-threatening diseases or conditions	**OUTPATIENT care:** $20.00 COPAYMENT per visit for care received from your PCP. $35.00 COPAYMENT per visit for care received from any other TUFTS HEALTH PLAN PROVIDER.
	INPATIENT care: $500.00 COPAYMENT per admission.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Preventive health care for MEMBERS under age 6	Covered in full
Notes: ● Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS. ● MEMBER cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	
Preventive health care for MEMBERS age 6 and older	Covered in full
Notes: ● Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS. ● MEMBER cost-sharing will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	
Prosthetic devices **(AR)**	20% COINSURANCE
Radiation therapy **(AR)**	Covered in full
Rehabilitative and HABILITATIVE physical and occupational therapy services **(AR) (BL)** **Note:** Visit limits do not apply to the treatment of autism spectrum disorders.	$35.00 COPAYMENT per visit.
Respiratory therapy/pulmonary rehabilitation services	Covered in full

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Routine annual gynecological exam **Notes:** ● Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine annual gynecological exam is subject to an office visit COPAYMENT. ● MEMBER cost-sharing will also apply to diagnostic tests or laboratory tests when they are ordered as part of a preventive services visit. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services, and see our website at **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** for more information about which laboratory services are considered preventive.	Covered in full.
Scalp hair prostheses or wigs **(BL)**	Covered in full
Smoking cessation counseling services	Covered in full.
Special formulas **(AR)**	**Low protein foods:** Covered in full. **Nonprescription enteral formulas:** Covered in full. **Special medical formulas:** Covered in full.
Spinal manipulation **(BL)**	$35.00 COPAYMENT
Surgery - Bone marrow transplants for breast cancer, hematopoietic stem cell transplants and human solid organ transplants **(AR)**	**Facility Services:** $500.00 COPAYMENT per admission. **Physician, surgical & medical services:** Covered in full.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Surgery – Gender affirming procedures and related services **(AR)** **Note:** Gender affirming procedures and related services only qualify as COVERED SERVICEs when authorized in advance by an AUTHORIZED REVIEWER and obtained within the 50 United States. Please contact the Member Services Department for more information.	**Medical surgery:** ● DAY SURGERY: Covered as described under "DAY SURGERY." ● INPATIENT services: Covered as described under "Hospital INPATIENT services (acute care)" or "Surgery - Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment." **OUTPATIENT care related to gender reassignment surgery (including pre-operative and post-operative care):** Covered as described under "Office visits to diagnose and treat illness or injury". **Speech therapy services:** Covered as described under "MEDICALLY NECESSARY diagnosis and treatment of speech, hearing, and language disorders." **Behavioral health care services related to gender reassignment surgery (pre-operative and post-operative):** Covered as described under "Behavioral health and substance abuse services". **Prescription medications:** Covered as described under the "Prescription Drug Benefit".
Surgery - in a PROVIDER's office **(AR)**	$20.00 COPAYMENT per visit for care received from your PCP. $35.00 COPAYMENT per visit for care received from any other TUFTS HEALTH PLAN PROVIDER.
Surgery - Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity or impairment **(AR)**	**Facility Services:** $500.00 COPAYMENT per admission. **Physician, surgical & medical services:** Covered in full.
Telemedicine services obtained through TUFT HEALTH PLAN's designated telemedicine vendor (Also called "telehealth") Telemedicine services obtained through a TUFTS HEALTH PLAN PROVIDER	**General medicine/behavioral health services:** Covered in full **Dermatology services:** Covered in full **PCP:** $20.00 COPAYMENT per visit.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
	Any Other TUFTS HEALTH PLAN PROVIDER: $35.00 COPAYMENT per visit.
Notes: ● A telemedicine services visit with a NETWORK PROVIDER will apply the same COST SHARING AMOUNT that applies to an in-person office visit with that PROVIDER. ● Please see “Behavioral health and substance use disorder services” and “Autism spectrum disorder services” in this “Benefit Overview” for COST SHARING AMOUNTs that apply to those benefits.	**Remote Patient Monitoring:** Covered in full **Remote medical data transfer/evaluation:** Covered in full
URGENT CARE	
In a PROVIDER's office	$20.00 COPAYMENT for care received from a PCP. $35.00 COPAYMENT applies per visit for care received from any other NETWORK PROVIDER.
In a behavioral health/substance use disorder PROVIDER's office	$20.00 COPAYMENT for care received from a PCP.
In a LIMITED SERVICE MEDICAL CLINIC	$20.00 COPAYMENT for care received from a PCP.
In a hospital-based OUTPATIENT walk-in clinic	$20.00 COPAYMENT for care received from a PCP. $35.00 COPAYMENT applies per visit for care received from any other NETWORK PROVIDER.
Mobile URGENT CARE	$35.00 COPAYMENT
In a FREE-STANDING URGENT CARE CENTER	$35.00 COPAYMENT

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Important Note: This table provides basic information about your benefits under this plan. Please see the COVERED SERVICES table below, "Benefit Limits", and Chapter 3 for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICES	YOUR COST
Vision care services	
Routine eye examination **(BL)**	$20.00 COPAYMENT per visit.
Other vision care services **(AR)** **Note:** MEMBER COST SHARING AMOUNTS will also apply to diagnostic tests or laboratory services when they are ordered during a visit for other vision care services. Please see "Diagnostic testing" and "Laboratory tests" for information on your COST SHARING AMOUNTS for these services.	**Care provided by an optometrist (O.D.):** $20.00 COPAYMENT per visit. **Note**: One pair of eyeglass lenses and standard frames following cataract surgery or other surgery to replace the natural lens of the eye are covered in full. See Chapter 3 for more information.
	Care provided by an ophthalmologist (M.D.): $20.00 COPAYMENT per visit for care received from your PCP.
	$35.00 per visit for care received from any other TUFTS HEALTH PLAN PROVIDERS.
TUFTS HEALTH PLAN MEMBER Discounts	
For information on how you can take advantage of discounts on a variety of health products, services, and treatments, such as acupuncture, massage therapy, and wellness programs, see "TUFTS HEALTH PLAN MEMBER Discounts" in Chapter 3.	

Prescription Drug Benefit
For information about your COPAYMENTS and/or COINSURANCE for covered prescription drugs, see the "Prescription Drug Benefit" section in Chapter 3.

(AR) - These services or certain services within this benefit category may require approval by an AUTHORIZED REVIEWER. Your PROVIDER will obtain this approval for you. Please see "AUTHORIZED REVIEWER Approval" in Chapter 1 for more information. (BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Benefit Limits

Extended Care Services
Covered up to 100 days per CONTRACT YEAR.

Hearing Aids
Hearing aids for CHILDREN age 21 and under are covered up to $2,000 per ear every 36 months. This includes both the amount TUFTS HEALTH PLAN pays and the MEMBER's COST SHARING AMOUNT.

Rehabilitative and HABILITATIVE occupational therapy
Rehabilitative occupational therapy services covered up to 30 visits per CONTRACT YEAR.

HABILITATIVE occupational therapy services covered up to 30 visits per CONTRACT YEAR.

Rehabilitative occupational therapy services covered up to 2 evaluations per CONTRACT YEAR.

HABILITATIVE occupational therapy services covered up to 2 evaluations per CONTRACT YEAR.

Rehabilitative and HABILITATIVE physical therapy
Rehabilitative physical therapy services covered up to 30 visits per CONTRACT YEAR.

HABILITATIVE physical therapy services covered up to 30 visits per CONTRACT YEAR.

Rehabilitative physical therapy services covered up to 2 evaluations per CONTRACT YEAR.

HABILITATIVE physical therapy services covered up to 2 evaluations per CONTRACT YEAR.

Note: Visit limits do 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 later in this document.

Routine eye examinations
Coverage is provided for one routine eye examination every 24 months per CONTRACT YEAR.

Scalp Hair Prostheses or Wigs
Covered up to a maximum benefit of $350 per CONTRACT YEAR.

Spinal manipulation
The maximum benefit payable in each CONTRACT YEAR is 12 visits per person.

Travel Reimbursement for COVERED SERVICES Restricted by State Law

Covered travel expenses are reimbursed up to a maximum of $2,500 per MEMBER per CONTRACT YEAR.

Chapter 1 - How Your HMO Plan Works

How the Plan Works

PRIMARY CARE PROVIDERS

Each MEMBER must choose a PRIMARY CARE PROVIDER (PCP). The PCP will provide or authorize your health care services. Until you choose a PCP, we will not pay for any services, except for EMERGENCY care.

Note: If you require non-EMERGENCY services, call your PCP. Your PCP will provide or coordinate your care. Without authorization from your PCP, services will not be covered. Never wait until your condition becomes an EMERGENCY to call.

Please see "About your PRIMARY CARE PROVIDER" for more details.

MEDICALLY NECESSARY COVERED SERVICES

We will pay for COVERED SERVICES that are MEDICALLY NECESSARY. You will pay a COST SHARING AMOUNT for most COVERED SERVICES. See "Benefit Overview" for more information.

SERVICE AREA (see Appendix A)

In most cases, you must receive your care in the TUFTS HEALTH PLAN SERVICE AREA. This does not apply to EMERGENCY or URGENT CARE while traveling outside of the SERVICE AREA. See Our DIRECTORY OF HEALTH CARE PROVIDERS at **www.tuftshealthplan.com**.

If a service cannot be provided by a TUFTS HEALTH PLAN PROVIDER in the SERVICE AREA, call Member Services for assistance.

Note: Certain services may be available outside of the SERVICE AREA through Our telemedicine vendor. For more information, please visit **https://member.teladoc.com/tuftshealthplan**.

PROVIDER network

We offer MEMBERS access to an extensive network of physicians, hospitals, and other PROVIDERS throughout the SERVICE AREA.

Changes to our PROVIDER network

Our network of PROVIDERS may change during the year. This can happen for many reasons, including:

- including a PROVIDER's retirement;
- moving out of the SERVICE AREA; or
- failure to continue to meet our credentialing standards.

Because PROVIDERS are independent contractors who do not work for TUFTS HEALTH PLAN, this can also happen if TUFTS HEALTH PLAN and the PROVIDER are unable to reach agreement on a contract.

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

Coverage

If you....	AND you are....	THEN....
receive routine health care services, visit a specialist, or receive covered elective procedures	in the Standard or Extended SERVICE AREA	you are covered, if you receive care through your PCP or with PCP referral .
	outside the Standard or Extended SERVICE AREA	you are not covered.
are ill or injured	in the Standard or Extended SERVICE AREA	you are covered. Please see the "EMERGENCY care and URGENT CARE" section for information on when referrals are required.
	outside the Standard or Extended SERVICE AREA	you are covered for URGENT CARE.
have an EMERGENCY	in the Standard or Extended SERVICE AREA	you are covered.
	outside the Standard or Extended SERVICE AREA	you are covered.

Care that could have been foreseen before leaving the Standard or Extended SERVICE AREA is not covered. This includes, but is not limited to:

- deliveries within one month of the due date. This includes postpartum care and care provided to the newborn CHILD.
- long-term conditions that need ongoing medical care.

Continuity of Care

If you are an existing MEMBER

If your PROVIDER is disenrolled for reasons other than quality or fraud, you may continue to see your PROVIDER for the following continuing care conditions. Unless otherwise indicated below, you may see your PROVIDER for up to 90 days from the date of termination or the date we notify you of the termination, whichever is later:

- If you are receiving treatment for a Serious or Complex Condition.
- If you are pregnant, you may see your PROVIDER through your first postpartum visit.
- If you are an INPATIENT.
- If you are scheduled to undergo urgent or emergent surgery, including postoperative.
- If you are terminally ill, you may see your PROVIDER as long as necessary. Terminally ill is defined as having a life expectancy of 6 months or less.

Note: Serious and Complex Condition means:

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

Note: If you have a complex care need, you may continue to see your PROVIDER for up to 90 days. This will allow your care to be transitioned to a TUFTS HEALTH PLAN PROVIDER. The “Conditions for coverage of continued treatment” section below does not apply to PROVIDERS treating Members with complex care needs.

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

To choose a new PCP, call Member Services. Member Services will help you to select one. You can also see the DIRECTORY OF HEALTH CARE PROVIDERS, which is available on our website.

If you are enrolling as a new MEMBER

When you enroll, if none of the health plans offered by the GROUP include your PROVIDER, you may continue to see your PROVIDER if:

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

Conditions for coverage of continued treatment

TUFTS HEALTH PLAN may condition coverage of continued treatment upon the PROVIDER's agreement:

- to accept reimbursement from TUFTS HEALTH PLAN at the rates applicable prior to notice of disenrollment as payment in full;
- not to impose cost sharing with respect to a MEMBER in an amount that would exceed what could have been imposed if the PROVIDER has not been disenrolled;
- to adhere to the quality assurance standards of TUFTS HEALTH PLAN;
- to provide us with necessary medical information related to the care provided; and
- to adhere to TUFTS HEALTH PLAN's policies and procedures. This includes procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by TUFTS HEALTH PLAN.

Referrals, AUTHORIZED REVIEW, and INPATIENT Notification

Referrals

A referral is an approval notice sent to another TUFTS HEALTH PLAN PROVIDER (and Us) by your PCP. This notice tells the other TUFTS HEALTH PLAN PROVIDER (and Us) in advance how many visits and the type of specialty services you can receive. In most cases, you must have a referral to see any TUFTS HEALTH PLAN PROVIDER other than your PCP. See "**Referrals for specialty services**" and "**When referrals are not required**" later in this chapter.

AUTHORIZED REVIEWER Approval

Prior approval by an AUTHORIZED REVIEWER is required for certain COVERED SERVICES. This is an approval request usually sent to Us by a TUFTS HEALTH PLAN PROVIDER. It asks Us to determine in advance if certain services are covered under your plan. We require approval for services identified by **(AR)** in the "Benefit Overview."

Note: EMERGENCY Care does not require prior approval.

Your TUFTS HEALTH PLAN PROVIDER is responsible for obtaining any required approval.

If a request for coverage is denied, you have a right to appeal. Please see Chapter 6 for more information.

INPATIENT NOTIFICATION

INPATIENT Notification is a process that informs Us about all INPATIENT admissions and transfers to another hospital. We or Our delegate evaluate the expected hospital stay and proposed medical care; and verify MEDICAL NECESSITY. We or Our delegate:

- may assess the need for a care management program after discharge; or
- recommend an alternative treatment setting.

When Care is Provided by a TUFTS HEALTH PLAN PROVIDER

Your TUFTS HEALTH PLAN PROVIDER or Hospital is responsible for notifying Us of your INPATIENT admission or transfer.

When Care is Provided by a NON-TUFTS HEALTH PLAN PROVIDER

Your plan does not include coverage for NON-TUFTS HEALTH PLAN PROVIDER. See "EMERGENCY Care and URGENT CARE" for additional information.

INPATIENT Hospital Services

- **You may need INPATIENT services.** In most cases, you will be admitted to your PCP's TUFTS HEALTH PLAN HOSPITAL. Your PCP or other TUFTS HEALTH PLAN PROVIDER is responsible for:
  - notifying Us on your behalf; and
  - obtaining any required approval by an AUTHORIZED REVIEWER.
- **INPATIENT Notification does not guarantee payment to the PROVIDER.** We will not pay claims:
  - for persons not eligible for coverage;
  - for persons who receive care determined not to be MEDICALLY NECESSARY; or
  - if a claim is for a non-COVERED SERVICE.
- If you choose to stay INPATIENT after it has been determined that further INPATIENT services are no longer MEDICALLY NECESSARY, we will not pay for any costs incurred after that time.
- **You may be admitted to a facility which is not the TUFTS HELATH PLAN HOSPITAL in your PCP's PROVIDER ORGANIZATION.** If your PCP determines that transfer is appropriate, you will be transferred to the hospital in your PCP's PROVIDER ORGANIZATION or another TUFTS HEALTH PLAN HOSPITAL. We may not pay for care provided in the facility to which you were first admitted after transfer arrangements have been made.

EMERGENCY Care and URGENT CARE

EMERGENCY Care

Definition of EMERGENCY

EMERGENCY is defined as an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- serious jeopardy to the physical and/or behavioral health of a MEMBER, an unborn CHILD, or another person; 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.

Examples of conditions requiring EMERGENCY care are:

- severe pain;
- broken leg;
- loss of consciousness;
- vomiting blood;
- chest pain;
- difficulty breathing; or
- any medical condition that is quickly getting worse.

Follow these guidelines for receiving EMERGENCY care

- If needed, call 911 for EMERGENCY medical assistance. If 911 services are not available, call the local number for EMERGENCY medical services.
- Go to the nearest EMERGENCY medical facility.
- You do not need approval from your PCP before receiving EMERGENCY care.
- If you receive EMERGENCY care, you or someone acting for you should call
- TUFTS HEALTH PLAN within 48 hours after receiving care. You are also encouraged to contact your PCP to arrange for any necessary follow-up care.
- If you receive EMERGENCY care from a non-TUFTS HEALTH PLAN PROVIDER , we will pay the PROVIDER up to the REASONABLE CHARGE. You will be responsible for any applicable COST SHARING AMOUNT. You may receive a bill for these services.

Note: If you receive a bill, see “Bills from PROVIDERS” in Chapter 6.

Urgent Care

Definition of Urgent Care

URGENT CARE is defined as care provided when your health is not in serious danger but you need immediate attention for a condition, unforeseen illness, or injury. Examples in which URGENT CARE might be needed are:

- a broken or dislocated toe;
- sudden extreme anxiety;
- a cut that needs stitches but is not actively bleeding; or
- symptoms of a urinary tract infection.

Note: Care provided after the condition is stabilized and the MEMBER is safe for transport is not considered URGENT CARE.

EMERGENCY Care and URGENT CARE, continued

Follow these guidelines for receiving Urgent Care

Place of Service	TUFTS HEALTH PLAN PROVIDER	Non-TUFTS HEALTH PLAN PROVIDER/Inside of the Service Area	Non-TUFTS HEALTH PLAN PROVIDER/Outside of the SERVICE AREA
LIMITED SERVICE MEDICAL CLINIC or FREE-STANDING URGENT CARE Center	You are covered for URGENT CARE. No referral is required.	You are covered for URGENT CARE with a referral from your PCP.	You are covered for URGENT CARE. No referral is required.
EMERGENCY room	You are covered for URGENT CARE. No referral is required.	You are covered for URGENT CARE. No referral is required.	You are covered for URGENT CARE. No referral is required.
Mobile URGENT CARE	You are covered for URGENT CARE. No referral is required.	You are covered for URGENT CARE. No referral is required.	You are covered for URGENT CARE. No referral is required.
Primary Care PROVIDER's (PCP's) office	You are covered for URGENT CARE. No referral is required.	Not applicable.	Not applicable.
PROVIDER's office (non-PCP) or hospital-based walk-in clinic	You are covered for URGENT CARE with a referral from your PCP.	You are covered for URGENT CARE with a referral from your PCP.	You are covered for URGENT CARE. No referral is required.
Behavioral Health/Substance Use PROVIDER's office	You are covered for URGENT CARE. No referral is required.	You are covered for URGENT CARE. No referral is required.	You are covered for URGENT CARE. No referral is required.

