

Minuteman Nashoba Health Group

#10962-000

Exclusive Provider Option

Description of Benefits

June 1, 2006

With Administrative Services Provided by

TUFTS  Health Plan

**333 Wyman Street
Waltham, MA 02454**

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN
333 Wyman Street
P.O. Box 9112
Waltham, Massachusetts 02454-9112

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

IMPORTANT PHONE NUMBERS:

Emergency Care

For routine care, you should always call your *Primary Care Physician (PCP)* before seeking care. If you have an urgent medical need and cannot reach your *PCP* or your *PCP's Covering Physician*, 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 Coordination of Benefits (COB) Department at 1-888-880-8699 for questions about coordination of benefits and workers compensation. For example, call the COB Department if you have any questions about how *Tufts Health Plan (Tufts HP)* coordinates coverage with other health care coverage that you may have. The COB Department is available from 8:30 a.m. – 5:00 p.m. Monday through Thursday, and 10:00 a.m. – 5:00 p.m. on Friday.

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

Member Services Department

Call the *Tufts HP* Member Services Department at 1-800-462-0224 for general questions, assistance in choosing a *PCP*, benefit questions, and information regarding eligibility for enrollment and billing.

Mental Health Services

If you need assistance in receiving information regarding mental health benefits, please contact Member Services at 1-800-462-0224.

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 1-800-815-8580 or 1-800-868-5850. You will reach the *Tufts HP* Member Services Department.

Massachusetts Relay (MassRelay)

1-800-720-3480

IMPORTANT ADDRESSES:

Appeals and Grievances Department

If you need to call *Tufts HP* about a concern or appeal, contact a Member Services Coordinator at 1-800-462-0224. To submit your appeal or grievance in writing, send your letter to:

Tufts Health Plan

Attn: Appeals and Grievances Department

705 Mount Auburn Street

P.O. Box 9193

Watertown, MA 02471-9193

Web site

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

Translating services for 140 languages

Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For information, please call the Member Services Department.

خدمات المترجمين والترجمة المتعلقة بالإجراءات الإدارية متوفرة لمساعدتك في هذا الشأن. لطلب هذه الخدمات، الرجاء الاتصال بقسم علاقات الزبون التابع لخدمة "تفتس هلس بلان".

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងរៀប រៃនៃគំរោងថែរក្សាសុខភាពរបស់ Tufts ។

相關管理程序的口譯和筆譯服務隨時為您提供協助。如需要這些服務，請打電話給「Tufts 健康計劃顧客聯絡部」。

Des services d'interprétariat et de traduction liés aux procédures administratives sont disponibles. Pour demander ces services, veuillez contacter le département des relations avec la clientèle de Tufts Health Plan.

Για την εξυπηρέτησή σας, υπάρχουν διαθέσιμες υπηρεσίες ερμηνείας και μετάφρασης σχετικά με τις διοικητικές διαδικασίες. Για να ζητήσετε αυτές τις υπηρεσίες, τηλεφωνήστε στο Τμήμα Πελατειακών Σχέσεων του Προγράμματος Ιατροφαρμακευτικής Ασφάλισης Tufts.

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການທຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts, ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

Temos disponíveis serviços de tradução e interpretação relacionados aos procedimentos administrativos. Para obter estes serviços, ligue para o departamento de relações com o cliente do Tufts Health Plan.

С целью оказать Вам помощь по административным процедурам предлагаются устные и письменные переводческие услуги. Если Вам нужны эти услуги, позвоните, пожалуйста, в Отдел связей с клиентами Плана здравоохранения «Тэфтс» Tufts.

Los servicios de traducción e interpretación en relación a procedimientos administrativos están disponibles para ayudarle. Para solicitar este servicio, favor de llamar al departamento de relaciones con el cliente de Tufts Health Plan.

Genyen sèvis tradiksyon ak entèprèt disponib pou ede ou nan zafè ki gen rapò ak jan administrasyon an fè sèvis li. Pou ou mande sèvis sa yo, tanpri rele depatman sèvis kliyan Tufts Health Plan.

Sono disponibili servizi di traduzione e interpretariato relativamente alle procedure amministrative. Per richiedere tali servizi, contattare l'ufficio relazioni clienti del Tufts Health Plan.

1-800-462-0224

TDD

Telecommunications Device for the Deaf

1-800-815-8580 or 1-800-868-5850

MassRelay

1-800-720-3480

Plan Information

Plan Name	Minuteman Nashoba Health Group Exclusive Provider Option (EPO) Plan
Plan Sponsor	Minuteman Nashoba Health Group
Plan Sponsor Address	c/o Group Benefits Strategies, Inc. 15 Midstate Drive, Suite 110 Auburn, MA 01501
Plan Sponsor's ID Number (EIN)	04-6001121
Plan Number	10962-000
Tufts HP Effective Date	This <i>Plan</i> became effective as of January 1, 1993.
Description of Benefits Effective Date	This <i>Description of Benefits</i> is effective June 1, 2006. It may be amended in accordance with Chapter 7.
Plan Year	June 1 st – May 31 st
Benefit Year	Calendar Year.
Plan Sponsor and Agent for Service of Legal Process	Minuteman Nashoba Health Group c/o Group Benefits Strategies, Inc. 15 Midstate Drive, Suite 110 Auburn, MA 01501
Type of Plan	Medical and Prescription Drug Benefits.
Plan Administration	The <i>Plan</i> is administered by the <i>Plan Sponsor</i> . The cost of medical benefits is the responsibility of the <i>Sponsor</i> under a self-funded arrangement.
Collective Bargaining Agreement	<p>The health benefits option under the <i>Plan</i> described in this <i>Description of Benefits</i> is maintained pursuant to a collective bargaining agreement and among the participating governmental units of the Minuteman Nashoba Health Group.</p> <p>A copy of such agreement may be obtained upon written request from participating governmental units.</p>
Plan Fiscal Year	The fiscal records of the <i>Plan</i> are kept on a plan year basis ending on each May 31 st .
Loss of Benefits	The <i>Plan Sponsor</i> may terminate the <i>Plan</i> at any time, or may modify, amend, or change the provisions, terms and conditions of the <i>Plan</i> . No consent of any participant or <i>Member</i> shall be required to terminate, modify, amend or change the <i>Plan</i> .
Employee Contribution to Benefits	<p>Benefits for <i>Employee</i> only:</p> <ul style="list-style-type: none">• The <i>Employee</i> is required to contribute to the cost of benefits. <p>Benefits for <i>Employee</i> and Dependents:</p> <ul style="list-style-type: none">• The <i>Employee</i> is required to contribute to the cost of benefits.