Important notes about EMERGENCY Care and URGENT CARE

- You do not need approval from your PCP before receiving EMERGENCY care.
- If you are admitted INPATIENT after receiving EMERGENCY or URGENT CARE services, you or someone acting for you must call TUFTS HEALTH PLAN within 48 hours after receiving care. A family member or the attending PROVIDER can call make this for you. (Notification from the attending PROVIDER satisfies this requirement.)
- If you receive URGENT CARE, you or someone acting for you should contact your PCP to arrange for any necessary follow-up care.
- EMERGENCY or URGENT CARE services are covered, whenever you need it, anywhere in the world. Continued services after the EMERGENCY or URGENT condition has been stabilized may not be covered in certain instances. For example, if we determine, in coordination with the MEMBER's PROVIDERs:
  - that the MEMBER is safe for transport back into the SERVICE AREA; and
  - it is appropriate and cost-effective to transport the MEMBER.
- An EMERGENCY or URGENT CARE PROVIDER located outside of the SERVICE AREA may:
  - bill TUFTS HEALTH PLAN directly; or
  - require you to pay at the time of service. We will reimburse you up to the REASONABLE CHARGE. You must pay the applicable COST SHARING AMOUNT. See "Bills from PROVIDER / MEMBER Reimbursement Process" in Chapter 6 for more information.

About Your PRIMARY CARE PROVIDER

Importance of choosing a PCP

Each MEMBER must choose a PCP. The PCP you choose will be associated with a specific TUFTS HEALTH PLAN PROVIDER ORGANIZATION. You will usually receive COVERED SERVICES from professionals and facilities associated with that PROVIDER ORGANIZATION. Once you have chosen a PCP, you are eligible for all COVERED SERVICEs.

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

What a PCP does

A PCP:

- provides routine health care;
- arranges care with other TUFTS HEALTH PLAN PROVIDERS; and
- provides referrals for other health care services. OUTPATIENT behavioral health/substance use disorder services from a TUFTS HEALTH PLAN PROVIDERS do not require a referral.

Your PCP, or a COVERING PROVIDER, is available 24 hours a day. Your PCP will coordinate your care by treating you or referring you to specialty services.

Choosing a PCP

You must choose a PCP from the list in our DIRECTORY OF HEALTH CARE PROVIDERS at **www.tuftshealthplan.com**. If you already have a PROVIDER who is listed as a PCP, in most instances you may choose that PROVIDER as your PCP. Once you have chosen a PCP who is part of our network,you must inform us of your choice in order to be eligible for all COVERED SERVICEs.

If you do not have a PCP or your PCP is not listed in our directory, call Member Services for assistance.

Notes:

- Under certain circumstances required by law, if your PCP is not in our network, you will be covered for a short period of time for services provided by that PCP. Member Services can give you more information. Please see "Continuity of Care."
- For additional information about a PROVIDER, contact the **Massachusetts Board of Registration in Medicine**. The Board provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (800) 377-0550 or **www.mass.gov/massmedboard**.

Contacting your new PCP

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

- contact your new PCP and identify yourself as a TUFTS HEALTH PLAN MEMBER,
- ask your previous PROVIDER to transfer your medical records to your new PCP, and
- make an appointment for a check-up or to meet your PCP.

If you can't reach your PCP by phone right away

If your PCP cannot take your call at once, always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call.

You may need medical services after hours. If so, please contact your PCP or a covering PROVIDER. Your PCP, or a covering PROVIDER is available 24 hours a day, 7 days a week. If you need INPATIENT behavioral health or substance use disorder services after hours, call 1-800-208-9565.

Note: In a medical emergency, you do not have to contact your PCP or a covering PROVIDER. Instead, proceed to the nearest emergency medical facility for treatment. See “EMERGENCY Care and URGENT CARE” for more information.

About Your PRIMARY CARE PROVIDER, continued

Changing your PCP

You may change your PCP as needed. In certain instances, we may require you to do so. The new PCP will not be considered your PCP until:

- you choose a new PCP from our DIRECTORY OF HEALTH CARE PROVIDERS;
- you report your choice to Member Services; and
- we approve the change.

Note: You may not change your PCP while you are INPATIENT or in a partial hospitalization program. In limited circumstances, TUFTS HEALTH PLAN may approve an exception.

Canceling appointments

You may need to cancel an appointment with a PROVIDER. Always give as much notice as possible (at least 24 hours). If your PROVIDER charges for missed appointments that you did not cancel in advance, we will not pay any charges.

Referrals for specialty services

Every PCP is associated with a specific PROVIDER ORGANIZATION. If you need to see a specialist, your PCP will make the referral. Your PCP will select and refer you to another PROVIDER in the same PROVIDER ORGANIZATION. This helps to provide quality and continuity of care.

You may need specialty care that is not available within your PCP's PROVIDER ORGANIZATION. If so, your PCP will choose a specialist in another PROVIDER ORGANIZATION and make the referral. Your PCP will consider any long-standing relationships you have with specialists, as well as your clinical needs. (A long-standing relationship means that you have recently seen or been treated repeatedly by that specialist.)

You may require specialty care which is not available through any TUFTS HEALTH PLAN PROVIDER . If so, your PCP may refer you to a PROVIDER not associated with TUFTS HEALTH PLAN. This requires the prior approval of an AUTHORIZED REVIEWER.

Note:

- A referral must be obtained **before** you receive COVERED SERVICES from a specialist. If you do not obtain a referral **prior** to receiving services, the services will not be covered.

Referral forms for specialty services
Except as noted below, your PCP must complete a referral every time you are referred to a specialist. Your PCP may ask you to give a referral form to the specialist. Your PCP must approve referrals that a specialist may make to other PROVIDERS. Make sure your PCP has made a referral before you go to another PROVIDER. A PCP may authorize a standing referral for specialty care.

AUTHORIZED REVIEWER Authorization

In addition, certain COVERED SERVICES described in Chapter 3 must be approved in advance by an AUTHORIZED REVIEWER. If you do not obtain authorization, we will not cover those services.

When Referrals are Not Required

The following COVERED SERVICES do not require a referral. You must obtain these services from a TUFTS HEALTH PLAN PROVIDER except:

- as listed in this chapter;
- for URGENT CARE outside of our SERVICE AREA; or
- for EMERGENCY care.

Referrals are not required for:

- URGENT CARE within the SERVICE AREA, when received in an Emergency room, or a LIMITED SERVICE MEDICAL CLINIC or FREE-STANDING URGENT CARE CENTER that participates with TUFTS HEALTH PLAN.
- Mammography screenings at the following intervals:
  - one baseline at 35-39 years of age;
  - one every year at age 40 and older; or
  - as otherwise MEDICALLY NECESSARY.
- Pregnancy terminations.
- Prostate and colorectal exams
- Routine eye exams.
- Other vision care from an optometrist.
- Spinal manipulation
- Dental surgery, orthodontic treatment and management, or preventive and restorative dentistry. No referral is required when provided for the treatment of cleft lip or cleft palate.
- Acupuncture services
- Medical treatment provided by an optometrist.
- OUTPATIENT behavioral health/substance use disorder services.
- Oral surgery. (However, prior approval by an AUTHORIZED REVIEWER is required.)
- Telemedicine services, when received from the designated telemedicine vendor.
- The following specialty care provided by who is an obstetrician, gynecologist, certified nurse midwife or family practitioner:
  - Maternity Care.
  - MEDICALLY NECESSARY evaluations and related health care services for acute or EMERGENCY gynecological conditions.
  - Routine annual gynecological exam. This includes any MEDICALLY NECESSARY obstetric or gynecological follow-up care.

Utilization Management

TUFTS HEALTH PLAN has a utilization management program. This is employed to evaluate whether health care services provided to MEMBERS are: (1) MEDICALLY NECESSARY and (2) provided in the most appropriate and efficient manner.

Certain services must be MEDICALLY NECESSARY for coverage to apply. MEDICAL NECESSITY Guidelines are used to determine MEDICAL NECESSITY. These Guidelines are developed for services found to be effective in limited clinical circumstances.

The Guidelines are:

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

TUFTS HEALTH PLAN considers these guidelines as well as the MEMBER'S individual needs. Evaluations are performed on a case-by-case basis.

The program includes prospective, concurrent, and retrospective reviews. They are also known as AUTHORIZED REVIEWS. AUTHORIZED REVIEWS are performed by an AUTHORIZED REVIEWER.

Prospective reviews determine whether proposed treatments are MEDICALLY NECESSARY. These reviews occur before the treatments begin. They are also referred to as "Pre-Service Reviews".

Concurrent reviews are used to:

- monitor the course of treatment as it occurs; and
- determine when treatment is no longer MEDICALLY NECESSARY.

Retrospective reviews are used to evaluate the MEDICAL NECESSITY of care after it has been provided. We engage in these reviews to more accurately determine if a MEMBER'S services are appropriate. They are also referred to as “Post-Service Reviews”.

TIMEFRAMES TO REVIEW YOUR REQUEST FOR COVERAGE

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

Utilization Management, continued

*See “Processing of Plan Benefits” in Appendix B for determination procedures under the Department of Labor’s (DOL) Regulations.

Utilization review helps MEMBERs in the following ways:

- These reviews let MEMBERs know if proposed health care services are MEDICALLY NECESSARY. This allows MEMBERs to make informed decisions about their care.
- These reviews evaluate if the treatment is the most appropriate for the MEMBER. This enhances the quality of care and convenience for MEMBERs.
- By evaluating treatment cost effectiveness, COST SHARING AMOUNTs may be reduced.
- These reviews help to control overall plan costs. This plays an important part in making sure health care plans continue to be affordable.

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

Note: Utilization reviews make coverage decisions. You and your PROVIDER make all treatment decisions.

MEMBERS can call to determine the status of these reviews:

- behavioral health or substance use disorder reviews - 1-800-208-9565;
- all other reviews – Call Member Services.

Extension of Hospitalization

All INPATIENT stays are monitored. You may need to stay in the hospital longer than the originally approved stay. If this happens, TUFTS HEALTH PLAN will request additional clinical information from the hospital. This information will be reviewed to determine if additional hospital days should be approved. It may be determined that your INPATIENT stay is no longer MEDICALLY NECESSARY. If this happens, you will be notified that any additional days will not be covered. You will be responsible for paying for all charges if you choose to stay beyond the discharge date.

Care Management

Some MEMBERS with Severe Illnesses or Injuries may warrant care management intervention. This will occur under the case management program. Under this program:

- use of the most appropriate and cost-effective treatment is encouraged; and
- the MEMBER's treatment and progress are supported.

If a MEMBER is identified as an appropriate candidate for care management or referred to the program, that MEMBER and his or her TUFTS HEALTH PLAN PROVIDER may be contacted to discuss a treatment plan and establish prioritized goals. Alternative covered services available to the MEMBER may also be discussed.

The treatment plan may be reviewed from time-to-time. The MEMBER and the MEMBER's PROVIDER may be contacted if alternatives to the treatment plan are identified.

A Severe Illness or Injury may include, but is not limited to, the following:

- serious heart or lung disease;
- certain neurological diseases;
- severe traumatic injury;
- major depressive disorder;
- schizophrenia;
- high-risk pregnancy and newborn CHILDREN;
- AIDS or other immune system diseases;
- cancer;
- bipolar disorder; or
- substance use disorders.

Services provided through a care management program may be subject to COST SHARING AMOUNTS.

Individual case management (ICM)

We may also authorize an individual case management ("ICM") plan for a MEMBER. The MEMBER must have a Severe Illness or Injury and already be a part of the care management program. The plan is designed to arrange for the most appropriate services for the MEMBER.

Under the plan, a MEMBER may be approved for alternative services that are not otherwise covered. This will occur only if we determine that all of the following conditions are met:

- medical treatment will be needed for an extended duration;
- the services are MEDICALLY NECESSARY;
- the services are provided directly to the MEMBER;
- the alternative services and supplies are provided in place of more expensive services;
- the MEMBER and an AUTHORIZED REVIEWER agree to the alternative treatment program; and
- the MEMBER's condition shows improvement, as determined over time by an AUTHORIZED REVIEWER.

The alternative services will be monitored to ensure they continue to meet these conditions. If they fail to do so, we may modify or terminate coverage of services. Please note that ICM plans are not used:

- to authorize services that are excluded from coverage;
- to authorize services that are subject to the Utilization Review program; and
- to authorize services that are not MEDICALLY NECESSARY.

Financial Arrangements between TUFTS HEALTH PLAN and TUFTS HEALTH PLAN PROVIDERS

Methods of payment to TUFTS HEALTH PLAN PROVIDERS

Our goal is to encourage preventive care and active management of illnesses. The financial reimbursement system we use ensures appropriate access to care. It also rewards PROVIDERS for providing high quality care. We use a variety of mutually agreed upon methods of payment to compensate TUFTS HEALTH PLAN PROVIDERS.

The DIRECTORY OF HEALTH CARE PROVIDERS indicates the method of payment for each PROVIDER. Regardless of the method of payment, we expect all participating PROVIDERS to use sound medical judgment when providing care. This approach ensures the provision of MEDICALLY NECESSARY care. It also reduces the number of unnecessary tests and procedures which can be both harmful and costly to MEMBERS.

Care provided to our MEMBERS is reviewed through its Quality of Health Care Program. Feel free to discuss with your PROVIDER how he or she is paid.

Member Identification Card

Introduction

We give each MEMBER an identification card (Member ID).

Reporting errors

Check your Member ID carefully. If any information is wrong, call Member Services.

Identifying yourself as a MEMBER

Your Member ID is used to identify you as a MEMBER. Please:

- carry your Member ID at all times;
- have your Member ID with you for appointments; and
- show your Member ID before you receive services. You must tell the office staff that you are a MEMBER.

IMPORTANT NOTE: If you do not identify yourself as a MEMBER, then:

- we may not pay for the services; and
- you will be responsible for the costs.

Membership requirement

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

Member ID number

If you have questions about your member ID number, call Member Services.

Information Resources for MEMBERS

Obtaining information about TUFTS HEALTH PLAN

The following information will be available from the Massachusetts Office of Patient Protection:

- Independently published information assessing MEMBER satisfaction and evaluating the quality of health care services.
- The percentage of physicians who terminated participation contracts during the previous calendar year. This information will contain the 3 most common reasons for voluntary and involuntary disenrollment.
- The percentage of premium revenue spent on health care services for the most recent year.
- A report that details the following information for the previous calendar year:
  - the numbers of filed appeals, appeals denied internally, and appeals withdrawn; and
  - the number of external appeals pursued after exhausting the internal appeals process, as well as the resolution of all those appeals.

How to obtain this information

Contact the Office of Patient Protection.

- Phone: 1-800-436-7757.
- Fax #: 1-617-624-5046.
- Website: **www.mass.gov/hpc/opp**
- Email: HPC-OPP@state.ma.us
- Write a letter to the Office:

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

Chapter 2 - Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule under GROUP CONTRACTS

You are eligible as a SUBSCRIBER only if you are an employee of a GROUP; and you

- meet your GROUP's and TUFTS HEALTH PLAN's eligibility rules; and
- live, work or reside in the SERVICE AREA.

Your SPOUSE or your CHILD is eligible as a DEPENDENT only if you are a SUBSCRIBER and that SPOUSE or CHILD:

- qualifies as a DEPENDENT, as defined in this EVIDENCE OF COVERAGE; and
- meets your GROUP's and TUFTS HEALTH PLAN's eligibility rules; and
- lives, works or resides in the SERVICE AREA*.

Note: CHILDREN are not required to maintain primary residence in the SERVICE AREA. However, care outside the SERVICE AREA is limited to EMERGENCY or URGENT CARE only.

Proof of eligibility

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

Enrollment

When to enroll

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

- during the annual OPEN ENROLLMENT PERIOD; or
- within the 30 days of the date you or your DEPENDENT is first eligible for this coverage.

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

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

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

- your coverage under the other health coverage ends involuntarily;
- your marriage; or
- the birth, adoption, or placement for adoption of your DEPENDENT CHILD.

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

- you or your DEPENDENT are eligible under a state Medicaid plan or state Children's Health Insurance Program (CHIP) and the Medicaid or CHIP coverage is terminated;
- you or your DEPENDENT becomes eligible for a PREMIUM assistance subsidy under a state Medicaid plan or CHIP.

EFFECTIVE DATE of coverage

If we accept your application and receive the needed PREMIUM, coverage starts on the date chosen by your GROUP. Enrolled DEPENDENT'S' coverage starts when the SUBSCRIBER's coverage starts, or at a later date if the DEPENDENT becomes eligible after the SUBSCRIBER became eligible for coverage. A DEPENDENT's coverage cannot start before the SUBSCRIBER's coverage starts.

If you or your enrolled DEPENDENT is an INPATIENT on your EFFECTIVE DATE, your coverage starts on the later of:

- the EFFECTIVE DATE, or
- the date we are notified and given the chance to manage your care.

Adding DEPENDENTS under FAMILY COVERAGE

When DEPENDENTS may be added

After you enroll, you may apply to add any DEPENDENTS who are not currently enrolled in TUFTS HEALTH PLAN only:

- during the OPEN ENROLLMENT PERIOD that applies to you; or
- within 30 days after any of the following events:
  - a change in your marital status,
  - the birth of a CHILD,
  - the adoption of a CHILD as of the earlier of the date the CHILD is placed with you for the purpose of adoption or the date you file a petition to adopt the CHILD,
  - a court orders you to cover a CHILD through a qualified medical child support order,
  - a DEPENDENT loses other health care coverage involuntarily,
  - a DEPENDENT moves into the SERVICE AREA, or
  - if your GROUP has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add DEPENDENTS

1. If you have Family Coverage, fill out either a group-approved form or Tufts Health Plan forma membership application form listing the Dependents. Give the form to your GROUP, either during your Open Enrollment Period or within 30 days after the date of an event listed above, under “When Dependents may be added.”

2. If you don’t have Family Coverage, ask your GROUP to change your Individual CONTRACT to Family Coverage and then follow the procedure above.

EFFECTIVE DATE of DEPENDENTS' coverage

If we accept your application to add DEPENDENTS, we will send you a Member ID card for each DEPENDENT.

EFFECTIVE DATES will be no later than:

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

Availability of benefits after enrollment

COVERED SERVICES for an enrolled DEPENDENT are available as of the DEPENDENT's EFFECTIVE DATE. There are no waiting periods. Maternity benefits are available even if the pregnancy began before your EFFECTIVE DATE.

Note: We will only pay for COVERED SERVICES which are provided on or after your EFFECTIVE DATE.

Newborn CHILDREN and ADOPTIVE CHILDREN

Importance of enrolling and choosing a PCP for newborn CHILDREN and ADOPTIVE CHILDREN

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

You must enroll your ADOPTIVE CHILD within 30 days after the CHILD has been adopted or placed for adoption with you for that CHILD to be covered from the date of his or her adoption. Otherwise, you must wait until the next OPEN ENROLLMENT PERIOD to enroll the CHILD.

Steps to follow to choose a PCP for newborn CHILDREN and ADOPTIVE CHILDREN

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

Continuing Eligibility for DEPENDENTS

When coverage ends

DEPENDENT coverage for a CHILD ends on the last day of the month in which the CHILD's 26th birthday occurs .

Coverage after termination

When a CHILD loses coverage under this EVIDENCE OF COVERAGE, he or she may be eligible for federal or state continuation or to enroll in an INDIVIDUAL CONTRACT. See Chapter 5 for more information.

How to continue coverage for DISABLED DEPENDENTS

1. About 30 days before the CHILD no longer meets the definition of DEPENDENT, call Member Services.

2. Give proof, acceptable to us, of the CHILD's disability.

When coverage ends for a DISABLED DEPENDENTS.

DISABLED DEPENDENT coverage ends when the DEPENDENT no longer meets the definition of DISABLED DEPENDENT, or the SUBSCRIBER fails to give us proof* of the DEPENDENT's continued disability.

Coverage after termination for a DISABLED DEPENDENTS

The former DISABLED DEPENDENT may be eligible to enroll in coverage under an INDIVIDUAL CONTRACT. See Chapter 5 for more information.

Rule for former SPOUSES (Also see Chapter 5)

If you and your SPOUSE divorce or legally separate, your former SPOUSE may continue coverage as a DEPENDENT under your FAMILY COVERAGE in accordance with Massachusetts law.

Note: If you remarry, your former SPOUSE's coverage as a DEPENDENT under your FAMILY COVERAGE will end. However, your former SPOUSE may continue coverage under an INDIVIDUAL CONTRACT through your employer GROUP. If your former SPOUSE remarries, coverage will end unless continuation is still available under federal law.

Continuing Eligibility for DEPENDENTS, continued

How to continue coverage for former SPOUSES for GROUP CONTRACT

Follow these steps to continue coverage for a former SPOUSE:

- Call a Member Services Representative within 30 days after the divorce decree is issued to tell us about your divorce.
- Send us proof* of your divorce or separation when asked.

***Important Note about DISABLED DEPENDENT and former SPOUSES coverage:** If you enrolled for coverage directly with TUFTS HEALTH PLAN, this proof must be provided to Us.

Keeping our records current

You must notify us of any changes that affect you or your DEPENDENTS' eligibility. Examples of these changes are:

- birth, adoption, changes in marital status, or death;
- your remarriage or the remarriage of your former SPOUSE, when the former SPOUSE is an enrolled DEPENDENT under your FAMILY COVERAGE;
- moving out of the SERVICE AREA or temporarily residing out of the SERVICE AREA for more than 90 consecutive days;
- address changes; and
- changes in an enrolled DEPENDENT's status as a CHILD or DISABLED DEPENDENT.

Forms to report these changes are available from your GROUP or from the Member Services Department.

Chapter 3 - COVERED SERVICES

When health care services are COVERED SERVICES

Health care services and supplies are COVERED SERVICES only if they are:

- listed as COVERED SERVICES in this chapter;
- MEDICALLY NECESSARY, as determined by TUFTS HEALTH PLAN or Our designee;
- consistent with applicable state or federal law;
- consistent with the Medical Necessity Guidelines in effect at the time the services or supplies are provided. This information is available to you on our website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/overview**, or by calling Member Services;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your PCP, except in an EMERGENCY or for URGENT CARE (see Chapter 1 “How Your HMO Plan Works” for more information);
- obtained within the 50 United States. The only exceptions are EMERGENCY care or URGENT CARE services while traveling, which are COVERED SERVICES when provided outside of the 50 United States; and
- approved by an AUTHORIZED REVIEWER, in some cases.

Note: Certain services may be available when you are traveling outside of the 50 United States through the TUFTS HEALTH PLAN telemedicine vendor. For more information, visit Our website or contact Member Services **https://tuftshealthplan.com/member/employer-individual-or-family-plans/tools-resources/digital-tools/telehealth**.

Note: Certain COVERED SERVICES described in this chapter must be approved in advance by an AUTHORIZED REVIEWER. If prior approval is not obtained, you may have to pay the full cost of those services and supplies.

COVERED SERVICES

Health care services and supplies only qualify as COVERED SERVICES if they meet the requirements shown above for "When health care services are COVERED SERVICES". The following section describes those services that qualify as COVERED SERVICES.

Notes:

- For information about your costs for the COVERED SERVICES listed below (for example, COPAYMENTS, DEDUCTIBLES and COINSURANCE), see the "Benefit Overview" section at the beginning of this document.
- Information about the day, dollar, and visit limits under this plan are listed in certain COVERED SERVICES in this chapter and in the “Benefit Overview” section at the beginning of this document.

EMERGENCY care

(no PCP referral required)

Notes:

- The EMERGENCY room COPAYMENT is waived if the EMERGENCY room visit results in immediate hospitalization or DAY SURGERY. If you are admitted as an INPATIENT after receiving EMERGENCY care, please call TUFTS HEALTH PLAN in order to have your EMERGENCY room COPAYMENT waived.
- If you receive EMERGENCY COVERED SERVICES from a non-TUFTS HEALTH PLAN PROVIDER , you will be responsible for any applicable COST SHARING AMOUNT. You may receive a bill for these services. Please call Member Services or see "Bills from PROVIDERS" in Chapter 6 for more information on 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 COPAYMENT may apply if DAY SURGERY services are received.

TUFTS HEALTH PLAN offers coverage for services and medications for pain management that are alternatives to opioids. Services include, but are not limited to:

- Spinal manipulation
- Acupuncture services
- Physical therapy
- Nutrition counseling

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

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

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

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

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

Acupuncture services

(no PCP referral required)

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

Please see the “Benefit Overview” at the beginning of this document for more information.

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

Ambulance services

- Ground, sea, and air ambulance transportation for EMERGENCY care are COVERED SERVICES.
  - Air ambulance services means transportation by helicopter or fixed wing plane (for example, Medflight).
- Non-EMERGENCY ambulance transportation is covered only when determined to be MEDICALLY NECESSARY.

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

Autism spectrum disorders – diagnosis and treatment

(Requires the prior approval of an AUTHORIZED REVIEWER.)

- 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 Mental Disorders.

TUFTS HEALTH PLAN provides coverage for the following COVERED SERVICES:

- HABILITATIVE or rehabilitative care. This coverage includes, but is 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 habilitative physical or occupational therapy" benefit do not apply to coverage for autism spectrum disorders.
- prescription drugs, covered under your "Prescription Drug Benefit.
- psychiatric and psychological care, covered under your "Behavioral Health and Substance Use Disorder Services" benefit below.
- therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your “Physical and occupational therapy services” and “MEDICALLY NECESSARY diagnosis and treatment of speech, hearing and language disorders” benefits below.

Behavioral Health and Substance Use Disorder Services (OUTPATIENT, INPATIENT, and Intermediate)

OUTPATIENT services

Services to diagnose and treat BEHAVIORAL HEALTH DISORDERS (including diagnosis, detoxification, and treatment of substance use disorders).

OUTPATIENT treatment of substance use disorders includes methadone maintenance or methadone treatment related to chemical dependency disorders. Psychological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury" as described earlier in this chapter.

Annual behavioral health wellness examinations can be performed by a behavioral health/substance use disorder PROVIDER or by a PCP during a routine physical examination. A behavioral health wellness examination is a screening or assessment that seeks to identify any behavioral health needs and appropriate resources for treatment.

Note: Prior approval is required for psychological testing and neuropsychological assessment services.

INPATIENT and intermediate services

COVERED SERVICES include:

- 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, or substance use disorder facility.
  - **Note:** Prior approval is not required for INPATIENT psychiatric services.

- Intermediate behavioral health and substance use disorder services for BEHAVIORAL HEALTH DISORDERS. Intermediate services are defined as MEDICALLY NECESSARY care that is more intensive than traditional OUTPATIENT services, but less intensive than 24-hour hospitalization. Some examples are:

  - level III community-based detoxification;
  - intensive OUTPATIENT programs;
  - crisis stabilization;
  - partial hospital programs.

Emergency Services Programs are covered as intermediate behavioral health and substance use disorder services under Massachusetts law. Emergency Services Programs provide community-based EMERGENCY psychiatric services, including, but not limited to: behavioral health crisis assessment, intervention, and stabilization services. These services are available 24 hours per day, 7 days per week and can be received through mobile crisis intervention services, adult community crisis stabilization services, and Emergency Service PROVIDER community-based locations.

In Massachusetts, designated Community Behavioral Health Centers (CBHCs) serve as regional hubs of coordinated and integrated behavioral health/substance use disorder treatment and can provide the services listed above. To find a CBHC in our network, please visit the website at **www.tuftshealthplan.com**, and click on “Find a Doctor,” or call Member Services.

INPATIENT and intermediate services for child-adolescent BEHAVIORAL HEALTH DISORDERS

The following services are available to children and adolescents until age 19, and their parents and/or appropriate caregiver, when MEDICALLY NECESSARY:

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

  ICBAT programs admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs treat patients with clinical presentations similar to those referred to INPATIENT services, but who are able to be cared for safely in an unlocked setting. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour hospital setting.

  These services do not require prior approval*.

  The following services are covered intermediate services. Services may be provided by an appropriate health care professional under the supervision of a LICENSED BEHAVIORAL HEALTH PROFESSIONAL:

- **Community-based acute treatment (CBAT)** – Services provided in a staff-secure setting on a 24-hour basis. CBAT programs provide intensive therapeutic services including, but not limited to:
  - daily medication monitoring;
  - psychiatric assessment;
  - nursing care;
  - individual, group and family therapy;
  - case management;
  - family assessment and consultation; and
  - discharge planning.

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

  These services do not require prior approval*.

INPATIENT and intermediate services for child-adolescent BEHAVIORAL HEALTH DISORDERS, continued

- **In-home behavioral services** – A combination of behavior management therapy and behavior management monitoring. These services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:
- Monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver.
- Therapy that addresses challenging behaviors that interfere with a child's successful functioning. “Behavior management therapy" shall include:
  - behavioral assessment and observation of the youth;
  - development of a behavior plan; and
  - interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy.

Coverage may also include short-term counseling and assistance. In-home behavioral services may require prior approval for coverage to apply.

- **In-home therapy services** – Clinical intervention or ongoing training, as well as therapeutic support. The intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. These services may require prior approval for coverage to apply and include:
  - A therapeutic relationship between a clinician, a CHILD, and a CHILD's family to treat the CHILD’s needs. This may include improvement of the family’s ability to provide effective support and promote healthy functioning. Work may also be performed with family members to enhance problem solving, limit setting, and communication.
  - Implementation of a treatment plan that involve therapeutic interventions that teach the child to understand and control his/her feelings. Family members will also receive support in addressing the CHILD’s needs.

Intermediate services for child-adolescent Behavioral Health Disorders, continued

- **Intensive care coordination (ICC)** – A collaborative service that provides case management services to patients with a serious emotional disturbance. ICC supports the medical, behavioral health, and psychosocial needs of a patient and the patient's family. This service includes:
  - an assessment;
  - the development of a care plan;
  - referrals to appropriate levels of care;
  - monitoring of goals, and
  - coordinating with other social supports and state agencies.

The service shall include both face-to-face and telephonic meetings as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate. Intensive care coordination services may require prior approval for coverage to apply. You or your PROVIDER must notify TUFTS HEALTH PLAN within 3 days of your initial visit by calling the Behavioral Health Department at 1-800-208- 9565.

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

These services may include:

- teaching parent(s)/caregiver(s) about the youth's needs and resiliency factors;
- teaching parent(s)/caregiver(s) how to navigate services; and
- identifying services in their communities, including self-help groups.

Family support and training services do not require prior approval.

Intermediate services for child-adolescent Behavioral Health Disorders, continued

- **Therapeutic mentoring services*** – Services designed to support or to improve age-appropriate social functioning. Therapeutic mentoring is a skill building service that includes:
  - coaching the child in age-appropriate behaviors;
  - interpersonal communication support;
  - problem solving training; and
  - conflict resolution training.

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

Therapeutic mentoring services do not require prior approval.

*The MEMBER must be approved to receive services through a clinical hub provider (i.e., a provider for outpatient therapy, in-home therapy, or ICC). The clinical hub provider serves as the primary behavioral health care provider for the youth and will coordinate with other service providers.

For more information about the services available under this benefit, please see the Behavioral Health Department at 1-800-208-9565 or see our website.

Cardiac rehabilitation services

Services for OUTPATIENT treatment of cardiovascular disease that:

- meet the standards put into effect by the Massachusetts Commissioner of Public Health; and
- begin within 26 weeks of the diagnosis.

We cover only the following services:

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

Note: We do not cover the program phase that maintains rehabilitated cardiovascular health.

Chemotherapy administration

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

Chiropractic care

See "Spinal manipulation".

Cleft lip or cleft palate treatment and services for CHILDREN

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

- **Medical and facial surgery:** This includes surgical management and follow-up care by plastic surgeons;
- **Oral surgery:** This includes surgical management and follow-up care by oral surgeons;
- **Dental surgery or orthodontic treatment and management:** No referral from the CHILD's PCP is required for these services;
- **Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy:** No referral from the CHILD's PCP is required for these services;
- **Speech therapy and audiology services:** Covered as described under "MEDICALLY NECESSARY diagnosis and treatment of speech, hearing and language disorders";
- **Nutrition services:** Covered as described under "Nutritional counseling".

Services must be prescribed by the treating physician or surgeon. The PROVIDER must certify that the services are MEDICALLY NECESSARY because of the cleft lip or cleft palate.

Colonoscopies

See “Diagnostic or preventive screening procedures” later in this chapter.

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.

Diabetes self-management training and educational services

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

Important Note: We will only cover these services when provided by a TUFTS HEALTH PLAN PROVIDER who is a certified diabetes health care provider.

Diagnostic imaging

Including:

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

Note: Prior approval is required for these services.

Diagnostic or preventive screening procedures

Examples include, but are not limited to, colonoscopies, sigmoidoscopies, and endoscopies.

Diagnostic testing

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

DURABLE MEDICAL EQUIPMENT

Equipment must meet the following definition:

DURABLE MEDICAL EQUIPMENT is a device or instrument of a durable nature that:

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

The equipment must also be the most appropriate available amount, supply or level of service for the MEMBER in question. This will be 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 covered under this benefit.

(**Note:** Certain equipment may require prior approval for coverage to apply.)

Note: You may be responsible for paying towards the cost of DURABLE MEDICAL EQUIPMENT covered under this plan. Please see the "Benefit Overview" section.

The following examples of covered and non-covered items are for illustration only.

Examples of covered items (this list is not all-inclusive):

- the purchase of a manual or electric (non-hospital grade) breast pump or the rental of a hospital grade electric breast pump for pregnant or post-partum MEMBERS, when prescribed by a physician (**Note:** These breast pumps are covered in full);
- cranial helmets;
- gradient stockings (up to three pairs every 365 days);
- the following equipment when used to diagnose or treat insulin-dependent, non-insulin dependent, or gestational diabetes;
  - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind;
  - therapeutic/molded shoes and inserts to treat a severe diabetic foot disease; and
  - visual magnifying aids;
- custom-made oral appliances for the treatment of sleep apnea (prefabricated oral appliances are not covered);
- oxygen concentrators (stationary and portable);
- prosthetic devices, except for arms, legs or breasts*; and
  Important Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Prosthetic Devices" benefit.
- power/motorized wheelchairs.

We will decide whether to purchase or rent the equipment for you. This equipment must be purchased or rented from a DURABLE MEDICAL EQUIPMENT PROVIDER that has an agreement with us to provide such equipment.

(continued on next page)

Early intervention services for a DEPENDENT CHILD

Services provided by programs that meet the standards established by the Massachusetts Department of Public Health. Early intervention services include, but are not limited to:

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

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

Extended care services

(Requires the prior approval of an AUTHORIZED REVIEWER.)

SKILLED nursing, rehabilitation or chronic disease hospital services that are provided in a Medicare-certified:

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

Family planning

Coverage is provided for contraceptive services, including consultations, examinations, and procedures. These services must be 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;
  - implantable contraceptives;
  - intrauterine devices (IUDs);
  - Depo-Provera or its generic equivalent; and
  - any other MEDICALLY NECESSARY contraceptive device*.

The following services are covered when provided with a pregnancy termination:

- Pre-pregnancy termination evaluations and examinations;
- Pre-operative counseling;
- Ultrasounds;
- Laboratory services, including pregnancy testing, blood type, and Rh factor;
- Rh (D) immune globulin (human);
- Anesthesia (general or local);
- Post-pregnancy termination care;
- Follow-up; and
- Advice on contraception or referral to family planning services.

The term “pregnancy termination” shall not include providing care related to a pregnancy or miscarriage.

***Notes:**

- Please note that we cover certain contraceptives, such as oral contraceptives, and over-the-counter female contraceptives, condoms, and diaphragms under a Prescription Drug Benefit. If those contraceptives are covered under that Benefit, they are not covered here. This plan also covers in full the following contraceptives: oral contraceptives; diaphragms; and other hormonal contraceptives; condoms; and FDA-approved over-the-counter female contraceptives. Coverage applies when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription. In addition, please note that contraceptives and female sterilization procedures are covered in full. To determine whether a specific family planning service is covered in full or subject to a COST SHARING AMOUNT, please see **https://www.tuftshealthplan.com/documents/providers/payment-policies/preventive-services** or call Member Services.