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Benefit Overview

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

COPAYMENTS	
• <u>Emergency Care:</u>	
• Emergency room	\$50
• In physician's office	\$10
• <u>Other Covered Services:</u>	
• Office Visit	\$10
• <i>Inpatient Services</i>	Covered in full.
• <i>Day Surgery</i>	Covered in full.
Note: For certain <i>Outpatient</i> services listed as "covered in full" in the table below, you may be charged an Office Visit <i>Copayment</i> when these services are provided in conjunction with an office visit.	

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see “Benefit Limits” and Chapter 3 for detailed explanations of *Covered Services*, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	PAGE
<i>Emergency Care</i>		
Treatment in an Emergency room	\$50 <i>Copayment</i> per visit. (waived if admitted as an <i>Inpatient</i>)	3-1
Treatment in a physician’s office	\$10 <i>Copayment</i> per visit.	3-1
A Member should call Tufts Health Plan within 48 hours after <i>Emergency care</i> is received.		

COVERED SERVICE	YOUR COST	PAGE
<i>Outpatient Care</i>		
Cardiac rehabilitation	Covered in full.	3-2
Diabetes self-management training and educational services	\$10 <i>Copayment</i> per visit.	3-2
Early intervention services for a <i>Dependent Child (BL)</i>	Covered in full up to \$5,200 per calendar year, up to a lifetime maximum of \$15,600.	3-2
Family planning (procedures, services, and contraceptives)	Office Visit: \$10 <i>Copayment</i> per visit Day Surgery: Covered in full.	3-2
Hemodialysis	Covered in full.	3-2
Infertility services (AR)	\$10 <i>Copayment</i> applies per visit. Note: Approved Assisted Reproductive Technology services are covered in full.	3-3
Maternity care Note: <i>Providers</i> may collect <i>Copayments</i> in a variety of ways for this coverage (for example at the time of your first visit, at the end of your pregnancy or in installments). Please check with your <i>Provider</i> .	\$10 <i>Copayment</i> applies per visit. Note: This Office Visit <i>Copayment</i> will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.	3-3

(AR) – These services may require approval by an *Authorized Reviewer*

(BL) – Benefit Limit applies. See “Benefit Limits” and “*Covered Services*” in Chapter 3 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see “Benefit Limits” and Chapter 3 for detailed explanations of *Covered Services*, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	PAGE
<i>Outpatient Care, continued</i>		
Oral Health Services (AR)	<p>Office Visit: \$10 <i>Copayment</i> applies per visit.</p> <p>Emergency Room: \$50 <i>Copayment</i> applies per visit.</p> <p>Inpatient Services: Covered in full.</p> <p>Day Surgery: Covered in full.</p>	3-4
<i>Outpatient medical care</i>		
Allergy testing and treatment	\$10 <i>Copayment</i> per visit.	3-5
Allergy injections	Covered in full.	3-5
Chemotherapy	Covered in full.	3-5
Cytology screenings (annual) (BL)	Covered in full.	3-5
Diagnostic Imaging (AR) <ul style="list-style-type: none"> • General imaging (such as x-rays and ultrasounds) and • MRI / MRA, CT/CTA, PET and nuclear medicine 	<p>General imaging: Covered in full.</p> <p>MRI/MRA: Covered in full.</p> <p>CT/CTA: Covered in full.</p> <p>PET: Covered in full.</p> <p>Nuclear medicine: Covered in full.</p>	3-5

(AR) – These services may require approval by an *Authorized Reviewer*

(BL) – Benefit Limit applies. See “Benefit Limits” and “*Covered Services*” in Chapter 3 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see “Benefit Limits” and Chapter 3 for detailed explanations of *Covered Services*, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	PAGE
<i>Outpatient Care, continued</i>		
Diagnostic tests and laboratory services (AR) Note: Colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies are covered under this benefit when performed as <i>Outpatient</i> diagnostic procedures. When performed as <i>Outpatient</i> surgical procedures, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies are covered as <i>Day Surgery</i> . For more information, see “ <i>Day Surgery</i> ” later in this section or call Member Services.	Covered in full.	3-5
Human leukocyte antigen (HLA) testing	Covered in full.	3-5
Immunizations	Covered in full.	3-5
Lead screenings	Covered in full.	3-5
Mammography screenings (BL)	Covered in full.	3-5
Radiation therapy	Covered in full.	3-5
Respiratory therapy	Covered in full.	3-5
Therapy for speech, hearing, and language disorders (AR)	\$10 <i>Copayment</i> applies per visit.	3-5
Nutritional counseling (BL)	\$10 <i>Copayment</i> applies per visit.	3-5
Office visits to diagnose and treat illness and injury	\$10 <i>Copayment</i> applies per visit.	3-5
<i>Outpatient</i> surgery in a physician’s office	\$10 <i>Copayment</i> applies per visit.	3-5
Patient care services provided as part of a qualified clinical trial (for treatment of cancer)	\$10 <i>Copayment</i> applies per visit.	3-5
Pediatric dental care for <i>Members</i> under age 12	Covered in full	3-6
Preventive health care for <i>Members</i> under age 6	\$10 <i>Copayment</i> applies per office visit.	3-6
Preventive health care for <i>Members</i> age 6 and older	\$10 <i>Copayment</i> applies per office visit.	3-6
Short term physical and occupational therapy services (AR) (BL)	Physical Therapy: \$10 <i>Copayment</i> applies per visit. Occupational Therapy: \$10 <i>Copayment</i> applies per visit.	3-7

(AR) – These services may require approval by an *Authorized Reviewer*

(BL) – Benefit Limit applies. See “Benefit Limits” and “Covered Services” in Chapter 3 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see “Benefit Limits” and Chapter 3 for detailed explanations of *Covered Services*, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	PAGE
<i>Outpatient Care, continued</i>		
Spinal manipulation (BL)	\$10 <i>Copayment</i> applies per visit.	3-7
<i>Day Surgery</i>		
<i>Day Surgery</i> (AR)	Covered in full.	3-7
<i>Inpatient Care</i>		
Acute hospital services (AR)	Covered in full.	3-8
Bone marrow transplants for breast cancer and human organ transplants (AR)	Covered in full.	3-8
Extended care (AR) (BL)	Covered in full.	3-8
Maternity care	Covered in full.	3-9
Patient care services provided as part of a qualified clinical trial (for treatment of cancer)	Covered in full.	3-9
Reconstructive surgery and procedures (AR)	Covered in full.	3-9

(AR) – These services may require approval by an *Authorized Reviewer*

(BL) – Benefit Limit applies. See “Benefit Limits” and “*Covered Services*” in Chapter 3 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see “Benefit Limits” and Chapter 3 for detailed explanations of *Covered Services*, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	PAGE
Mental Health Care and Substance Abuse Services		
Mental Health Care Services To contact the <i>Tufts HP</i> Mental Health Department, call 1-800-208-9565. (See “Benefit Limits” and Chapter 3 for visit, day, and dollar limits)		
<i>Outpatient</i> services (AR) (BL)	\$10 <i>Copayment</i> applies per office visit.	3-10
<i>Inpatient</i> services (AR) (BL)	Covered in full.	3-11
Intermediate care (AR) (BL)	Covered in full.	3-11
Substance Abuse Services To contact the <i>Tufts HP</i> Mental Health Department, call 1-800-208-9565. (See “Benefit Limits” and Chapter 3 for visit, day, and dollar limits)		
<i>Outpatient</i> services (AR) (BL)	<u>Detoxification Services</u> : \$10 <i>Copayment</i> applies per visit. <u>Substance Abuse Treatment Services</u> : \$10 <i>Copayment</i> applies per visit.	3-11
<i>Inpatient</i> services (AR) (BL)	Covered in full.	3-11
Intermediate care (AR) (BL)	Covered in full.	3-11

(AR) – These services may require approval by an *Authorized Reviewer*

(BL) – Benefit Limit applies. See “Benefit Limits” and “*Covered Services*” in Chapter 3 for more information.

Benefit Overview, continued

Important Note: This table provides basic information about your benefits under this plan. Please see “Benefit Limits” and Chapter 3 for detailed explanations of *Covered Services*, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums).

COVERED SERVICE	YOUR COST	PAGE
Other Health Services		
Ambulance services (AR)	Covered in full.	3-12
<i>Durable Medical Equipment</i> (AR) (BL)	Covered in full up to a maximum of \$2500 per calendar year.	3-12
Home health care (AR)	Covered in full.	3-13
Hospice care (AR)	Covered in full.	3-13
Injectable medications (AR)	Covered in full.	3-14
Low protein food (BL)	Covered in full.	3-14
Medical supplies	Covered in full.	3-14
Nonprescription enteral formulas (AR)	Covered in full.	3-14
Scalp hair prostheses or wigs for cancer or leukemia patients (BL)	Covered in full.	3-14
Special medical formulas (AR)	Covered in full.	3-14
Prescription Drug Benefit		
For information about your <i>Copayments</i> for covered prescription drugs, see the “Prescription Drug Benefit” section in Chapter 3.		3-15

(AR) – These services may require approval by an *Authorized Reviewer*

(BL) – Benefit Limit applies. See “Benefit Limits” and “*Covered Services*” in Chapter 3 for more information.

Benefit Limits

Durable Medical Equipment

The maximum benefit payable in each calendar year for *Covered Services* is \$2500 per person.

Important Note: This benefit limit does not apply to breast prostheses following a mastectomy.

Early Intervention Services

Covered in full up to \$5,200 per calendar year, up to a lifetime maximum of \$15,600.

Extended Care Services

Covered up to 100 days per calendar year.

Manual Manipulation of the Spine

The maximum benefit payable in each calendar year is 12 visits per person.

Mental Health *Inpatient* Services

In a general hospital, a mental health hospital, or a substance abuse facility, the maximum benefit payable in each calendar year is 60 days.** See Chapter 1 for information on *Tufts HP's Designated Facility* Program.

**Two mental health day treatment/partial hospital days count as one of the 60 *Inpatient* days you get per calendar year.

Important Note: This benefit limit does not apply to *Inpatient* diagnosis and treatment of Biologically-based *Mental Disorders*; Certain *Mental*, behavioral or emotional *Disorders* for *Children* under the age of 19; and Rape-related *Mental* or emotional *Disorders*. (See Chapter 3 for more information.)

Mental Health *Outpatient* Services

The maximum benefit payable in each calendar year is 24 visits.

Important Note: This benefit limit does not apply to *Outpatient* diagnosis and treatment of Biologically-based *Mental Disorders*; Certain *Mental*, behavioral or emotional *Disorders* for *Children* under the age of 19; and Rape-related *Mental* or emotional *Disorders*. (See Chapter 3 for more information.)

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients

Covered up to a maximum benefit of \$350 per calendar year.

Special Medical Formulas

The maximum benefit payable in each calendar year for low protein foods is \$2,500 per calendar year.

Substance Abuse *Inpatient* Services

The maximum benefit payable in each calendar year is 30 days of *Inpatient* substance abuse services.** (After the Member has exhausted the maximum *Inpatient* substance abuse services benefit, *Inpatient* detoxification will continue to be covered for as many days as is *Medically Necessary*.) See Chapter 1 for information on *Tufts HP's Designated Facility* Program.