Hearing aids

Coverage is provided for hearing aids (one per ear per prescription change) for CHILDREN age 21 or younger. This includes hearing aid evaluations, the fitting and adjustment of hearing aids, and supplies, including ear molds.

Hemodialysis

- OUTPATIENT (including in the home) hemodialysis; and
- OUTPATIENT (including in the home) peritoneal dialysis.

Home health care

(Requires the prior approval of an AUTHORIZED REVIEWER)

We will cover 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 MEDICALLY NECESSARY:
  - speech therapy;
  - occupational therapy;
  - medical/psychiatric social work;
  - nutritional consultation;
  - the use of DURABLE MEDICAL EQUIPMENT; and
  - the services of a part-time home health aide.

*To be considered homebound, you do not have to be bedridden. However, your condition should be such that there exists a normal inability to leave the home. If you leave the home, you may be considered homebound if the absences are infrequent, for short periods, or to receive medical treatment. Please note that this homebound requirement does not apply to palliative care.

Note:

- Home health care services for physical and occupational therapies are only covered to the extent that they are provided to restore function lost or impaired (see "Physical and occupational therapy services"). However, those services are not subject to the 60-day period for improvement for rehabilitative therapy services or the visit limits.
- Sleep studies performed in the home are not covered under this "Home health care" benefit. Instead, they are covered as described under "Diagnostic testing" earlier in this chapter.

Hospice care services

Prior approval by an AUTHORIZED REVIEWER is required.

We will cover the following services for MEMBERS who are terminally ill (having a life expectancy of 6 months or less):

- PROVIDER services;
- nursing care provided by or supervised by a registered professional nurse;
- social work services;
- volunteer services; and
- counseling services. This includes bereavement counseling for the MEMBER's family. These services are available for up to one year following the MEMBER's death.

Hospice care services can be provided:

- in a home setting;
- on an OUTPATIENT basis; and
- on a short-term INPATIENT basis. Coverage applies for the control of pain and management of clinical problems which cannot, for medical reasons, be managed in a home setting

Hospital INPATIENT care (Acute care)

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

Note: Approval by an AUTHORIZED REVIEWER is required, except for EMERGENCY care.

House calls

COVERED SERVICEs in the home include preventive services, diagnostic treatment, and follow-up care as appropriate. A licensed or certified PROVIDER must provide this care.

Certain services provided during a house call may require prior approval for coverage to apply. Please see the "Benefit Overview" for more information.

The COST SHARING AMOUNT that applies to these services will depend upon the type of service provided. When you receive a COVERED SERVICE in your home (other than Home Health Care), you will pay the same COST SHARING AMOUNT that applies to that service when it is provided in an office or facility setting.

Human leukocyte antigen testing or histocompatibility locus antigen testing

For use in bone marrow transplantation. Coverage applies when necessary to establish a MEMBER's bone marrow transplant donor suitability. Includes:

- costs of testing for A, B or DR antigens, or
- any combination consistent with criteria established by the Department of Public Health;

Prior approval by an AUTHORIZED REVIEWER is required.

Immunizations and vaccinations

Coverage is provided as recommended by the Center for Disease Control and Prevention (CDC). Coverage includes travel vaccines.

Infertility services

Services for the diagnosis and treatment of Infertility.

(I.) Diagnosis of Infertility: Diagnostic procedures and tests are covered when provided during an infertility evaluation. These services require prior approval for coverage to apply.

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

If a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive shall be included in the calculation of the one year or six month period, as applicable.

The following procedures are COVERED SERVICES and require prior approval for MEMBERS with a diagnosis of infertility.

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

A. Assistive Reproductive Technology ("ART") procedures, including:

- In-vitro fertilization (IVF) and/or embryo transfer;
- Frozen embryo transfer (FET);
- Gamete intra-fallopian transfer (GIFT);
- Donor oocyte (DO/IVF);
- Donor embryo/frozen embryo transfer (DE/FET);
- Intracytoplasmic sperm injection (ICSI);
- Assisted hatching (AH);
- Cryopreservation of embryos/blastocysts;
- Cryopreservation of sperm;
- Cryopreservation of oocytes.

MEMBERS who meet the criteria for infertility services, have a documented diagnosis of infertility, are using their own eggs, and are self-paying for a surrogate, may be authorized for ovarian stimulation, egg retrieval and fertilization. Prior approval is required for coverage to apply.

B. Other related treatments, including:

- artificial insemination;
- gonadotropin medication (FSH);
- artificial insemination used in conjunction with gonadotropin medication; and
- procurement and processing of eggs or storage of inseminated eggs when associated with active infertility treatment.

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

Infertility services, continued

(III.) Preimplantation Genetic Diagnosis (PGD) testing with I.V.F.:

PGD testing is covered when either of the partners is a known carrier for certain genetic disorders. PGD testing with IVF may be covered **for MEMBERS who do not have a diagnosis of infertility** in certain circumstances. For instance, when the fetus would be at risk for an inherited genetic disorder associated with severe disability and/or premature death. Prior approval is required for coverage of PGD testing.

NOTE: Oral and injectable drugs used in the treatment of infertility are covered only when the MEMBER:

- is covered by a Prescription Drug Benefit; and
- has been approved for associated infertility treatment.

Injectable, infused, or inhaled medications

Injectable, infused, or inhaled medications are: (1) required for an office visit to diagnose and treat illness or injury; or (2) received at home with a home infusion PROVIDER.

Notes:

- Prior approval and quantity limitations may apply.
- Intravenous Immunoglobulin (IVIg) therapy is covered for Pediatric Autoimmune Neuropsychiatric Disorders and Pediatric Acute-Onset Neuropsychiatric Syndromes.
- Coverage includes the components required to administer these medications.
- Medications that are covered under our pharmacy benefit are not covered under this benefit.

Laboratory tests

including, but not limited to, blood tests, urinalysis, throat cultures, genetic testing, and lipid profiles.

Notes:

- Laboratory tests must be ordered by a licensed PROVIDER and performed at a licensed laboratory.
- Prior approval is required for some laboratory tests.
- Certain laboratory tests associated with preventive care are covered in full when billed in accordance with our Preventive Services Payment Policy. An example of this is the colorectal cancer screening test Cologuard. If a laboratory test is not billed according to this policy, it will be subject to a COST SHARING AMOUNT.

Lead screenings

Mammograms

(no PCP referral required)

Covered at the following intervals:

- one baseline at 35-39 years of age,
- one every year at age 40 and older, or
- as otherwise MEDICALLY NECESSARY

Maternity care

OUTPATIENT Maternity Care-- Routine and Non-Routine Care

(no PCP referral required)

- prenatal care, exams, and tests; and
- postpartum care provided in a PROVIDER's office

Note: COST SHARING AMOUNTS will apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of routine maternity care.

INPATIENT Maternity Care

(no PCP referral required)

- hospital and delivery services, and
- well newborn CHILD care in hospital.

Includes INPATIENT care for mother and newborn CHILD for at least:

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

Notes:

- Coverage will include one home visit by a registered nurse, physician, or certified nurse midwife. Additional home visits can be approved when MEDICALLY NECESSARY. COVERED SERVICES will also include, but not be limited to, parent education, assistance, and training in breast or bottle feeding.
- This coverage will be available to a mother and her newborn CHILD regardless of whether or not there is an early discharge.

MEDICALLY NECESSARY diagnosis and treatment of speech, hearing and language disorders

(Requires the prior approval of an AUTHORIZED REVIEWER).

Note: Short-term cognitive retraining or cognitive rehabilitation services are covered under this benefit. Coverage applies only when provided to restore function lost or impaired as the result of an accidental injury or sickness. Measurable improvement must be anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery.

Medical supplies

Coverage applies to certain types of medical supplies from an authorized vendor. This includes ostomy, tracheostomy, catheter supplies and insulin pumps.

Note:

- These supplies must be obtained from a vendor that has an agreement with us to provide such supplies.
- Prior approval is required for these supplies.

Nutritional counseling

Coverage is provided when prescribed by a physician and performed by a registered dietician/nutritionist. Visits are covered:

- When MEDICALLY NECESSARY, for the purpose of treating an illness; or
- As preventive services. This includes obesity screenings, healthy diet counseling, and behavior change and counseling.

Note: Weight loss programs and clinics are not covered.

Office visits to diagnose and treat illness or injury

Coverage includes, but is not limited to:

- office visits for evaluations and consultations; and
- MEDICALLY NECESSARY evaluations and related services for acute or EMERGENCY gynecological conditions.

Coverage also includes evidence-based, integrated psychiatric collaborative care services to treat both behavioral health and substance use disorders. Psychiatric collaborative care services are used to develop structured care management plans for MEMBERs and are provided through a primary care team that consists of a PRIMARY CARE PROVIDER, a care manager, and a psychiatric consultant.

Psychiatric collaborative care services are not available through all PRIMARY CARE PROVIDERs and are not appropriate for all MEMBERs. Please see the “Benefit Overview” at the front of this EVIDENCE OF COVERAGE for the applicable MEMBER COST SHARING AMOUNT that applies to this service.

Oral health services

The following oral health services are covered.

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

- Non-EMERGENCY care
  The following services are covered in an INPATIENT or DAY SURGERY setting. Coverage includes facility, PROVIDER, and surgical charges. Prior approval is required for coverage to apply.
  - Extraction of seven or more permanent teeth during one visit
  - Surgical treatment of skeletal jaw deformities
  - Surgical repair related to Temporomandibular Joint Disorder

  In addition, surgical removal of impacted or unerupted teeth when embedded in bone is covered in an INPATIENT, DAY SURGERY, or office setting. Coverage includes facility, PROVIDER, and surgical charges. Prior approval is only required if received in an INPATIENT or DAY SURGEY setting.

Important Notes:

- Coverage does not apply to Non-EMERGENCY oral health services provided by a dentist. MEMBERS must receive these services from an oral surgeon.
- X-rays performed in association with Non-EMERGENCY oral health services are covered as described under “Diagnostic imaging.”

Pap Smear

Covered for one annual screening for women age 18 and older or as MEDICALLY NECESSARY.

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

INPATIENT and OUTPATIENT

Services provided as part of a qualified clinical trial are covered to the same extent as they would be covered if the MEMBER did not receive care in a clinical trial.

Preventive health care for MEMBERS under age 6

Coverage is provided for:

- physical examinations;
- history;
- measurements;
- appropriate immunizations and lab tests;
- hearing exams and screenings;
- neuropsychiatric evaluations; and
- developmental assessments.

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine exam is subject to an office visit COPAYMENT. COST SHARING AMOUNTS will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine exam.

Preventive health care for MEMBERS age 6 and older

Coverage is provided for:

- physical examinations, including appropriate immunizations and lab tests; and
- hearing exams and screenings for MEMBERS under age 18.

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine exam is subject to an office visit COPAYMENT. COST SHARING AMOUNTS will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of a routine exam.

Prosthetic devices

(Requires the prior approval of an AUTHORIZED REVIEWER.*)

We cover the cost (including repairs) of breast prostheses and prosthetic arms and legs. Coverage is provided for the most appropriate MEDICALLY NECESSARY model that adequately meets the MEMBER's needs.

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

Radiation therapy

(Requires the prior approval of an AUTHORIZED REVIEWER.)

Rehabilitative and HABILITATIVE physical and occupational therapy services

(Requires the prior approval of an AUTHORIZED REVIEWER.)

Rehabilitative physical and occupational therapy services, including cognitive rehabilitation and 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 sickness. TUFTS HEALTH PLAN must determine that the MEMBER's condition is subject to significant improvement within a period of 60 days from the initial treatment.

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

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

- provided by a licensed physical therapist; and
- in compliance with MEDICALLY NECESSITY guidelines.

Respiratory therapy/pulmonary rehabilitation services

Routine annual gynecological exam

Includes any follow-up obstetric or gynecological care determined to be MEDICALLY NECESSARY as a result of that exam (No PCP referral required).

Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine exam is subject to an Office Visit COPAYMENT. COST SHARING AMOUNTS will also apply to diagnostic tests or diagnostic laboratory tests when they are ordered as part of an exam.

Scalp hair prostheses or wigs

Scalp hair prostheses or wigs when needed for hair loss suffered as a result of the treatment for any form of cancer or leukemia. Coverage also applies for certain pathologic conditions such as: alopecia areata, alopecia totalis, alopecia medicamentosa, or permanent loss of scalp hair due to injury.

Smoking cessation counseling sessions

Including individual, group, and telephonic smoking cessation counseling services that:

- are provided in accordance with current guidelines established by the Department of Health and Human Services; and
- meet the requirements of the ACA.

Note: Coverage is also provided for prescription smoking cessation agents and generic over-the-counter smoking cessation agents when prescribed by a physician. For more information, see the “Prescription Drug Benefit” section.

Special formulas

(Requires the prior approval of an AUTHORIZED REVIEWER.)

Includes the following formulas when prescribed by a PROVIDER:

- **Low protein foods**
  When provided to treat inherited diseases of amino and organic acids.

- **Nonprescription enteral formulas**
  Coverage is provided:
  - for home use for treatment of malabsorption.
  - when MEDICALLY NECESSARY.

- **Special medical formulas**
  When MEDICALLY NECESSARY to protect the unborn fetuses of women with phenylketonuria or for the treatment of certain inherited diseases.

Spinal manipulation

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

Surgery - Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants

(Requires the approval of an AUTHORIZED REVIEWER.)

- Bone marrow transplants for MEMBERS diagnosed with breast cancer who meet the criteria established by the Department of Public Health.
- Hematopoietic stem cell transplants and human solid organ transplants for MEMBERS who are the recipients. These services must be provided at a TUFTS HEALTH PLAN designated transplant facility. We pay for charges incurred by the donor, but only to the extent that charges are not covered by any other health care coverage. This includes:
  - evaluation and preparation of the donor, and
  - surgery and recovery services.

  Notes:
  - We do not cover charges of MEMBERS who donate to non-MEMBERS.
  - We cover the MEMBERS's search expenses for donors not related by blood when MEDICALLY NECESSARY. These services are only covered to the extent that expenses are not covered by any other health care coverage.
  - We cover a MEMBERS's human leukocyte antigen (HLA) testing.

Surgery -- Gender affirming procedures and related services

COVERED SERVICEs include:

- Inpatient services for MEMBERs undergoing gender affirming surgery and related surgical procedures. This includes certain associated surgical procedures not otherwise covered under this plan.
- DAY SURGERY for surgical procedures related to the gender affirming surgery. This includes certain associated surgical procedures not otherwise covered under this plan.
- OUTPATIENT medical care (pre-operative or post-operative) related to gender affirming surgical procedures.
- Behavioral health care services (pre-operative or post-operative) related to gender affirming surgical procedures or the gender affirming process.
- Prescription medications required as part of the gender affirming process.
- Speech therapy services, including voice modification and communication therapy.

These services require prior approval for coverage to apply. Gender affirming surgical procedures and related services only qualify as Covered Services when obtained within the 50 United States.

Surgery - in a PROVIDER's office

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

Approval by an AUTHORIZED REVIEWER is required, except (i) for the treatment of cleft lip or cleft palate for CHILDREN under the age of 18; or (ii) in connection with a mastectomy. Coverage is provided for:

- services required to relieve pain or to restore a bodily function that is impaired;
- the following services in connection with mastectomy:
  - reconstruction of the breast affected by the mastectomy;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance, and
  - prostheses and treatment of physical complications.

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

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

Note: Cosmetic surgery is not covered.

Telemedicine services

We cover telemedicine services in the same manner as an in-person consultation. Telemedicine services are provided through audio, video, or other electronic media communications. Telemedicine services are available for both medical and behavioral health/substance use disorder services.

Telemedicine services may be obtained from a TUFTS HEALTH PLAN PROVIDER through TUFTS HEALTH PLAN's designated telemedicine vendor. When you obtain services from a TUFTS HEALTH PLAN PROVIDER, you will pay the same COST SHARING AMOUNT that applies to an office visit with that PROVIDER. In addition, you will need to follow the same rules about referrals. When you access services through the vendor, you will pay the COST SHARING AMOUNT listed in the "Benefit Overview". No referrals are required.

At your choice, audio-only consultation services are available to you. The same COST SHARING AMOUNT as indicated for telemedicine services applies.

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

- Remote patient monitoring services; and
- Remote evaluation of transferred medical data recorded on an electronic device.

See the "Benefit Overview" for the COST SHARING AMOUNTS that apply to these additional telemedicine services.

Travel Reimbursement for COVERED SERVICES Restricted by State Law

You are eligible to receive reimbursement of certain expenses incurred when traveling to receive a COVERED SERVICE that is restricted by law in the state where you reside.

MEMBERS must meet the following criteria to receive reimbursement:

- The service is covered under your plan;
- Access is restricted or unavailable as a result of state law; and
- You must travel more than 100 miles from your residence.

TUFTS HEALTH PLAN will reimburse you and, when necessary, one companion for specific transportation and lodging expenses. These expenses must be essential to receiving the COVERED SERVICE. Coverage for a companion is only available when the assistance of that companion is necessary to enable the MEMBER to receive the COVERED SERVICE. The companion does not need to be a TUFTS HEALTH PLAN MEMBER.

Reimbursement is provided for the following travel expenses:

1. Round trip transportation between your residence and the location in which you receive the COVERED SERVICE. Coverage includes the cost of air, train, bus, taxi, and ridesharing services as well as car rentals, tolls, and parking fees.

- Travel by air and train is limited to coach-class tickets.
- Mileage is based on the current IRS medical mileage reimbursement, which includes gasoline.

2. Lodging for up to $50 per day (up to $100 if you travel with a companion) when the medical care is provided by a physician in a hospital (or in a facility which is the equivalent of a hospital).

- Lodging is limited to hotel and motel rooms.

The following travel expenses are also not covered:

- Alcohol and tobacco;
- Meals;
- Entertainment;
- Tips and gratuities;
- Personal care and hygiene products;
- Telephone calls;
- Childcare expenses;
- Lost wages;
- Expenses for anyone other than you and a companion; and
- Luxury transportation services.

To receive reimbursement, you must submit the following information to the Member Reimbursement Medical Claims Department:

- A completed Travel Benefit Reimbursement Form, which can be obtained from our website at **www.tuftshealthplan.com**; and
- The documents listed on the form that are required for proof of service and payment.

The mailing address is listed on the form.

Please note:

- You must send your travel expenses within 12 months from the date of travel. If you do not, they cannot be considered for payment. Most completed reimbursement requests are processed within 30 days. Incomplete requests may take longer.
- Failure to adhere to the requirements explained above may result in your reimbursement being taxable income.