**Note: Two substance abuse day treatment/partial hospital days count as one of the 30 *Inpatient* days you get per calendar year.

Important Note: If the *Inpatient* substance abuse treatment services are provided in conjunction with treatment of a *Mental Disorder* (as described in Chapter 3), your coverage amount is the applicable benefit amount described above under "Mental Health *Inpatient* Services".

Substance Abuse *Outpatient* Detoxification Services

Outpatient detoxification is covered for as many visits as are *Medically Necessary*.

Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each calendar year is \$500.

Important Note: If the substance abuse *Outpatient* services are provided in conjunction with treatment of a *Mental Disorder* (as described in Chapter 3), your coverage amount is the applicable benefit amount described above under "Mental Health *Outpatient* Services."

Chapter 1

How Your Exclusive Provider Option Plan Works

Overview

Introduction

This booklet contains your *Description of Benefits*. It describes Minuteman Nashoba Health Group's *Employee* health benefits plan, which is referred to here as the "*Plan*." This is a self-funded plan, which means Minuteman Nashoba Health Group, the *Plan Sponsor*, is responsible for the cost of the *Covered Services* you receive under it. Italicized words are defined in the Glossary in Appendix A.

How the *Plan* works

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

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

About the *Tufts HP* Network

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

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

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

Eligibility for Benefits

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

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

Calls to Member Services

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

Calls to the *Tufts HP* Member Services Department may, on occasion, be monitored to assure quality service.

How the *Plan* Works

Primary Care Physicians

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

Medically Necessary services and supplies

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

Service Area

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

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

Changes to Tufts HP Provider network

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

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

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

Coverage

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

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

Continuity of Care

If you are an existing *Member*

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

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

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

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

Continuity of Care, continued

If you are enrolling as a new *Member*

When you enroll as a *Member*, if none of the health plans offered by the *Employer* at that time include your *Provider*, you may continue to see your *Provider* if:

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

Conditions for coverage of continued treatment

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

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

About Your *Primary Care Physician*

Importance of choosing a *PCP*

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

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

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

What a *PCP* does

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

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

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

About your *Primary Care Physician*, continued

Choosing a *PCP*

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

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

Notes:

- Under certain circumstances required by law, if your physician is not in the *Tufts HP* network, you will be covered for a short period of time for services provided by your physician. A Member Services Coordinator can give you more information. Please see “Continuity of Care” on page 1-6.
- For additional information about a *PCP* or specialist, the Massachusetts Board of Registration in Medicine provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 727-0773 or www.massmedboard.org.

Contacting your new *PCP*

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

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

If you can't reach your *PCP*

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

If you need medical services after hours, please contact your *PCP* or a *Covering Physician*. Your *PCP*, or a *Covering Physician*, is available 24 hours a day, 7 days a week. If you need *Inpatient* mental health or substance abuse services after hours, please call 1-800-208-9565 for assistance.

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

Changing your *PCP*

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

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

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

Canceling appointments

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

About your *Primary Care Physician*, continued

Referrals for specialty services

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

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

If you require specialty care which is not available through any *Tufts HP Provider* (this is a rare event), your *PCP* may refer you, with the prior approval of an *Authorized Reviewer*, to a *Provider* not associated with *Tufts HP*.

Notes:

- *Covered Services* provided by non-*Tufts HP Providers* are not paid for unless authorized in advance by your *PCP* and approved by an *Authorized Reviewer*.
- For mental health and substance abuse services, you do not need a referral from your *PCP*; however, you may need authorization from a *Tufts HP Mental Health Authorized Reviewer*. See “*Inpatient and intermediate mental health/substance abuse services*” and “*Outpatient mental health/substance abuse services*” later in this chapter for more information.

Referral forms for specialty services

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

Authorized Reviewer approval

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

About your *Primary Care Physician*, continued

When referrals are not required

The following *Covered Services* do not require a referral or prior authorization from your *Primary Care Physician*.

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

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

Methods of payment to *Tufts HP Providers*

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

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

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

Member Identification Card

Introduction

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

Reporting errors

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

Member Identification Card, continued

Identifying yourself as a *Tufts HP Member*

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

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

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

IMPORTANT NOTE: If you do not identify yourself as a *Tufts HP Member*, then

- the *Plan* may not pay for the services provided, and
- you would be responsible for the costs.

Membership requirement

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

Membership identification number

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

Utilization Management

Introduction

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

Utilization management

Tufts HP has a utilization management program. The purpose of the program is to control health care costs by evaluating whether health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. Under this program, *Tufts HP* sometimes engages in prospective, concurrent, and retrospective review of health care services.

Tufts HP uses prospective review to determine whether proposed treatment is *Medically Necessary* before that treatment begins.

Tufts HP engages in concurrent review to monitor the course of treatment as it occurs and to determine when that treatment is no longer *Medically Necessary*.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, *Tufts HP* engages in retrospective review to more accurately determine the appropriateness of health care services provided to *Members*.

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

IMPORTANT NOTE: Members can call *Tufts Health Plan* at 1-800-462-0224 to determine the status or outcome of utilization review decisions.

Utilization Management, continued

Specialty case management

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

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

Tufts HP may contact that *Member* and his or her *Tufts HP Provider* to discuss a treatment plan and establish short and long term goals. The *Tufts HP Specialty Case Manager* may suggest alternative treatment settings available to the *Member*.

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

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

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

- high-risk pregnancy and newborn *Children*;
- serious heart or lung disease;
- cancer;
- certain neurological diseases;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- severe traumatic injury.

Individual case management (ICM)

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

As a part of the ICM plan, *Tufts HP* may authorize coverage for alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if *Tufts HP* determines that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary*;
- the alternative services and supplies are in place of more expensive treatment that qualifies as *Covered Services*;
- the *Member* and an *Authorized Reviewer* agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition, as determined periodically by an *Authorized Reviewer*.

When *Tufts HP* authorizes an ICM plan, *Tufts HP* will also indicate the *Covered Service* that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the *Member* would have received for the *Covered Service*.

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

When You Are Ill or Injured (Non-Emergency Care)

Introduction

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

Rule

Always call your *PCP*. Without authorization from your *PCP*, services will not be covered.

Important: Never wait until your condition becomes an *Emergency* to call.

Procedure

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

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

Inpatient hospital services

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

Transfer to a *Tufts HP Hospital*

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

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

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

Charges after the discharge hour

If you choose to stay as an Inpatient after a *Tufts HP Provider* has scheduled your discharge or determined that further *Inpatient* services are no longer *Medically Necessary*, the *Plan* will not cover any costs incurred after that time.

Inpatient and intermediate mental health/substance abuse services

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

The *Designated Facilities*

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

Outpatient mental health/ substance abuse services

Your mental health and substance abuse *Provider* will obtain the necessary authorization for *Outpatient* mental health/substance abuse services by calling *Tufts HP's Outpatient* Mental Health/Substance Abuse program at 1-800-208-9565. You or your *PCP* may also call *Tufts HP's Outpatient* Mental Health/Substance Abuse program for authorization.

When You Need *Emergency* or *Urgent Care*

Guidelines for receiving *Emergency* care

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

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.
- You do not need approval from your *PCP* before receiving *Emergency* care.
- If you receive *Outpatient Emergency* care at an emergency facility, you or someone acting for you should call your *PCP* or *Tufts HP* within 48 hours after receiving care. You are encouraged to contact your *Primary Care Physician* so your *PCP* can provide or arrange for any follow-up care that you may need.
- If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts HP* within 48 hours after receiving care. (Notification from the attending physician satisfies this requirement.)
- If you receive *Emergency Covered Services* from a non-*Tufts HP Provider*, the *Plan* will cover the cost of services up to the *Usual and Customary Charge*. You pay the applicable *Copayment* and any difference between what the *Plan* covered and what the non-*Tufts HP Provider* charged for the service.

Guidelines for receiving *Urgent Care*

Follow these guidelines for receiving *Urgent Care*

If you are in the *Service Area*

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

If you are outside the *Service Area*

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

What to Do When Traveling or When a *Student Dependent* In School Outside the *Service Area*

Introduction

This topic tells you what to do if you need care outside the *Tufts HP Service Area*. When traveling or when a *Student Dependent* in school outside the *Service Area*, you must know the types of services that are not covered by the *Plan*.

Coverage outside the *Service Area*

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

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

Chapter 2

Eligibility, Enrollment and Continuing Eligibility

Eligibility

Waiting Period

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

New hires should check with their *Employer* for information about waiting periods.

Eligibility rule

You are eligible as a *Subscriber* only if you are an *Employee* and you:

- meet the *Plan's* eligibility rules (including the requirement for minimum hours described below); and
- maintain primary residence in the *Service Area*; and
- live in the *Service Area* for at least 9 months in each period of 12 months.*

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

- qualifies as a *Dependent*, as defined in this *Description of Benefits*; and
- meets the *Plan's* eligibility rules; and
- maintains primary residence in the *Service Area*; and
- lives in the *Service Area* for at least 9 months in each period of 12 months.*

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

Minimum Hours

In order to be eligible for coverage under the *Plan*, you must work a minimum of 20 hours per week or be otherwise qualified by Massachusetts General Law 32 (B), as accepted by the Minuteman Nashoba Health Group participating governmental units.

If you live outside Tufts HP's Service Area

If you live outside *Tufts HP's Service Area*, you can be covered only if:

- the *Plan* offers coverage for *Student Dependents*, and you are enrolled as a *Student Dependent*;
- you are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced *Spouse* for whom coverage is required.

Note: See "Coverage outside the *Service Area*" in Chapter 1 for more information.

Proof of eligibility

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

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

Enrollment

When to enroll

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

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

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

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

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

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

Effective Date of coverage

Enrolled *Dependents'* coverage starts when the *Subscriber's* coverage starts, or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

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

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

Adding *Dependents*

When *Dependents* may be added

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

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

Adding *Dependents*, continued

How to add *Dependents*

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

Step	Action
1	Do you have <i>Family Coverage</i> ? <ul style="list-style-type: none">• If <u>yes</u>, go to the next step.• If <u>no</u>, ask the <i>Plan Sponsor</i> through your <i>Employer</i> to change your <i>Individual Coverage</i> to <i>Family Coverage</i>.
2	Fill out a member application form listing the <i>Dependents</i> .
3	Give the form to your <i>Employer</i> either: <ul style="list-style-type: none">• during your <i>Employer's Open Enrollment Period</i>, or• within 30 days after the date of an event listed above, under "When <i>Dependents</i> may be added."

Effective Date of *Dependents*' coverage

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

Effective Dates will be no later than:

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

Availability of benefits after enrollment

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

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

Newborn *Children* and *Adoptive Children*

Introduction

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

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

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

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

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

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

Step	Action
1	Choose a <i>PCP</i> from the list of <i>PCPs</i> in the <i>Tufts HP Directory of Health Care Providers</i> or call a Member Services Coordinator for help.
2	Call the physician and ask him or her to be the newborn or <i>Adoptive Child's PCP</i> .
3	If he or she agrees, call a Member Services Coordinator to report your choice.

Continuing Eligibility for *Dependents*

Introduction

This topic tells you about continuing eligibility for:

- *Student Dependents*; and
- *Disabled Dependents*.

Rule for *Student Dependents*

When an enrolled *Child* reaches age 19, the *Child's* coverage will end. The *Child* may continue coverage under the *Subscriber's Family Coverage* if he or she is:

- unmarried; and
- between age 19 and age 25; and
- enrolled as a full-time student at an accredited educational institution.