URGENT CARE

Services may be provided to you in a PROVIDER's office, a LIMITED SERVICE MEDICAL CLINIC, a hospital-based walk-in clinic, a mobile URGENT CARE unit, or a FREE-STANDING URGENT CARE CENTER.

Please note: You may be eligible to receive mobile urgent care services. Availability will depend upon your location. Please refer to the "Benefit Overview" for more information.

Vision care services

- Routine eye examination for MEMBERS: Coverage is provided for one routine eye examination every 24 months. You must receive routine eye examinations from a PROVIDER in the EyeMed Vision Care network.
- Other vision care services: Coverage is provided for eye examinations and necessary treatment of a medical condition. Prior approval is required for coverage to apply.

Note: One pair of eyeglass lenses and standard frames will be covered in each CONTRACT YEAR following a MEMBER's cataract surgery or other surgery to replace the natural lens of the eye. This coverage applies when the MEMBER does not receive an intraocular implant.

TUFTS HEALTH PLAN MEMBER Discounts

You may take advantage of MEMBER Discounts. Our MEMBER Discounts include the fitness reimbursement and weight management program reimbursement. Go to Our website for further details and required reimbursement forms at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/discounts-perks/overview**.

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";
- approved by the United States Food and Drug Administration (FDA);
- provided to treat an injury, illness, or pregnancy;
- MEDICALLY NECESSARY; and
- written by a TUFTS HEALTH PLAN participating PROVIDER, except in cases of authorized referral or in Emergencies.

The "Prescription Drug Coverage Table" below describes your prescription drug benefit amounts. We place all covered drugs into a “tier.” Each tier has its own COST SHARING AMOUNT and is described below:

- Tier-1 drugs: Medications on this tier have the lowest COST SHARING AMOUNT.
- Tier-2 drugs: Medications on this tier have the middle COST SHARING AMOUNT.
- Tier-3 drugs: Medications on this tier have the highest COST SHARING AMOUNT.

Notes:

- There are a limited number of medical drugs and supplies identified on the formulary as medical. These drugs and supplies are covered under your medical benefits but may be obtained at a retail pharmacy (for instance, spacers for asthma treatment).
- Certain prescribed, self-administered (including oral) administered anticancer medications used to kill or slow the growth of cancerous cells are covered in full . For oral medications, this COST SHARING AMOUNT applies for up to a 30-day supply.
- Smoking cessation agents (both prescription and generic over-the-counter agents when prescribed by a PROVIDER) are covered in full.
- Most generic drugs are covered on Tier 1 or Tier 2.
- 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 https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies or call Member Services for more information.
- In compliance with Massachusetts law, opioid medications listed as Schedule II or Schedule III controlled substances will be filled at a lesser quantity than prescribed if the MEMBER requests it. If the MEMBER requests the lesser quantity, no additional cost or penalty will be enforced on the MEMBER. If the MEMBER fills a lesser quantity than is prescribed of a Schedule II opioid controlled substance, and then decides to fill the remainder of the original prescription at the same pharmacy within 30 days of the original prescription date, no additional COPAYMENT or other cost sharing will be applied. Please see Appendix C, “Schedule II and III Opioid Medications” for a list of these medications.
- Pursuant to Massachusetts law, naloxone (an opioid antagonist) is available without a prescription when obtained from a Massachusetts pharmacy. Whoever requests naloxone at a pharmacy will be billed for the medication, even if that person is picking up the medication for someone else.
- COST SHARING AMOUNTs for medications subject to quantity limitations may differ. Some medications may be limited to a quantity per COPAYMENT. For more information, please see the formulary on our website.

Prescription Drug Coverage Table

DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs) when you obtain them directly from a TUFTS HEALTH PLAN designated retail pharmacy.	
TIER-1 drugs:	$15.00 COPAYMENT for up to a 30-day supply. $30.00 COPAYMENT for a 31-60-day supply. $45.00 COPAYMENT for a 61-90-day supply.
TIER-2 drugs:	$30.00 COPAYMENT for up to a 30-day supply. $60.00 COPAYMENT for a 31-60-day supply. $90.00 COPAYMENT for a 61-90-day supply.
TIER-3 drugs:	$50.00 COPAYMENT for up to a 30-day supply. $100.00 COPAYMENT for a 31-60-day supply. $150.00 COPAYMENT for a 61-90-day supply.
Notes: ● If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorized the generic equivalent, you will pay the applicable tier COST SHARING AMOUNT plus the difference in cost between the brand-name drug and the generic drug. ● You always pay the applicable COST SHARING AMOUNT, even if the cost of the drug is less than the COST SHARING AMOUNT. ● If the cost of a drug is less than the minimum COST SHARING AMOUNT, you pay only for the cost of the drug.	
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a TUFTS HEALTH PLAN designated mail services pharmacy.	
TIER-1 drugs:	$30.00 COPAYMENT for up to a 90-day supply.
TIER-2 drugs:	$60.00 COPAYMENT for up to a 90-day supply.
TIER-3 drugs:	$100.00 COPAYMENT for up to a 90-day supply.

What is Covered

For a current list of covered drugs, please go to our website at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies**, or call Member Services.

We cover 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."
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; oral diabetes medications that influence blood sugar levels.
- Generic and brand-name contraceptives, including oral contraceptives, diaphragms, condoms, 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*. Certain brand-name contraceptives may be covered when requested through the Formulary Exception Process by your PROVIDER.
  *Note: This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, condoms, and other self-administered hormonal contraceptives (e.g., patches, rings) that by law require a prescription, and FDA-approved over-the-counter female contraceptives (e.g., female condoms, contraceptive spermicides) when prescribed by a licensed PROVIDER and dispensed at a pharmacy pursuant to a prescription. See “Family planning” earlier in this chapter for information about other contraceptive drugs and devices that qualify as COVERED SERVICES.
- Fluoride for CHILDREN.
- Injectables and biological serum included on the list of covered drugs on our website. MEDICALLY NECESSARY hypodermic needles and syringes required to inject these medications are also covered. For more information, call Member Services or see our website.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, in the medical literature, or by the Commissioner of Insurance.
- Compounded medications, are covered if: (1) the MEMBER is under the age of 18; (2) the active ingredients are listed on the formulary; and (3) one or more agents within the compound is FDA-approved and requires a prescription by law. Compounded medications are covered for MEMBERs over the age of 18 when determined to be MEDICALLY NECESSARY. 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 at **https://tuftshealthplan.com/member/employer-individual-or-family-plans/plans-benefits/pharmacy-benefit/pharmacy-formularies** or you can call Member Services for more information.
- Prescription smoking cessation agents.
- Certain medications used for bowel preparation in colonoscopy procedures are covered in full for MEMBERs ages 45 through 74. For more information, please call Member Services or see the formulary on our website.

Note: Certain prescription drug products may be subject to one of the “TUFTS HEALTH PLAN" Pharmacy Management Programs” described below.

TUFTS HEALTH PLAN Pharmacy Management Programs
In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, we have developed the following Pharmacy Management Programs:

Quantity Limitations Program
We limit the quantity of selected medications that MEMBERS can receive for cost, safety and/or clinical reasons.

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

Step Therapy PA Program

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

Designated Specialty Pharmacy Program:
We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for MEMBERS. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-day supply of medication at one time and it is delivered directly to the MEMBERS'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-Formulary Drugs:
There are thousands of drugs listed on the TUFTS HEALTH PLAN covered drug list. In fact, most drugs are covered. There are, however, select drugs that TUFTS HEALTH PLAN currently does not include on the formulary. In many cases, these drugs are not on the formulary because there are safe, comparably effective and cost-effective alternatives available. Our goal is to keep pharmacy benefits as affordable as possible. If your doctor feels that one of the non-formulary drugs is needed, your doctor can submit a request for coverage under the Formulary Exception Process.

Note: Drugs approved through the Formulary Exception Process may be subject to the highest COPAYMENT.

New-To-Market Drug Evaluation Process:
New-To-Market drug products are reviewed for safety and clinical effectiveness by the TUFTS HEALTH PLAN's Pharmacy and Therapeutics Committee. We then make a coverage determination based on the Committee's recommendation. A new drug product will not be covered until this process is completed - usually within 6 months of the drug product's availability.

Limited Distribution Drugs:

Limited Distribution Drugs treat complex conditions and are only available through certain pharmacies. Select Limited Distribution Drugs will be limited to a 30-day supply. The formulary will indicate when a Limited Distribution Drug is limited to a 30-day supply.

90-Day Prescription Drug Benefit at a Pharmacy
You may purchase up to a 90-day supply of most maintenance medications from a participating pharmacy. When you obtain a 90-day prescription, you will pay the equivalent of three monthly MEMBER COST SHARING AMOUNTs.

Maintenance medications are those prescribed for the long-term treatment of chronic conditions. Although most maintenance medications are available for a 90-day supply, we may limit drugs for clinical reasons or to prevent potential waste. For example, controlled substance medications in schedules II and III (e.g., opioids, stimulants, testosterone, etc.) are excluded from a 90-day supply. Also, drugs included in the Specialty Pharmacy Program, discussed above, are not available for a 90-day supply.

Note: ADD/ADHD medications can be filled for a 60-day supply at retail.

Formulary Exception Process:

If your PROVIDER feels it is MEDICALLY NECESSARY for you to take medications that are not on a formulary or restricted under any of the “TUFTS HEALTH PLAN Pharmacy Management Programs” described above, he or she may submit a request for coverage. We will review the request and provide you with notification of our coverage decision within seventy-two (72) hours of receiving all necessary information to make a MEDICAL NECESSITY determination. Coverage decisions for medications restricted under the Step Therapy Program will be made within three (3) business days of receiving all necessary information. We will approve the request if it meets our guidelines for coverage. For more information, you can call a Member Services Representative.

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

The TUFTS HEALTH PLAN website has a list of covered drugs with their tiers. We may change a drug’s tier during the year. For example, if a brand drug’s patent expires, we may change the drug’s status by moving the brand drug from Tier-2 to Tier-3 or no longer covering the brand drug when a generic alternative becomes available.

If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check our website or call a Member Services.

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

Filling Your Prescription

Where to Fill Prescriptions:

Fill your prescriptions at a TUFTS HEALTH PLAN designated pharmacy. Our designated pharmacies include:

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

How to Fill Prescriptions:

- Make sure the prescription is written by a TUFTS HEALTH PLAN participating PROVIDER, except in cases of authorized referral or in Emergencies.
- 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 our 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, we offer you two choices for filling your prescription:

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

*The following may not be available to you through a TUFTS HEALTH PLAN designated mail services pharmacy:

- Medications for short term medical conditions;
- Certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- Medications that are part of our Quantity Limitations program; or
- Medications that are part of our Designated Specialty Pharmacy program.

Note: Your COST SHARING AMOUNTS for covered prescription drugs are shown in the "Prescription Drug Coverage Table" above.

Exclusions from Benefits

This chapter lists services (and categories of services), supplies, and medications that are excluded (not covered) under this EVIDENCE OF COVERAGE. **The following are not covered even if they are prescribed or recommended by a PROVIDER.** The exclusion headings used here are intended to group similar services, treatments, items or supplies together. Actual exclusions appear underneath each heading.

General Exclusions:

The following are excluded from coverage under this EVIDENCE OF COVERAGE:

- Any service, supply or medication is excluded:
  - That is not a COVERED SERVICE as defined in Appendix A and described in Chapter 3
  - That is not MEDICALLY NECESSARY as defined in Appendix A and described in Chapter 3
  - That is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
  - That is received outside of the SERVICE AREA, except as described in Chapter 1, **How the Plan Works**
  - That is related to non-COVERED SERVICE
  - That is primarily for your, or another person's, personal comfort or convenience
  - If there is a less intensive level of service, supply, or medication, or more cost effective alternative, that can be safely and effectively provided
  - If the service, supply or medication can be safely and effectively provided to you in a less intensive setting
  - That is required by a third party that is not otherwise MEDICALLY NECESSARY (examples of a third party are an employer, an insurance company, school or court)
  - That you are not legally obligated to pay for; or you would not be charged for if you had no health plan
  - That is provided to you by a relative who is not a PROVIDER; or that is provided to you by an immediate family member (by blood or marriage), even if that relative is a PROVIDER and the services are authorized by your PCP. Please note: if you are a PROVIDER, you cannot provide or authorize services for yourself, be your own PCP, or be the PCP of a member of your immediate family (by blood or marriage)
  - That is provided to a non-MEMBER, except as described in Chapter 3 for the following:
    - bereavement counseling services under Hospice care services;
    - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or banking donor sperm or inseminated eggs, under "Infertility services" (to the extent such costs are not covered by the donor's health coverage, if any);
    - organ donor charges under "Surgery - Bone marrow transplants for breast cancer, Hematopoietic stem cell transplants, and human solid organ transplants."
- We do not cover the cost of services (including tuition-based programs) that offer educational, vocational, recreational or personal development activities, including, but not limited to: therapeutic schools, camps, wilderness or ranch programs, sports or performance enhancement programs, spas/resorts, leadership or behavioral coaching or Outward Bound. We will provide coverage for MEDICALLY NECESSARY OUTPATIENT or intermediate behavioral health services provided by LICENSED BEHAVIORAL HEALTH PROFESSIONALs while the MEMBER is in a tuition-based program, subject to plan rules, including any network requirements or COST SHARING.
- Any additional fee a PROVIDER may charge as a condition of access, or any amenities that access fee is represented to cover is excluded. Please consult with your PROVIDER to see if he or she charges such a fee.
- Any care for conditions that (a) have benefits available under worker's compensation, or other government programs (except Medicaid) or (b) must be treated in a public facility under state or local law.
- Any drug, medicine, material or supply for use outside of the hospital or any other facility, except as described in Chapter 3.
- Medications and other products that can be purchased over-the-counter except those listed as covered in Chapter 3.
- Any examinations, evaluations or services for educational purposes or developmental purposes. This includes physical therapy, speech therapy, and occupational therapy, except as provided in Chapter 3. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities, and behavioral problems and developmental delays and services to treat speech, hearing and language disorders in a school-based setting. The term "developmental" refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social or language milestones that is not caused by an underlying medical illness or condition.

- All Non-Conventional medicine services, (a) provided independently or together with conventional medicine, AND (b) all related testing, laboratory testing, services, supplies, procedures and supplements associated with this type of medicine, are excluded.

The following are not covered, even if they are prescribed or recommended by a PROVIDER. The exclusion headings used here are intended to group similar services, treatments, items, or supplies together. Actual exclusions appear underneath each heading.

Acupuncture services

- Acupuncture services are excluded except as described in Chapter 3. Excluded services include:
- Acupuncture in lieu of anesthesia
- Acupuncture when used as an anesthetic during a surgical procedure
- Adjunctive therapies, such as, but not limited to: moxibustion, herbs, oriental massage, etc.
- Precious metal needles (e.g., gold, silver, etc.)
- Any other service not specifically listed as a COVERED SERVICE.

Dental care

The following dental care services, treatments, and supplies are not covered unless (a) an exception is specifically stated in these exclusions or (b) such dental care services, treatments and supplies are described as a COVERED SERVICE in Chapter 3. These exclusions do not apply to the treatment of cleft lip or cleft palate for CHILDREN under the age of 18, as described under the "Cleft lip or cleft palate treatment and services for CHILDREN" benefit in Chapter 3.

- Alteration of teeth
- Care related to deciduous (baby) teeth
- Dental supplies
- Orthodontia, even when it is an adjunct to other surgical or medical procedures
- Periodontal treatment
- Preventive dental care, in Chapter 3
- Restorative services including, but not limited to, crowns, fillings, root canals and bondings
- Skeletal jaw surgery, except as provided under the "Oral health services" and “Surgery – Gender affirming procedures and related services” benefits in Chapter 3
- Splints and oral appliances (except for sleep apnea, as stated under "Durable Medical Equipment" in Chapter 3
- Surgical removal or extraction of teeth, except as provided under "Oral health services" in Chapter 3
- TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies

Durable Medical Equipment (DME), orthoses or prosthetic devices

DME, orthoses and prosthetic devices are not covered except as described in Chapter 3. Exclusions include, but are not limited to, the following items. Call Member Services for questions about coverage of a specific item.

- air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers;
- articles of special clothing, mattress and pillow covers, including hypo-allergenic versions;
- bath and toilet aids, including, but not limited to: tub seats/benches/stools, raised toilet seats, commodes, and rails;
- bed-related items, including bed trays, bed pans, bed rails, bed cradles, over-the-bed tables, and bed wedges;
- car seats;
- car/van modifications;
- certain wearable devices (e.g. smartwatches, bracelets, patches) used for physiological monitoring and fitness tracking (e.g. Fitbit);
- comfort or convenience devices;
- dentures;
- ear plugs;
- emergency response systems (e.g., LifeAlert);
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts, or stair climbers;
- exercise equipment and saunas;
- externally powered exoskeleton assistive devices and orthoses;
- foot orthotics, fittings, and arch supports. The only exception is for therapeutic/molded shoes and inserts to treat a severe diabetic foot disease or other systemic illness. A systemic illness is a disease that causes severe circulatory compromise in the legs or feet;
- heat and cold therapy devices, including, but not limited to: hot packs, cold packs and water pumps with or without compression wrap;
- heating pads, hot water bottles, paraffin bath units and cooling devices;
- hot tubs, jacuzzis, swimming pools, or whirlpools;
- manual home blood pressure monitor with cuff and stethoscope;
- mattresses except for mattresses used with a hospital bed and ordered by a Provider. Commercially available standard mattresses not used primarily to treat an illness or injury, even if used with a hospital bed, are not covered;
- Prefabricated oral appliances;
- wheelchair trays.

Experimental or Investigative

A drug, device or medical treatment or procedure (collectively, "treatment") that is Experimental or Investigative is not covered. If a treatment is Experimental or Investigative, we will not pay for any related treatments provided to the member for the purpose of furnishing the Experimental or Investigative treatment.