How to continue coverage for *Student Dependents*

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

Step	Action
1	Obtain a <i>Student Dependent</i> verification form from <i>Tufts HP</i> within 90 days before the <i>Child's</i> 19th birthday. Call a Member Services Coordinator to obtain a form.
2	Fill out the form.
3	Send the completed form to <i>Tufts HP</i> within 30 days before the <i>Child's</i> 19th birthday.
4	Give <i>Tufts HP</i> a new <i>Student Dependent</i> verification form, as required by the <i>Tufts HP Student Dependent</i> verification process.

When coverage ends

Student Dependent coverage ends when the *Student Dependent*:

- reaches age 25; or
- marries; or
- graduates, in which case coverage ends on the last day of the month in which the student graduates; or
- takes a leave of absence due to a serious illness or injury that prevents the *Student Dependent* from continuing as a *Student Dependent*. In that case, coverage ends 90 days after the date the student last went to class; or
- stops full-time study. If full-time study stops during a semester, then coverage will end on the last day of the month during which the student attended classes. If full-time study stops during a semester break, then coverage will end on the last day of the month before the next scheduled semester.

Coverage after termination

The former *Student Dependent* may be eligible for federal continuation coverage or to enroll in *Nongroup Coverage*. See Chapter 5 for more information.

Continuing Eligibility for *Dependents*, continued

Rule for *Disabled Dependents*

An enrolled *Child* can also continue to be covered after age 19 under the *Subscriber's Family Coverage* if he or she:

- is unmarried; and
- became permanently physically or mentally disabled before age 19 (or before losing eligibility as a *Student Dependent*); and
- is incapable of supporting himself or herself due to disability; and
- is chiefly financially dependent on the *Subscriber*; and
- lives with the *Subscriber* or *Spouse*; and
- was covered under the *Subscriber's Family Coverage* immediately before reaching age 19 (or before losing eligibility as a *Student Dependent*) or has had other group health coverage at all times since the disability began.

How to continue coverage for *Disabled Dependents*

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

Step	Action
1	About 30 days before the <i>Child's</i> 19th birthday (or 30 days before losing eligibility as a <i>Student Dependent</i>), call a Member Services Coordinator.
2	Give proof, acceptable to <i>Tufts HP</i> , of the <i>Child's</i> disability.

When coverage ends

Disabled Dependent coverage ends when:

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

Coverage after termination

The former *Disabled Dependent* may be eligible for federal continuation coverage or to enroll in *Nongroup Coverage*. See Chapter 5 for more information.

Keeping the *Plan's* records current

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

- birth, adoption, changes in marital status, or death;
- your 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 *Disabled Dependent* or *Student Dependent*.

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

Chapter 3

Covered Services

Overview

Introduction

This chapter describes the health care services and supplies that the *Plan* covers.

Covered Services

When health care services are Covered Services

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

- listed as *Covered Services* in this chapter;
- *Medically Necessary*;
- consistent with applicable law;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your *PCP*, except in an *Emergency* or for *Urgent Care* (see “When You Need *Emergency* or *Urgent Care*” earlier in this *Description of Benefits* for more information and also see When Referrals are Not Required at the *Authorized Level of Benefits* on page 1-6);
- approved by an *Authorized Reviewer*, in some cases; and
- in the case of *Inpatient* or intermediate mental health/substance abuse services, provided or authorized by a *Designated Facility*.

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

Emergency care

- *Emergency* care in an emergency room; or
- in a physician’s office (no *PCP* referral required).

Notes:

- The *Emergency Room Copayment* is waived if the *Emergency* room visit results in immediate hospitalization.
- If you receive *Emergency Covered Services* from a non-*Tufts HP Provider*, the *Plan* will pay up to the *Usual and Customary Charge*. You pay the applicable *Copayment* and any difference between what the *Plan* paid and what the non-*Tufts HP Provider* charged for the service.

Outpatient care

Cardiac rehabilitation services

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

The *Plan* covers only the following services:

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

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

Covered Services, continued

Outpatient care (continued)

Diabetes self-management training and educational services

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

Important Notes:

- The Plan will only cover these services when provided by a *Tufts HP Provider* who is a certified diabetes health care provider.
- Medical nutritional therapy provided under this benefit is not subject to any visit limit described in the "Nutritional counseling" benefit later in this chapter.

Early intervention services for a *Dependent Child*

Services provided by early intervention programs. Early intervention services include, but are not limited to:

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

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

Family planning

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

- Procedures
 - sterilization; and
 - pregnancy terminations (no *PCP* referral required).
- Services
 - medical examinations;
 - consultations;
 - birth control counseling; and
 - genetic counseling.
- Contraceptives
 - cervical caps;
 - Intrauterine devices (IUDs);
 - Levonorgestrel (Norplant®);
 - Depo-Provera; and
 - any other *Medically Necessary* contraceptive device that has been approved by the United States Food and Drug Administration*.

***Note:** Please note that *Tufts HP* covers certain contraceptives, such as oral contraceptives and diaphragms, under a Prescription Drug Benefit. If those contraceptives are covered under that benefit, they are not covered here.

Hemodialysis

- *Outpatient* hemodialysis; and
- *Outpatient* peritoneal dialysis.

Covered Services, continued
Outpatient care (continued)

Infertility services

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

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

Infertility services include:

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

- diagnostic procedures and tests;
- artificial insemination (intrauterine or intracervical) when done with non-donor (partner) sperm; and
- procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.

(II.) the following procedures when approved in advance by an *Authorized Reviewer*:

- artificial insemination (intrauterine or intracervical) when done with donor sperm; and
- procurement and processing of eggs or inseminated eggs or banking of inseminated eggs when associated with active infertility treatment.

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

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

- I.V.F. (in-vitro fertilization and embryo transfer);
- D.O. (donor oocyte);
- F.E.T. (frozen embryo transfer);
- G.I.F.T. (gamete intra-fallopian transfer);
- Z.I.F.T. (zygote intra-fallopian transfer); and
- I.C.S.I. (intracytoplasmic sperm injection).