In accordance with requirements of Massachusetts and federal law, this exclusion does not apply to the following:

- long-term antibiotic treatment of chronic Lyme disease
- bone marrow transplants for breast cancer
- patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer or other life-threatening diseases or conditions
- off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS, if you have a Prescription Drug Benefit

Family planning or maternity care

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

Infertility services

Infertility services are not covered except as described in Chapter 3. Specifically, such services are excluded for MEMBERs who do not meet the definition of infertility provided under **Infertility services** in Chapter 3, except for COVERED SERVICES described under section (III.), Preimplantation Genetic Diagnosis (PGD) testing with IVF. Other exclusions include:

- Costs associated with donor recruitment and compensation
- Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an Authorized Reviewer, is provided at a Tufts Health Plan ART center, and the MEMBER is the sole recipient of the donor's eggs.
- Experimental infertility procedures
- Infertility services necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization.
- Long-term (more than 12 months) sperm or embryo cryopreservation unless the MEMBER is in active infertility treatment. We may approve short-term (less than 12 months) cryopreservation of sperm, oocytes, or embryos for certain medical conditions that may impact a MEMBER's future fertility.
- Reversal of voluntary sterilization
- The costs of surrogacy, which means all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile MEMBER. These costs include, but are not limited to: (1) use of donor egg and a gestational carrier; (2) costs for drugs necessary to achieve implantation in a surrogate, embryo transfer, and cryo-preservation and embryos; and (3) costs for maternity care if the surrogate is not a MEMBER.

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

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

Prescription drugs

Prescription drugs are covered as described in Chapter 3. We do not cover the following under this prescription drug benefit:

- Acne medications, unless MEDICALLY NECESSARY.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants), Depo-Provera or its generic equivalent (these are covered under your "Family Planning" benefit earlier in this Chapter).
- Compounded medications, unless: (1) the MEMBER is under the age of 18; (2) the active ingredients are listed on the formulary; and (3) one or more agents within the compound is FDA-approved and requires a prescription by law. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may also not be covered. For more information, call Member Services or check our website.
- Digital therapeutics and prescription digital therapeutics (PDTs), unless listed on the formulary;
- Drugs not listed on the formulary;
- Any drug products used exclusively for cosmetic purposes (e.g., Botox and Tretinoin);
- Drugs provided to you outside of an OUTPATIENT pharmacy. Certain drugs may be covered under your medical benefits;
- Drugs that have not been approved by the FDA for both safety and effectiveness. (This does not include off-label uses of FDA-approved drugs where use is recognized by established research documentation.);
- Drugs for asymptomatic onychomycosis, except for MEMBERs with diabetes, vascular compromise, or immune deficiency status.
- Drugs for the treatment of erectile dysfunction.
- Drugs classified as Schedule I controlled substances by the FDA (e.g., marijuana).
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above
- Drugs which are dispensed in an amount or dosage that exceeds our established quantity limitations.
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Homeopathic medications purchased with a prescription or over-the-counter.
- Immunization agents. These may be provided under "Immunizations and vaccinations" earlier in this chapter.
- Medications for the treatment of idiopathic short stature.
- Oral non-sedating antihistamines.
- Over-the-counter medications if not included on the list of covered drugs on our website.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check our website.
- Prescription medications when co-packaged with non-prescription products.
- Prescriptions filled at pharmacies other than TUFTS HEALTH PLAN designated pharmacies, except for EMERGENCY care.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescriptions written by Providers who do not participate in TUFTS HEALTH PLAN, except in cases of authorized referral or EMERGENCY care.
- Products that are FDA approved as devices, including therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Topical and oral fluorides for adults.
- Vitamins and dietary supplements, unless listed on the formulary.

Surgery

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

- Circumcisions performed in any setting other than a hospital, DAY SURGERY or a PROVDER's office;
- Cosmetic (to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under the "Surgery -- Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity and impairment" and “Surgery – Gender affirming procedures and related services” benefits in Chapter 3;
- Hair removal (for example, electrolysis, laser hair removal), except when MEDICALLY NECESSARY (1) to treat an underlying skin condition or (2) when determined to be MEDICALLY NECESSARY under the “Surgery -- Gender affirming procedures and related services” benefit described earlier in this chapter;
- Liposuction for cosmetic reasons, except as provided under the “Surgery – Gender affirming procedures and related services” benefit earlier in this chapter, or brachioplasty;
- Removal of tattoos;
- Rhinoplasty, except as provided under the "Surgery -- Reconstructive procedures, mastectomy surgeries, and surgeries to treat functional deformity and impairment" and “Surgery – Gender affirming procedures and related services” benefits" in Chapter 3;
- Treatment of spider veins; removal or destruction of skin tags.

Therapies

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

- Biofeedback, except for the treatment of urinary incontinence;
- Hypnotherapy;
- Massage therapies, cognitive rehabilitation programs and cognitive retraining programs, except as described under "Rehabilitative and Habilitative physical and occupational therapy services;"
- Neuromuscular stimulators and related supplies;
- Psychoanalysis;
- With respect to child-adolescent behavioral health intermediate care and OUTPATIENT services, TUFTS HEALTH PLAN will not pay for the following programs:
  - Programs in which the patient has a pre-defined duration of care without the ability to conduct concurrent determinations of continued medical necessity for an individual.
  - Programs that only provide meetings or activities that are not based on individualized treatment planning.
  - Programs that focus solely on improvement in interpersonal or other skills rather than services directed toward symptom reduction and functional recovery related to specific BEHAVIORAL HEALTH DISORDERS.

Transplants

Transplants are not covered except as described in Chapter 3.

Transportation

Transportation services are not covered except as described under "Ambulance services" in Chapter 3. Excluded transportation services include, but are not limited to, transportation by chair car, wheelchair van, or taxi.

Vision care

The following vision services, treatments, and supplies are not covered except as described under "Vision care services" and "Durable Medical Equipment" in Chapter 3:

- Eyeglasses (lenses or frames), contact lenses, or contact lens fittings;
- Refractive eye surgery (including radial keratotomy) for conditions that can be corrected by means other than surgery.

Other exclusions under the plan

- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products are not covered, except for the following:
  - Blood processing;
  - Blood administration;
  - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency) and von Willebrand disease. Prior approval is required for these services;
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders. Prior approval is required for these services;
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually provided and/or able to be validated);
- Custodial Care;
- Facility charges or related services if the procedure being performed is not a COVERED SERVICE, except as provided under "Oral health services" in Chapter 3;
- Hearing aids, except as described in Chapter 3;
- INPATIENT and OUTPATIENT weight-loss programs and clinics; relaxation therapies; services by a personal trainer; and exercise classes (diagnostic services related to any of these excluded programs or procedures are also excluded;
- Laboratory tests ordered by a MEMBER (online or through the mail), even if they are performed at a licensed laboratory;
- Travel expenses, including lodging related to receiving any covered service, except as listed in Chapter 3;
- Multi-purpose general electronic devices including, but not limited to, laptop computers, desktop computers, personal assistive devices (PDAs), tablets, and smartphones. All accessories for multi-purpose general electronic devices including USB devices and direct connect devices (e.g., speaker, microphone, cables, cameras, batteries, etc). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet, and all related accessories;
- Nutritional counseling, except as described under "Nutritional counseling" in Chapter 3;
- Private duty nursing (block or non-intermittent nursing;
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; casting or other support devices for the feet. Please note that this exclusion does not apply to routine foot care for MEMBERs diagnosed with diabetes or another systemic illness. A systemic illness is defined as a disease that causes severe circulatory compromise in the legs or feet. The exclusion also does not apply to therapeutic/molded shoes and inserts to treat severe diabetic foot disease or other systemic illness. Coverage applies when the need for therapeutic shoes and inserts has been certified by the treating doctor and:
  - 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.
- Service or therapy animals and related supplies;
- Snoring reduction devices and procedures, including, but not limited to: laser- assisted uvulopalatoplasty, somnoplasty, and snore guards;
- Wigs and scalp hair prostheses are not covered when provided for hair loss due to: male pattern baldness; female pattern baldness; or natural or premature aging.

Chapter 4 - When Coverage Ends

Reasons coverage ends

This coverage is guaranteed renewable to the extent required by federal law (45 C.F.R. 148.122), and may only non-renew or cancel coverage under the plan for the following reasons, when applicable: non-payment of premiums, fraud, market exit, movement outside of the SERVICE AREA, or cessation of bona fide association membership. Specifically, your coverage (including federal COBRA coverage and Massachusetts continuation coverage) ends when any of the following occurs:

- you lose eligibility because you:
  - enrolled under a GROUP CONTRACT and no longer meet your GROUP's or TUFTS HEALTH PLAN's eligibility rules; or
  - are a SUBSCRIBER or SPOUSE and no longer live, work or reside in the SERVICE AREA*; or
- you choose to drop coverage; or
- commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to any PROVIDER, any TUFTS HEALTH PLAN MEMBER, TUFTS HEALTH PLAN or any TUFTS HEALTH PLAN employee; or
- commit an act of misrepresentation or fraud; or
- your GROUP CONTRACT with TUFTS HEALTH PLAN ends. (For more information, see "Termination of a GROUP CONTRACT and Notice" later in this chapter.)

***Note:** CHILDREN are not required to live, work or reside in the SERVICE AREA. However, care outside of the SERVICE AREA is limited to EMERGENCY or URGENT CARE only.

Benefits after termination

TUFTS HEALTH PLAN will not pay for services you receive after your coverage ends even if:

- you were receiving INPATIENT or OUTPATIENT care when your coverage ended; or
- you had a medical condition (known or unknown), including pregnancy, that required medical care after your coverage 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 or TUFTS HEALTH PLAN′s eligibility rules.

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.

If you no longer live, work or reside in the SERVICE AREA
If you are a SUBSCRIBER or SPOUSE and you no longer live, work or reside in the SERVICE AREA, coverage ends as of the date you no longer live, work or reside there. CHILDREN are not required to live, work or reside in the SERVICE AREA. However, care outside of the SERVICE AREA is limited to EMERGENCY or URGENT CARE only.

Before you no longer live, work or reside in the SERVICE AREA, tell your GROUP or call a Member Services Representative to notify TUFTS HEALTH PLAN of the date you no longer live, work or reside there.

For more information about coverage available to you when you no longer live, work, or reside in the SERVICE AREA, contact a Member Services Representative.

You choose to drop coverage
Coverage ends if you decide you no longer want coverage and you meet any qualifying event your GROUP requires. To end your coverage, notify your GROUP at least 30 days before the date you want your coverage to end. You must pay PREMIUMS up through the day your coverage ends.

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

TUFTS HEALTH PLAN may terminate your coverage if you commit acts of physical or verbal abuse which:

- are unrelated to your physical or mental condition;
- pose a threat to any PROVIDER, any TUFTS HEALTH PLAN MEMBER, or TUFTS HEALTH PLAN or any TUFTS HEALTH PLAN employee.

Membership Termination for Misrepresentation or Fraud

Policy
TUFTS HEALTH PLAN may terminate your coverage 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 application;
- enrolling as a SPOUSE someone who is not your SPOUSE;
- receiving benefits for which you are not eligible;
- keeping for yourself payments made by TUFTS HEALTH PLAN that were intended to be used to pay a PROVIDER;
- abuse of the benefits under this plan, including the resale or transfer of supplies, medication, or equipment provided to you as COVERED SERVICES;
- allowing someone else to use your MEMBER ID; or
- submission of any false paperwork, forms, or claims information.

Date of termination
If TUFTS HEALTH PLAN terminates your coverage for misrepresentation or fraud, your coverage will end as of your EFFECTIVE DATE or a later date chosen by TUFTS HEALTH PLAN.

Payment of claims
TUFTS HEALTH PLAN will pay for all COVERED SERVICES you received between:

- your EFFECTIVE DATE; and
- your termination date, as chosen by TUFTS HEALTH PLAN. TUFTS HEALTH PLAN may retroactively terminate your coverage back to a date no earlier than your EFFECTIVE DATE.

TUFTS HEALTH PLAN will use any PREMIUM you paid for a period after your termination date to pay for any COVERED SERVICES you received after your termination date.

If the PREMIUM is not enough to pay for that care, TUFTS HEALTH PLAN, at its option, may:

- pay the PROVIDER for those services and ask you to pay TUFTS HEALTH PLAN back; or
- not pay for those services. In this case, you will have to pay the PROVIDER for the services.

If the PREMIUM is more than is needed to pay for COVERED SERVICES you received after your termination date, TUFTS HEALTH PLAN will refund the excess to your GROUP.

Termination of a GROUP CONTRACT and Notice

End of TUFTS HEALTH PLAN's and GROUP's relationship
If you enrolled under a GROUP CONTRACT, coverage will terminate if the relationship between your GROUP and TUFTS HEALTH PLAN ends for any reason, including:

- your GROUP's contract with TUFTS HEALTH PLAN terminates;
- your GROUP fails to pay PREMIUMS on time;
- TUFTS HEALTH PLAN stops operating; or
- your GROUP stops operating.

Notice of termination
If you enrolled through a GROUP, the GROUP CONTRACT will terminate if your GROUP fails to pay PREMIUMS on time. If this happens, TUFTS HEALTH PLAN will notify you of the termination in writing within 60 days after the EFFECTIVE DATE of termination. The notice will tell you that you can elect to continue your coverage under Temporary Continuation of Coverage (TCC) and coverage under an individual contract, as well as how to elect that coverage. If you elect Temporary Continuation of Coverage and pay the required PREMIUM, TCC coverage is available to you during the period between:

- the EFFECTIVE DATE of termination of your GROUP COVERAGE; and
- the date TUFTS HEALTH PLAN sends to you a written notice of termination.

The benefits available under Temporary Continuation of Coverage will be identical to those in your GROUP COVERAGE.

TUFTS HEALTH PLAN may terminate your coverage back to the date the GROUP CONTRACT terminated, if:

- TUFTS HEALTH PLAN sends you a written notice of termination;
- TUFTS HEALTH PLAN offers you the opportunity to elect Temporary Continuation of Coverage under an INDIVIDUAL CONTRACT; and
- you do not elect that coverage within the time period specified in the notice.

Upon termination of TCC, you may elect coverage under an INDIVIDUAL CONTRACT. For more information about this coverage, see "Coverage Under an INDIVIDUAL CONTRACT" at the end of Chapter 5.

If the GROUP CONTRACT terminates for any reason other than your GROUP's failure to pay PREMIUMS, TUFTS HEALTH PLAN will send a notice of termination to your GROUP with the effective date of termination. Your GROUP is responsible for notifying you of the termination. TUFTS HEALTH PLAN is not responsible if your GROUP does not notify you.

Transfer to Other Employer GROUP Health Plans

Conditions for transfer
You may transfer from TUFTS HEALTH PLAN to any other health plan offered by your GROUP only;

- during your GROUP's OPEN ENROLLMENT PERIOD;
- within 30 days after moving out of the SERVICE AREA; or
- as of the date your GROUP no longer offers TUFTS HEALTH PLAN.

Note: Both your GROUP and the other health plan must agree.

Chapter 5 - Continuation of GROUP CONTRACT Coverage

Federal Continuation Coverage (COBRA)

Rules for federal COBRA continuation

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible to continue coverage after GROUP COVERAGE ends if you were enrolled in TUFTS HEALTH PLAN through a GROUP which has 20 or more eligible employees and you experience a qualifying event which would cause you to lose coverage under your GROUP. For more information, please contact your GROUP.

Qualifying Events

A qualifying event is defined as:

- the SUBSCRIBER's death;
- termination of the SUBSCRIBER's employment for any reason other than gross misconduct;
- reduction in the SUBSCRIBER's work hours;
- the SUBSCRIBER's divorce or legal separation;
- the SUBSCRIBER's entitlement to Medicare; or
- the SUBSCRIBER's or SPOUSE's enrolled DEPENDENT ceases to be a DEPENDENT CHILD.

If a MEMBER experiences a qualifying event, he or she may be eligible to continue GROUP COVERAGE as a SUBSCRIBER or an enrolled DEPENDENT under federal COBRA law as described below.

When federal COBRA coverage is effective

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

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

Cost of Coverage

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

Federal Continuation Coverage (COBRA), continued

Duration of Coverage

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

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

When coverage ends

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

- Coverage costs are not paid on a timely basis.
- Your GROUP ceases to maintain any GROUP health plan.
- After the COBRA election, the qualified beneficiary obtains coverage with another 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.

Massachusetts Continuation Coverage

How to qualify for coverage

A MEMBER's GROUP COVERAGE under the GROUP CONTRACT may end because he or she experiences a qualifying event.

A qualifying event is defined as:

- the SUBSCRIBER's death;
- termination of the SUBSCRIBER's employment for any reason other than gross misconduct;
- reduction in the SUBSCRIBER's work hours;
- the SUBSCRIBER's divorce or legal separation;
- the SUBSCRIBER's entitlement to Medicare; or
- the SUBSCRIBER's or SPOUSE's enrolled DEPENDENT ceases to be a DEPENDENT CHILD.

If a MEMBER experiences a qualifying event, he or she may be eligible to continue GROUP COVERAGE as a SUBSCRIBER or an enrolled DEPENDENT under Massachusetts continuation coverage as described below.

Note: Same-sex marriages legally entered into in Massachusetts are recognized under Massachusetts law. Therefore, Massachusetts continuation does apply to same-sex SPOUSES. Contact your employer for more information.

When coverage begins

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

When coverage ends

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

Payment of PREMIUM

In most cases, you are responsible for payment of 102% of the GROUP PREMIUM for Massachusetts continuation coverage.

Rules for Massachusetts continuation

Under a Massachusetts law similar to COBRA, you may be eligible to continue coverage after GROUP COVERAGE ends if:

- you were enrolled in TUFTS HEALTH PLAN through a Massachusetts GROUP which has 2 - 19 eligible employees;
- you experience a qualifying event which would cause you to lose coverage under your GROUP;
- and you elect this continuation coverage by following the procedure described below.

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

Coverage under an INDIVIDUAL CONTRACT

When your coverage under federal COBRA continuation or Massachusetts continuation ends, you and your enrolled DEPENDENTS may be eligible to apply for coverage under an INDIVIDUAL CONTRACT. See "Coverage under an INDIVIDUAL CONTRACT" at the end of this chapter for more information.

Plant Closing

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

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

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

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

For more information, please contact your GROUP or the PLAN ADMINISTRATOR.

Coverage under an INDIVIDUAL CONTRACT

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

Chapter 6 - MEMBER Satisfaction

MEMBER Satisfaction Process

TUFTS HEALTH PLAN has a multi-level MEMBER Satisfaction Process including:

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

All calls should be directed to Our Member Services Department at **800-462-0224**. To submit your appeal or grievance in writing, send your letter to the P.O. Box address below. Or you may fax it to us at 617-972-9509. You may also submit your appeal or grievance electronically, along with any related information, via the secure online member portal at **mytuftshealthplan.com**.

Tufts Health Plan
Attn: Appeals and Grievances Department
P.O. Box 474
Canton, MA 02021

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

Tufts Health Plan
1 Wellness Way
Canton, MA 02021

Internal Inquiry
Call a TUFTS HEALTH PLAN Member Representative to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be explained or resolved within three (3) business days or if you tell a Member Representative that you are not satisfied with the response you have received from 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.

TUFTS HEALTH PLAN maintains records of each inquiry made by a MEMBER or by that MEMBER's authorized representative. The records of these inquiries and the response provided by TUFTS HEALTH PLAN are subject to inspection by the Commissioner of Insurance and the Health Policy Commission.

MEMBER Grievance Process
A grievance is a formal complaint about actions taken by TUFTS HEALTH PLAN or a TUFTS HEALTH PLAN 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 verbally, in writing, or through the secure online member portal. If you choose to file a grievance verbally, please call a TUFTS HEALTH PLAN Member Representative, who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your grievance in writing and fax it to us at 617-972-9509 or send it to the P.O. Box address provided at the beginning of this section. You may also submit your grievance electronically, along with any related information, via the secure online member portal. 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 TUFTS HEALTH PLAN PROVIDER names); and
- any supporting documentation.

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

Administrative Grievances
An administrative grievance is a complaint about a TUFTS HEALTH PLAN employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline
- If you file your grievance verbally or in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your grievance.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify TUFTS HEALTH PLAN that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your PROVIDERS to release medical information relevant to your grievance to TUFTS HEALTH PLAN. You must sign and return the form before TUFTS HEALTH PLAN can begin the review process. If you do not sign and return the form to TUFTS HEALTH PLAN within thirty (30) calendar days of the date you filed, TUFTS HEALTH PLAN may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance that are in the possession and control of TUFTS HEALTH PLAN.
- TUFTS HEALTH PLAN will review your grievance and will send you a letter regarding the outcome via certified or registered mail, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and TUFTS 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 verbally or in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your grievance.

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

Internal MEMBER Appeals

An appeal is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied based on medical necessity (an adverse determination) or a denial of coverage for a specifically excluded service or supply. The TUFTS HEALTH PLAN Appeals and Grievances Department will review all of the information submitted upon appeal, taking into consideration your benefits as detailed in this EVIDENCE OF COVERAGE.

It is important that you contact TUFTS HEALTH PLAN as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal. Appeals may be filed verbally, in writing, or through the secure online member portal at **mytuftshealthplan.com**. If you would like to file a verbal appeal, call a TUFTS HEALTH PLAN Member Services Representative who will document your concern and forward it to an Appeals and Grievances Specialist in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your appeal in writing and fax it to us at 617-972-9509 or send it to the P.O. Box address provided at the beginning of this section. You may also submit your appeal electronically, along with any related information, via the secure online member portal.

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.

Appeals Timeline

- If you file your appeal verbally or in writing, we will notify you in writing, within fifteen (15) days after receiving your written or verbal appeal, that your appeal has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Specialist coordinating the review of your appeal and our understanding of your concerns.
- If your request for review was first addressed through the Internal Inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify TUFTS HEALTH PLAN that you are not satisfied with the response you received during the Internal Inquiry process.
- TUFTS HEALTH PLAN will review your appeal, make a decision, and send you a decision letter via certified or registered mail within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and TUFTS HEALTH PLAN.

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

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

Office of Patient Protection

50 Milk Street, 8th Floor

Boston, MA 02109

(800) 436-7757

http://www.mass.gov/hpc/opp

When Medical Records are Necessary

If your appeal requires the review of medical records, you will receive a form that you will need to sign that authorizes your PROVIDERS to release to TUFTS HEALTH PLAN medical information relevant to your appeal. You must sign and return the form before TUFTS HEALTH PLAN can begin the review process. If you do not sign and return the form to TUFTS HEALTH PLAN within thirty (30) calendar days of the date you filed your appeal, TUFTS HEALTH PLAN may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal that are in the possession and control of TUFTS HEALTH PLAN

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

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

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

Expedited Appeals
We recognize that there are circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. We will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending PROVIDER should contact the Member Services Department. Under these circumstances, we will make a decision within seventy-two (72) hours after the review is initiated. If you have a terminal illness, we will make a decision within five (5) business days of receiving your appeal. If your treating PROVIDER (the practitioner responsible for the treatment or proposed treatment) certifies that the service being requested is MEDICALLY NECESSARY; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal appeal process, we will reverse the decision within forty-eight (48) hours after the review is initiated pending the outcome of the expedited appeal decision. If you are appealing coverage for DURABLE MEDICAL EQUIPMENT (DME) that we determined was not MEDICALLY NECESSARY, we will make a decision within less than forty-eight (48) hours of the receipt of certification. If you are an INPATIENT in a hospital, we will make a decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at our expense through the completion of the Internal Appeals Process. Only those services which were originally authorized by TUFTS HEALTH PLAN and which were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

We will notify you of our decision in writing via certified or registered mail within two (2) business days of the decision. If our decision is to deny coverage, you may request a conference. We will schedule the conference within 10 days (or within 5 business days if your physician determines, after talking with a TUFTS HEALTH PLAN Medical Affairs Department Physician or Psychological Testing Reviewer, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date). You may bring another person with you to the conference. At the conference, you and/or your authorized representative, if any, and a representative of TUFTS HEALTH PLAN who has authority to determine the disposition of the appeal, shall review the information provided.

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

If You are Not Satisfied with the Appeals Decision

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

External Review by the Office of Patient Protection
The Massachusetts Office of Patient Protection, which is not connected in any way with TUFTS HEALTH PLAN, administers an independent external review process for final coverage determinations based on medical necessity (final adverse determination). Appeals for coverage of services specifically excluded in your EVIDENCE OF COVERAGE and payment disputes are not eligible for external review.

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

To request an external review by the Office of Patient Protection, you must file your request in writing with the Office of Patient Protection within four (4) months of your receipt of written notice of the denial of your appeal by TUFTS HEALTH PLAN. The letter from TUFTS HEALTH PLAN notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection.

You, or your authorized representative, may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a PROVIDER, that delay in providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review. The review panel will make a decision within forty-five (45) calendar days for standard reviews and within seventy-two (72) hours for expedited reviews.

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

You or your authorized representative will have access to any medical information and records relating to your appeal in the possession of the TUFTS HEALTH PLAN or under its control.

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

External Review by the Office of Patient Protection, continued

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

- include an acknowledgement of the decision of the review agency;
- advise you of any additional procedures that you need to take in order to obtain the requested coverage or services;
- advise you of the date by which the payment will be made or the authorization for services will be issued by TUFTS HEALTH PLAN; and
- include the name and phone number of the person at TUFTS HEALTH PLAN who will assist you with final resolution of the appeal.

Please note: if you are not satisfied with TUFTS HEALTH PLAN's Member Satisfaction Process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care at 617-521-7372 or the Health Policy Commission's Office of Patient Protection at:

Health Policy Commission

Office of Patient Protection

50 Milk St., 8th Floor

Boston, MA 02109

Phone: 1-800-436-7757

Fax: 1-617-624-5046

Email: HPC-OPP@state.ma.us

Internet: www.mass.gov/hpc/opp

Bills from PROVIDERS

Occasionally, you may receive a bill from a 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 website 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 bill(s) 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. Reimbursements will be sent to the Subscriber at the address TUFTS HEALTH PLAN has on file.

If you receive COVERED SERVICES from a non-TUFTS HEALTH PLAN PROVIDER, we will pay up to the REASONABLE CHARGE for the services.

IMPORTANT NOTE:

Certain services you receive from non-TUFTS HEALTH PLAN PROVIDERS within our SERVICE AREA may be reimbursable. Some examples of these types of non-TUFTS HEALTH PLAN PROVIDERS include:

- radiologists, pathologists, and anesthesiologists who work in TUFTS HEALTH PLAN Hospitals; and
- EMERGENCY room specialists.

You may receive a bill from a PROVIDER who is not a TUFTS HEALTH PLAN PROVIDER. If this happens, please follow the member reimbursement process described above.

We reserve the right to be reimbursed by the MEMBER for payments made due to TUFTS HEALTH PLAN's error.

Pharmacy Expenses

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

Limitation on Actions

Limitation on Actions

You cannot file a lawsuit against TUFTS HEALTH PLAN for failing to pay or arrange for 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 our MEMBER Satisfaction Process, and then file your lawsuit within two years after the date you were first sent a notice of the denial. Going through our MEMBER Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage. However, if you choose to pursue external review by the Office of Patient Protection, the days from the date your request is received by the Office of Patient Protection until the date you receive the response are not counted toward the two-year limit.

Subrogation

The provisions of this section apply to all current and former plan participants. The provisions also apply to the parents, guardians, or other representatives of a DEPENDENT CHILD who incurs claims and is or has been covered by TUFTS HEALTH PLAN. TUFTS HEALTH PLAN's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative or administrator of your estate, your decedents, your heirs, your descendants, your beneficiaries, minors, and incompetent or disabled persons. These provisions will apply to all claims arising from your illness or injury. These claims include, but are 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 TUFTS HEALTH PLAN pays benefits. No adult SUBSCRIBER hereunder may assign any rights that the plan 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 TUFTS HEALTH PLAN.

TUFTS HEALTH PLAN's right of subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else (a "Third Party"). "Third Party" means any person or company that is, could be, or is claimed to be, responsible for the costs of injuries or illness to you. This includes such costs to any DEPENDENT covered under this plan.

TUFTS HEALTH PLAN may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or rewards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- no-fault, personal injury protection ("PIP"), or medical payments coverage ("MedPay") under any automobile policy to the extent permissible by law;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you for Third Party injuries.

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

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

TUFTS HEALTH PLAN's right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

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

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

MEMBER cooperation

You further agree:

- to notify TUFTS HEALTH PLAN promptly and in writing when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a claim to recover damages or obtain compensation;
- that 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;
- to cooperate with us and provide us with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this plan;
- to assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of health care services and supplies, and expenses, that we paid or will pay for your illness or injury;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any Third Party. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan;
- to serve as a constructive trustee for the benefit of this plan over any settlement or recovery funds received as a result of Third Party responsibility;
- that we may recover the full cost of all benefits provided by this plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from our recovery;
- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party; and
- that in the event you or your representative fails to cooperate with TUFTS HEALTH PLAN, you shall be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by TUFTS HEALTH PLAN in obtaining repayment.

Workers' compensation

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

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. TUFTS HEALTH 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 TUFTS HEALTH PLAN pays for the costs of health care services or medications for any work-related illness or injury, TUFTS HEALTH 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 TUFTS HEALTH PLAN for any work-related illness or injury, please contact the TUFTS HEALTH PLAN Liability and Recovery Department at 1-888-880-8699, x. 21098.

Constructive Trust

By accepting benefits from TUFTS HEALTH PLAN(whether the payment of such benefits is made to you directly or made on your behalf, for example, to a PROVIDER), you hereby agree that if you receive any payment from any responsible party as a result of an injury, illness, or condition, you will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to TUFTS HEALTH PLAN.

Subrogation Agent

TUFTS HEALTH PLAN may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as TUFTS HEALTH PLAN's agent.

Coordination of Benefits

Benefits under other plans

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

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

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

Primary and secondary plans

TUFTS HEALTH PLAN will coordinate benefits by determining which plan has to pay first when you make a claim and which plan has to pay second. TUFTS HEALTH PLAN will make these determinations according to applicable state law.

We determine the order of benefits using the first applicable rule set forth in 211 CMR 38.05 and pay or provide benefits pursuant to the rules set forth in 211 CMR 38.04 and 211 CMR 38.06. These regulations are available on the Massachusetts state website, **www.mass.gov/code-of-massachusetts-regulations-cmr**.

Right to receive and release necessary information

When you enroll, you must include information on your membership application about other health coverage you have. After you enroll, you must notify us of new coverage, or termination of other coverage, or if you are enrolled in any high DEDUCTIBLE health plan with a health savings account (HSA). We may ask for and give out information needed to coordinate benefits. You agree to provide information about other coverage and cooperate with TUFTS HEALTH PLAN's COB program.

Right to recover overpayment

TUFTS HEALTH PLAN may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. TUFTS HEALTH PLAN will recover only overpayments 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 Representative 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.

TUFTS HEALTH PLAN will pay benefits **before** Medicare:

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

TUFTS HEALTH PLAN will pay benefits **after** Medicare (including if you are eligible but not enrolled):

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

Note: In any of the circumstances described above, you will receive benefits for COVERED SERVICES that Medicare does not cover. If you are eligible for Medicare but do not have it because you failed to apply for it or you dropped it, the Plan will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The Plan will not pay any amounts that would have been paid by Medicare if you had properly applied for it. This applies to both Parts A and B of Medicare.

Use and Disclosure of Medical Information

The “Notice of Privacy Practices” explains how TUFTS HEALTH PLAN uses and discloses your medical information. If you have questions or would like a paper copy of our “Notice of Privacy Practices”, please call a Member Services Representative. You can also obtain a copy from our website.

Relationships between TUFTS HEALTH PLAN and PROVIDERS

TUFTS HEALTH PLAN arranges health care services. TUFTS HEALTH PLAN does not provide health care services. TUFTS HEALTH PLAN has agreements with PROVIDERS practicing in their private offices throughout the SERVICE AREA. These PROVIDERS are independent. They are not TUFTS HEALTH PLAN employees, agents or representatives. PROVIDERS are not authorized to:

- change this EVIDENCE OF COVERAGE;
- or assume or create any obligation for TUFTS HEALTH PLAN.

TUFTS HEALTH PLAN is not liable for acts, omissions, representations or other conduct of any PROVIDER.

Circumstances Beyond TUFTS HEALTH PLAN’s Reasonable Control

TUFTS HEALTH PLAN shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of TUFTS HEALTH PLAN. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, 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 TUFTS HEALTH PLAN PROVIDERS.

GROUP CONTRACT

Acceptance of the terms of the GROUP CONTRACT

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

Payments for coverage

TUFTS HEALTH PLAN will bill your GROUP and your GROUP will pay PREMIUMS to TUFTS HEALTH PLAN for you. TUFTS HEALTH PLAN is not responsible if your GROUP fails to pay the PREMIUM. This is true even if your GROUP has charged you (for example, by payroll deduction) for all or part of the PREMIUM.

Note: If your GROUP fails to pay the PREMIUM on time, TUFTS HEALTH PLAN may cancel your coverage in accordance with the GROUP CONTRACT and applicable state law. For more information on the notice to be provided, see "Termination of the GROUP CONTRACT and Notice" in Chapter 4.

TUFTS HEALTH PLAN may change the PREMIUM. If the PREMIUM is changed, the change will apply to all MEMBERS in your GROUP.

Changes to this EVIDENCE OF COVERAGE

TUFTS HEALTH PLAN may change this EVIDENCE OF COVERAGE. Changes do not require your consent. Notice of changes in COVERED SERVICES will be sent to your GROUP at least 60 days before the effective date of the modifications and will include information regarding any changes in clinical review criteria and detail the effect of such changes on a MEMBER's personal liability for the cost of such charges.

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

Exception: A change will not apply to you if you are an INPATIENT on the effective date of the change until your discharge date.

Note: If changes are made, they will apply to all MEMBERS in your GROUP, not just to you.

Notice

Notice to MEMBERS: When 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

P.O. Box 308

Canton, MA 02021

Enforcement of terms

TUFTS HEALTH PLAN may choose to waive certain terms of the GROUP CONTRACT, if applicable, including the EVIDENCE OF COVERAGE. This does not mean that TUFTS HEALTH PLAN gives up its rights to enforce those terms in the future.

When this EVIDENCE OF COVERAGE Is Issued and Effective

This EVIDENCE OF COVERAGE is issued and effective on your GROUP ANNIVERSARY DATE on or after January 1, 2024 and supersedes all previous EVIDENCES OF COVERAGE.

Appendix A - Glossary of Terms and Definitions

This section defines the terms used in this EVIDENCE OF COVERAGE.

ADOPTIVE CHILD
A CHILD is an ADOPTIVE CHILD as of the date he or she:

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

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

ALLOWED COST or ALLOWED AMOUNT

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

ANNIVERSARY DATE
The date upon which the GROUP CONTRACT first renews and each successive annual renewal date.

ANNUAL COVERAGE LIMITATIONS
Annual dollar or time limitations on COVERED SERVICES.

APPLIED BEHAVIORAL ANALYSIS (ABA)

The design, implementation, and evaluation of environmental modification, 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 the environment and behavior.

AUTHORIZED REVIEW
AUTHORIZED REVIEW refers to prospective, concurrent, and retrospective reviews of health care services for MEDICAL NECESSITY and is performed by an AUTHORIZED REVIEWER.

AUTHORIZED REVIEWER
An individual who reviews and approves certain services and supplies to MEMBERS. He or she is the TUFTS HEALTH PLAN*'s* Chief Medical Officer (or equivalent) or someone that person names.

BEHAVIORAL HEALTH DISORDERS

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

BEHAVIORAL HEALTH ACUTE TREATMENT

24-hour medically supervised behavioral health treatment for adults or adolescents provided in a medically managed or medically monitored INPATIENT facility, as defined by the Massachusetts Department of Public Health. Behavioral Health Acute Treatment services include, but are not limited to: evaluation, management, treatment, and discharge planning.

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

CHILD
The following individuals until the last day of the month in which the CHILD's 26th birthday occurs:

- the SUBSCRIBER's or SPOUSE's natural CHILD, stepchild, or ADOPTIVE CHILD; or
- the CHILD of an enrolled CHILD;
- any other CHILD for whom the SUBSCRIBER has legal guardianship; or
- any other CHILD who meets the IRS Code definition of a DEPENDENT of the SUBSCRIBER or the SPOUSE.

COINSURANCE
The percentage of costs you must pay for certain COVERED SERVICES.

- For services provided by a non-TUFTS HEALTH PLAN PROVIDER, your share is a percentage of the REASONABLE CHARGE for those services. Please note that costs in excess of the REASONABLE CHARGE are not subject to COINSURANCE. The MEMBER may be responsible for any charges in excess of the REASONABLE CHARGE.
- For services provided by a TUFTS HEALTH PLAN PROVIDER, your share is a percentage of:
  - the applicable TUFTS HEALTH PLAN fee schedule amount for those services; or
  - the TUFTS HEALTH PLAN PROVIDER's actual charges for those services,

  whichever is less.

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 calculated on an individual claim basis.

COMMUNITY HOSPITAL
Any TUFTS HEALTH PLAN HOSPITAL other than a TERTIARY HOSPITAL.