**Note: These ART procedures will only be considered *Covered Services* for *Members* with infertility:

- who are Massachusetts residents;
- who meet *Tufts HP*’s eligibility requirements, which are based on the *Member*’s medical history;
- who meet the eligibility requirements of *Tufts HP*’s contracting Infertility Services providers; and
- with respect to the procurement and processing of donor sperm, eggs or inseminated eggs or banking of donor sperm or inseminated eggs, to the extent such costs are not covered by the donor’s health care coverage, if any.

*Infertility is defined as the condition of a presumably healthy *Member* who has been unable to conceive or produce conception during a period of one year.

Maternity care

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

Notes:

- *Providers* may collect *Copayments* in a variety of ways for this coverage (for example, at the time of your first visit, at the end of your pregnancy, or in installments). Please check with your *Provider*.
- The Office Visit *Copayment* will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.

Covered Services, continued
Outpatient care, (continued)

Oral health services

- *Inpatient* services and *Day Surgery* (prior approval by an **Authorized Reviewer** is required for ***Inpatient and Day Surgery*** oral health services)

Coverage Rules – Oral Health *Inpatient* Services and *Day Surgery*

The *Inpatient* and *Day Surgery* oral health services listed below will qualify as **Covered Services** **only** when the following criteria are met:

- *Tufts HP* determines that the services cannot be safely and effectively provided in an office setting due to the existence of a specific and serious nondental organic impairment (for example, hemophilia) currently under active treatment; and
- the oral health services are directly related to maintaining health and are not cosmetic or experimental procedures.

Coverage is provided for the following services, subject to the criteria listed above in “Coverage Rules – Oral Health *Inpatient* Services and *Day Surgery*”:

- hospital, physician, and surgical charges for the following dental procedures only:
 - surgical removal of impacted teeth when embedded in bone or unerupted teeth when embedded in bone;
 - extraction of seven or more permanent teeth during one visit.
- hospital charges only for any other dental procedures.
- Surgical treatment of skeletal jaw deformities is covered only:
 - to achieve a functional occlusion for adequate chewing;
 - to relieve severe pain that is not responsive to other forms of treatment; or
 - for respiratory problems which result directly from the skeletal jaw deformity.

Important Note: Prior approval by an *Authorized Reviewer* is required.

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

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

- Temporomandibular Joint (TMJ) Disorder Treatment
Coverage is limited to:
 - initial diagnostic consultations with an oral and maxillofacial surgeon;
 - physical therapy (coverage is provided under “Short-term physical and occupational therapy services”)*; and
 - surgical repair or intervention*.

*must be approved by an *Authorized Reviewer*.

Note: No TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies are covered.

Covered Services, continued

Outpatient care, (continued)

Outpatient medical care

- Allergy testing (including antigens) and treatment, and allergy injections.
- chemotherapy;
- cytology screening (Pap Smear) - one annual screening for women age 18 and older;
- diagnostic imaging, including general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA, and PET tests and nuclear medicine (may require the approval of an *Authorized Reviewer*);
- diagnostic tests and laboratory services, including, but not limited to, glycosylated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles (**Important:** Colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies are covered under this benefit, when performed as *Outpatient* diagnostic procedures. When performed as *Outpatient* surgical procedures, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies are covered as *Day Surgery*. For more information, see “*Day Surgery*” later in this chapter or call Member Services. Some diagnostic tests (e.g., genetic testing) may require the approval of an *Authorized Reviewer*);
- human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a Member’s bone marrow transplant donor suitability.
Includes:
 - costs of testing for A, B or DR antigens; or
 - any combination consistent with the rules and criteria established by the Department of Public Health;
- immunizations;
- lead screenings;
- mammography screenings (no *PCP* referral required) 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*;
- *Medically Necessary* diagnosis and treatment of speech, hearing and language disorders (services may require the approval of an *Authorized Reviewer*);
- Nutritional counseling
Note: This visit limit does not apply to *Outpatient* nutritional counseling provided as part of:
 - an approved home health care plan (see “Home health care” benefit later in this chapter); or
 - diabetes self-management training and educational services (see benefit earlier in this chapter).Covered up to 8 visits per calendar year.
- Office visits to diagnose and treat illness or injury.
Note: This includes *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions (no *PCP* referral required).
- *Outpatient* surgery in a physician’s office.
- radiation therapy;
- respiratory therapy.

Patient care services provided as part of a qualified clinical trial for the treatment of cancer

As required by applicable law, patient care services provided as part of a qualified clinical trial for the treatment of cancer are covered to the same extent as those *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Covered Services, continued

Outpatient care (continued)

Pediatric dental care for *Members* under age 12

- preventive services:
 - oral prophylaxis (cleaning, scaling, and polishing of teeth) - once every 6 months
 - fluoride treatment - once every 6 months
- diagnostic services:
 - complete initial oral exam and charting - once per dentist
 - periodic oral exam - once every 6 months
- X-rays:
 - full mouth (complete set) - once every 5 years
 - chewing (back teeth) - once every 6 months
 - periapicals (single tooth) - as needed

Important: You must choose a dentist for your *Dependent Child* from the preferred dental provider directory. No referral is required from your *Child's PCP*. For more information about benefits and providers under this *Covered Service*, call a Member Services Coordinator.

Preventive health care for *Members* under age 6

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

Preventive health care for *Members* age 6 and older

- routine physical examinations, including appropriate immunizations and lab tests as recommended by a *Tufts HP Provider*;
- routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam (no *PCP* referral required) and hormone replacement therapy services;
- Annual routine eye exam.
- hearing examinations and screenings.

Covered Services, continued

Outpatient care (continued)

Short term physical and occupational therapy services

(Services may require the approval of an *Authorized Reviewer*)

Short term physical and occupational services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness. For these services to be covered, *Tufts HP* must determine that the *Member's* condition is subject to significant improvement within a period of 60 days from the initial treatment as a direct result of these therapies.