CONTRACT YEAR
The 12-month period in which benefit limits, DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, and COINSURANCE are calculated under this plan. A CONTRACT YEAR can be either a calendar year or a plan year.

- Calendar year: Coverage based on a calendar year runs from January 1st through December 31st within a year.
- Plan year: Coverage based on a plan year runs during a period of 12 consecutive months that are not a calendar year (for example, July 1st in one calendar year through June 30th in the following calendar year).

Note: For a GROUP CONTRACT, the CONTRACT YEAR is determined by the GROUP.

COPAYMENT
The cost you pay for certain COVERED SERVICES. COPAYMENTS are paid to the PROVIDER when you receive care unless the PROVIDER arranges otherwise. COPAYMENTS are included in the OUT-OF-POCKET MAXIMUM. See "Benefit Overview" at the front of this EVIDENCE OF COVERAGE for more information.

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 TUFTS HEALTH PLAN will pay. They must be:

- described in Chapter 3 (subject to the “Exclusions from Benefits” section in Chapter 3);
- MEDICALLY NECESSARY; and
- provided or authorized by your PCP and in some cases, approved by an AUTHORIZED REVIEWER.

These services include MEDICALLY NECESSARY coverage of pediatric specialty care, including behavioral health care, by PROVIDERs with recognized expertise in specialty pediatrics.

Note: COVERED SERVICES do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any PROVIDER, MEMBER, service, supply, or medication.

COVERING PROVIDER
The PROVIDER named by your PCP to provide or authorize services in your PCP's absence.

CUSTODIAL CARE

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

Note: CUSTODIAL CARE is not covered by TUFTS HEALTH PLAN.

DAY SURGERY
Any surgical procedure(s) provided to a MEMBER at a facility licensed by the state to perform surgery, and with an expected departure the same day, or in some instances, within 24 hours. Also referred to as "Ambulatory Surgery" or "Surgical Day Care".

DEPENDENT
The SUBSCRIBER′s SPOUSE, CHILD, or DISABLED DEPENDENT.

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

DIRECTORY OF HEALTH CARE PROVIDERS
A searchable list of TUFTS HEALTH PLAN PCPs and their affiliated TUFTS HEALTH PLAN HOSPITAL and certain other TUFTS HEALTH PLAN PROVIDERS.

Note: This list is updated from time to time to show changes in PROVIDERS affiliated with TUFTS HEALTH PLAN . For information about the PROVIDERS listed in the DIRECTORY OF HEALTH CARE PROVIDERS, you can call Member Services or check our website.

DISABLED DEPENDENT
The SUBSCRIBER's CHILD who:

- is currently permanently physically or mentally disabled and remains financially dependent on the SUBSCRIBER; and
- lives with the SUBSCRIBER or SPOUSE, in a licensed institution, or group home.

DURABLE MEDICAL EQUIPMENT
Devices or instruments of a durable nature that:

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

EFFECTIVE DATE
The date, according to TUFTS HEALTH PLAN's records, when you become a MEMBER and are first eligible for COVERED SERVICES.

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

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

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

EVIDENCE OF COVERAGE
This document and any future amendments.

EXPERIMENTAL OR INVESTIGATIVE
A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered EXPERIMENTAL OR INVESTIGATIVE and therefore, not MEDICALLY NECESSARY, if any of the following apply:

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

This definition is fully explained in the corresponding MEDICAL NECESSITY Guidelines.

FAMILY COVERAGE
Coverage for a SUBSCRIBER and his or her DEPENDENTS.

FREE-STANDING AMBULATORY SURGERY CENTER OR IMAGING CENTER
A free-standing facility such as a free-standing ambulatory surgery center or imaging center is a facility not affiliated with a hospital or a hospital system.

FREE-STANDING URGENT CARE CENTER
A medical facility that provides treatment for URGENT CARE services (see definition of URGENT CARE). A FREE-STANDING URGENT CARE CENTER primarily treats patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. A Free-standing URGENT CARE CENTER offers an alternative to certain emergency room visits for a MEMBER who is not able to visit his or her PRIMARY CARE PROVIDER or health care PROVIDER in the time frame that is felt to be warranted by their condition or symptoms. A REE-STANDING URGENT CARE CENTER does not provide EMERGENCY care, and is not appropriate for people who have life-threatening conditions. MEMBERS experiencing these conditions should go to an emergency room. FREE-STANDING URGENT CARE CENTERS are not part of a hospital or hospital system and are not LIMITED SERVICES MEDICAL CLININCS. To find a FREE-STANDING URGENT CARE CENTER in our network, please visit the website at **www.tuftshealthplan.com**, and click on "Find a Doctor", or call Member Services.

GROUP
An employer or other legal entity with which TUFTS HEALTH PLAN has an agreement to provide group coverage. An employer GROUP subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. If you are covered under a GROUP CONTRACT, 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 GROUP COVERAGE; and
- the GROUP agrees to pay a PREMIUM to TUFTS HEALTH PLAN on your behalf.

The GROUP CONTRACT includes this EVIDENCE OF COVERAGE and any amendments.

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

INDIVIDUAL CONTRACT
Coverage for a SUBSCRIBER only (no DEPENDENTS).

INPATIENT
A patient who is:

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

INPATIENT NOTIFICATION (formerly known as "Preregistration")
TUFTS HEALTH PLAN's process of validating all information required for all INPATIENT admissions and transfers. INPATIENT NOTIFICATION s not a guarantee of payment. See Chapter 1 for more information.

LICENSED BEHAVIORAL HEALTH PROFESSIONAL

A Licensed Behavioral Health Professional is any one of the following: a licensed psychiatrist; a licensed psychologist; a licensed independent clinical social worker; a licensed certified social worker; a licensed behavioral health counselor; a licensed supervised behavioral health counselor; a licensed psychiatric nurse behavioral health clinical specialist; a licensed psychiatric behavioral health nurse practitioner; a licensed physician assistant who practices in the area of psychiatry; a level I licensed alcohol and drug counselor; a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111; or a licensed marriage and family therapist.

LIMITED SERVICE MEDICAL CLINIC

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

MEDICALLY NECESSARY
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.

MEDICAL NECESSITY Guidelines are used to determine coverage of MEDICALLY NECESSARY services. These Guidelines are:

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

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

MEMBER
A person enrolled in TUFTS HEALTH PLAN under the GROUP CONTRACT. Also referred to as "you."

NON-CONVENTIONAL MEDICINE
A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the definition of MEDICAL NECESSITY and are not covered. PROVIDERS of these non-covered services may be contracting or non-contracting traditional medical providers. These services may be offered in connection with a traditional office visit. PROVIDERS of NON-CONVENTIONAL MEDICINE services often request payment up front because health insurance typically does not cover these services.

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

- holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields);
- manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi);
- mind-body medicine (e.g., hypnotherapy, medication, 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-TUFTS HEALTH PLAN PROVIDER
A PROVIDER that does not have an agreement with Us (either directly or with a provider network with whom We have a contract) to provide COVERED SERVICES to MEMBERS .

OBSERVATION
The use of hospital service 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
The period each year when TUFTS HEALTH PLAN and the GROUP allow eligible persons to apply for GROUP COVERAGE in accordance with the GROUP CONTRACT.

OUT-OF-POCKET MAXIMUM
The maximum amount of money paid by a MEMBER during a CALENDAR YEAR for certain COVERED SERVICES. The OUT-OF-POCKET MAXIMUM consists of COPAYMENTS and COINSURANCE.

It does not include:
- any amount paid for services, supplies, and medication that are not COVERED SERVICES under this plan.
- costs in excess of the REASONABLE CHARGE; or
- the PREMIUM you pay for this plan.

See “Benefit Overview” at the front of this EVIDENCE OF COVERAGE for detailed information about your OUT-OF-POCKET MAXIMUM.

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

- a PROVIDER′s office;
- a DAY SURGERY or ambulatory care unit; and
- an emergency room or OUTPATIENT clinic.

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

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).

PREMIUM
The total monthly cost of INDIVIDUAL or FAMILY COVERAGE which the GROUP pays to TUFTS HEALTH PLAN.

PRIMARY CARE PROVIDER
The TUFTS HEALTH PLAN physician, physician assistant, or nurse practitioner you have chosen from the DIRECTORY OF HEALTH CARE PROVIDERS and who has an agreement with us to provide primary care and to coordinate, arrange, and authorize the provision of COVERED SERVICES.

PROVIDER
A health care professional or facility licensed or certified in accordance with applicable law, including, but not limited to, hospitals, limited service medical clinics (if available), FREE-STANDING URGENT CARE CENTERS, physicians, physician assistants doctors of osteopathy, nurse midwives, registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, mental health counselors, independent clinical social workers, psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, alcohol and drug counselor, marriage and family therapists, speech-language pathologists, pharmacists; and audiologists.

TUFTS HEALTH 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 or certification, as applicable.

Notes:

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

PROVIDER ORGANIZATION
A PROVIDER ORGANIZATION is comprised of doctors and other health care PROVIDERS who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care. Also referred to as "PROVIDER GROUP".

REASONABLE CHARGE
The lesser of:

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

Note: Any amount the MEMBER pays in excess of the REASONABLE CHARGE is not included in the DEDUCTIBLE, COINSURANCE or OUT-OF-POCKET MAXIMUM.

ROUTINE NURSERY CARE
Routine hospital care provided to a well newborn CHILD immediately following birth until discharge from the hospital.

SERVICE AREA
The SERVICE AREA is the geographic area within which we have developed a network of PROVIDERS to afford MEMBERS with adequate access to COVERED SERVICES. The SERVICE AREA consists of the Standard Service Area and the Extended Service Area.

The Standard Service Area is comprised of all of Massachusetts, New Hampshire and Rhode Island.

The Extended Service Area includes certain towns in Connecticut, Maine, New York, and Vermont which:

- surround the Standard Service Area; and
- are within a reasonable distance from TUFTS HEALTH PLAN PCPs and specialists who provide the most-often used services, such as behavioral health practitioners and physicians who are surgeons or OB/GYNs.

Notes:

- There are generally no TUFTS HEALTH PLAN PCPs located within the Extended Service Area.
- For information about PROVIDERS in the Service Area, you can call the Member Services Department or check our website at **www.tuftshealthplan.com.**
- Certain services may be available outside of the SERVICE AREA through the TUFTS HEALTH PLAN telemedicine vendor. For more information, please visit **https://tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth**.

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

SPOUSE
The SUBSCRIBER's legal SPOUSE, according to the law of the state in which you reside, or divorced SPOUSE as required by Massachusetts law.

SUBSCRIBER
The person who:

- is an employee of the GROUP;
- who enrolls in TUFTS HEALTH PLAN and signs on behalf of himself or herself and any DEPENDENTS; and
- in whose name the PREMIUM is paid in accordance with a GROUP CONTRACT.

TERTIARY HOSPITAL
Each of the following hospitals:

- Beth Israel Deaconess Medical Center (Boston, MA);
- Boston Children's Hospital (Boston, MA);
- Boston Medical Center (Boston, MA);
- Brigham & Women's Hospital (Boston, MA);
- Concord Hospital (Concord, NH);
- Dana-Farber Cancer Institute (Boston, MA);
- Maine Medical Center (Portland, ME);
- Mary Hitchcock Memorial Hospital (Hanover, NH);
- Massachusetts Eye & Ear Infirmary (Boston, MA);
- Massachusetts General Hospital (Boston, MA);
- Miriam Hospital (Providence, RI);
- New England Baptist Hospital (Boston, MA);
- Newport Hospital (Newport, RI);
- Rhode Island Hospital, including Hasbro Children's Hospital (Providence, RI);
- Roger Williams Medical Center (Providence, RI);
- Southern New Hampshire Medical Center (Nashua, NH);
- Tufts Medical Center (Boston, MA);
- UMass Memorial Medical Center (Worcester, MA).

TUFTS HEALTH PLAN
Tufts Associated Health Maintenance Organization, Inc., a Massachusetts corporation d/b/a TUFTS HEALTH PLAN. TUFTS HEALTH PLAN is licensed by Massachusetts as a health maintenance organization (HMO). Also referred to as "we", "us" and "our".

TUFTS HEALTH PLAN HOSPITAL
A Community or Tertiary Hospital HOSPITAL which has an agreement with TUFTS HEALTH PLAN to provide certain COVERED SERVICES to MEMBERS. TUFTS HEALTH PLAN HOSPITALS are independent. They are not owned by TUFTS HEALTH PLAN. TUFTS HEALTH PLAN HOSPITALS are not TUFTS HEALTH PLAN's agents or representatives, and their staff are not TUFTS HEALTH PLAN's employees.

TUFTS HEALTH PLAN PROVIDER
A PROVIDER with which TUFTS HEALTH PLAN has an agreement to provide COVERED SERVICES to MEMBERS. PROVIDERS are not TUFTS HEALTH PLAN′s employees, agents or representatives.

URGENT CARE
Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which URGENT CARE might be needed are a broken or dislocated toe, 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.

Appendix B - ERISA Information and other State and Federal Notices

ERISA Rights

Note: Applies to Group Contracts only.

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

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

Receiving Information About Your Plan and Benefits
ERISA provides that all plan participants shall be entitled to:

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

Continuing Group Health Plan Coverage
ERISA provides that all plan participants shall be entitled to:

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

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

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

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

ERISA RIGHTS, continued

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

PROCESSING OF CLAIMS FOR PLAN BENEFITS

Note: Applies to Group Contracts only.

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

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

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

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

Urgent care claim: An "urgent care claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your provider's determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested. For urgent care claims, Tufts 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 decisions: A "concurrent care decision" is a determination relating to the continuation/reduction of an ongoing course of treatment to be provided over a period of time or number of treatments. If Tufts 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 hours prior to the expiration of the ongoing course of treatment). If you reach the end of a pre-approved course of treatment before requesting additional services, the "pre-service" or "post-service" time limits will apply.

PROCESSING OF CLAIMS FOR PLAN BENEFITS, continued

Types of claims, continued

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, we will respond to you within 30 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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

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

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

Note: Applies to Group Contracts only.

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

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

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

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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

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

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

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

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

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

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

PATIENT PROTECTION DISCLOSURE

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

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

You do not need prior authorization from Tufts Health Plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or see our website.

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

Under both Massachusetts laws and federal laws, benefits for behavioral health and substance use disorder services must be comparable to benefits for medical/surgical services. This means that Cost Sharing Amounts for behavioral health and substance use disorder services must be no greater than those for medical/surgical services. Also, Tufts Health Plan's authorization of behavioral health or substance use disorder services must be handled in a way that is comparable to and no more restrictive than the 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. Tufts Health Plan will send you or your provider a copy of the guidelines 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 Insurance Complaint Form. You may request the form by phone, by mail, or find it on the DOI's webpage at **www.mass.gov/ocabr/docs/doi/consumer/css-complaint-form.pdf**.

You may also submit a complaint by phone by calling 877-563-4467 or 617-521-7794. If you submit a complaint by phone, you must follow up in writing and include:

- your name and address;
- the nature of your complaint; and
- your signature authorizing the release of any information.

Filing a written complaint with the DOI is not the same as filing an appeal with Tufts Health Plan. You must also file an appeal with Tufts Health Plan in order to have a denial or reduction of coverage reviewed. This will protect your right to continued coverage of treatment while you wait for a decision. See Chapter 6 for more information.

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 (including pregnancy, sexual orientation, or gender identity).

Tufts Health Plan:

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

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way, you can file a grievance with:

Tufts Health Plan

Attention: Civil Rights Coordinator Legal Dept.

1 Wellness Way, Canton, MA 02021

Phone: 888.880.8699 ext. 48000, TTY number 800.439.2370 or 711

Fax: 617.972.9048

Email: OCRCoordinator@point32health.org.

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C. 20201

800.368.1019, 800.537.7697 (TDD)

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

tuftshealthplan.com | 800.462.0224

Appendix C – Schedule II and III Opioid Medications

Schedule II and Schedule III drugs are defined under Massachusetts law. Please see **http://www.mass.gov/** for those definitions.

Appendix C – Schedule II and III Opioid Medications

Effective January 1, 2024, the following opioid medications have been classified as Schedule II or Schedule III drugs. If you are prescribed any of these medications and wish to have a quantity less than what was prescribed, no additional cost or penalty will be imposed on you. If the MEMBER fills a lesser quantity of a Schedule II opioid drug, and then decides to fill the remainder at the same pharmacy within 30 days of the original prescription date, no additional cost will be applied. This list is subject to change throughout the year.

Schedule II medications

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

Schedule III medications

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

Appendix D -- COVID-19 Testing and Treatment

Your EOC has been amended as described below.

COVID-19 Testing

COVID-19 PCR and antigen testing is covered for when MEDICALLY NECESSARY. Coverage applies symptomatic individuals, individuals identified as close contacts and asymptomatic individuals under circumstances in accordance with Massachusetts law. COVID-19 testing intended for return to work, school, or other locations is not covered.

Antibody tests will be covered when MEDICALLY NECESSARY to support COVID-19 treatments. Testing is also covered for a MEMBER whose immune system is compromised and/or knowledge of antibodies may impact the outcome of treatment. Testing will not be covered when part of a “return to work” program.

MEDICALLY NECESSARY COVID-19 testing will be covered with no out-of-pocket costs*. COVID-19 testing does not require prior approval for coverage to apply.

COVID-19 Treatment

COVID-19-related treatment for all EMERGENCY INPATIENT, OUTPATIENT and cognitive rehabilitation services is covered when MEDICALLY NECESSARY. COVID-19-related treatment will be covered with no out-of-pocket costs*. MEMBER COST SHARING AMOUNTS may apply to COVERED SERVICES related to the treatment of reactions to COVID-19 vaccinations. MEMBERS are encouraged to see TUFTS HEALTH PLAN PROVIDER whenever possible. However, this policy is also applicable to treatment provided by NON-TUFTS HEALTH PLAN PROVIDERS**. COVID-19-related treatment does not require prior approval for coverage to apply.

COVID-19 Vaccinations

MEDICALLY NECESSARY COVID-19-vaccinations are covered with no out-of-pocket costs*. COVID-19 vaccinations do not require prior approval for coverage to apply.

For more information, please visit the “COVID-19 Resource Center” at **https://tuftshealthplan.com/covid-19/member/home**.

*If you are covered under a Saver plan, your plan is designed to comply with the IRS requirements for a “High Deductible Health Plan.” This means the DEDUCTIBLE may apply to certain services.

**MEMBERS on an HMO plan must receive all other non-EMERGENCY services from a TUFTS HEALTH PLAN PROVIDER.