Note: The limit does not apply to short-term physical or occupational therapy provided in conjunction with a physician's approved home health care plan. For more information, see "Home health care" described later in this chapter.

Spinal manipulation

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

Day Surgery

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

Note:

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

Covered Services, continued

Inpatient care

Bone marrow transplants for breast cancer and human organ transplants

(must be approved by an *Authorized Reviewer*)

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

Notes:

- The *Plan* does not cover donor charges of *Members* who donate organs to non-*Members*.
- The *Plan* covers a *Member's* donor search expenses for donors related by blood.
- The *Plan* covers the *Member's* donor search expenses for up to 10 searches for donors not related by blood. Additional donor search expenses for unrelated donors must be approved by an *Authorized Reviewer*.
- The *Plan* covers a *Member's* human leukocyte antigen (HLA) testing. See "Outpatient medical care" earlier in this chapter for more information.

Extended care (Extended care services require prior approval by an *Authorized Reviewer*)

In an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

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

If you no longer need acute care hospital services but cannot be transferred to an extended care facility because no bed is available, *Tufts HP* may arrange for the hospital you are in to provide you extended care services in the hospital. These additional hospital days will count toward the extended care 100-day limit.

Hospital services (Acute care)*

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

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

**This includes, but is not limited to, coverage for bariatric surgery (surgery for the treatment of morbid obesity and its co-morbidities.)

Covered Services, continued

Inpatient care, (continued)

Maternity care (no *PCP* referral required)

- hospital and delivery services, and
- well newborn *Child* care in hospital.

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

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

Notes:

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

Patient care services provided as part of a qualified clinical trial for the treatment of cancer

As required by applicable law, patient care services provided as part of a qualified clinical trial for the treatment of cancer are covered to the same extent as those Inpatient services would be covered if the *Member* did not receive care in a qualified clinical trial.

Reconstructive surgery and procedures

Coverage is provided for the cost of:

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

*Prosthetic devices are covered as described under "*Durable Medical Equipment*" later in this chapter. However, those prosthetic devices are not subject to the "*Durable Medical Equipment*" maximum of \$2500-per calendar year.

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

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

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

Notes:

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

Covered Services, continued

Mental Health Care Services (*Outpatient, Inpatient, and Intermediate*)

Diagnosis and treatment of Biologically-based *Mental Disorders*; Certain *Mental, behavioral, or emotional Disorders for Children* under age 19; Rape-related *Mental or emotional Disorders*; and all other *Mental Disorders* in accordance with applicable law.

- Biologically-based *Mental Disorders* are: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; and any other mental disorders added in accordance with applicable law.
- Certain *Mental, behavioral or emotional Disorders for Children* under age 19 are *Mental Disorders* which substantially interfere with or substantially limit the functioning and social interactions of the *Child*:
 - when documented by the *Child's PCP* or treating mental health *Provider* and authorized by the *Tufts Health Plan Mental Health Department*; or
 - when evidenced by, as a result of or caused by the *Mental Disorder*:
 - an inability to attend school,
 - the need to be hospitalized, or
 - a pattern of conduct which poses a serious danger to the *Child* or others.

Note: If the *Child* is engaged in an ongoing course of treatment as specified in the *Child's* treatment plan, this coverage may continue after age 19, until the course of treatment is completed or until the *Child* is no longer eligible for coverage, whichever occurs first. For more information, also see "Rule for *Disabled Dependents*" in Chapter 2.

- Rape-related *Mental or emotional Disorders* are covered when:
 - the *Member* is a victim of rape or assault with intent to commit rape;
 - the costs for treatment exceed the maximum amount awarded under applicable Massachusetts law.

Mental health services include the following *Outpatient, Inpatient* and *Intermediate* care services:

Outpatient* mental health care services for *Mental Disorders

Services to diagnose and treat *Mental Disorders*, given by the following *Tufts HP Providers*:

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

Notes:

- Psychopharmacological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury" as described earlier in this chapter.
- **Prior authorization by a *Tufts HP Mental Health Authorized Reviewer* is required for psychological testing and neuropsychological assessment services.**
- ***Outpatient* mental health care services require prior authorization. Please see "*Outpatient mental health/substance abuse services*" in Chapter 1 for more information.**
- **There is no limit on visits for Biologically-based *Mental Disorders*; Certain *Mental, behavioral or emotional Disorders for Children* under age 19; and Rape-related *Mental or emotional Disorders*.**
- **There is a 24 visit limit per calendar year for all other *Mental Disorders*.**

Covered Services, continued

Mental Health Care Services (Outpatient, Inpatient, and Intermediate) (continued)

Inpatient* and intermediate mental health care services for *Mental Disorders

(Authorization is required for these services. See “*Inpatient* and intermediate mental health/substance abuse services” in Chapter 1 for more information.)

- *Inpatient* mental health services for *Mental Disorders* in:
 - a general hospital;
 - a mental health hospital; or
 - a substance abuse facility.

Note: There is no limit for *Inpatient* mental health care services for Biologically-based *Mental Disorders*; Certain *Mental*, behavioral, or emotional *Disorders* for *Children* under age 19; and Rape-related *Mental* or emotional *Disorders*. For treatment of all other *Mental Disorders*, you are covered up to 60 days per calendar year.

- Intermediate mental health care services. These services are more intensive than traditional *Outpatient* mental health care services, but less intensive than 24-hour hospitalization. Some examples of Covered intermediate mental health care services are:
 - level III community-based detoxification;
 - acute residential treatment (longer term residential treatment is not covered);
 - crisis stabilization;
 - day treatment/partial hospital programs*; and
 - intensive *Outpatient* programs.

*Two mental health day treatment/partial hospital days count as one of the 60 *Inpatient* days you get per calendar year.

Substance Abuse Services (Outpatient, Inpatient, and Intermediate)

***Outpatient* substance abuse (alcohol and drug) services for substance abuse-related disorders**

- *Outpatient* substance abuse treatment services and/or *Outpatient* detoxification services

Notes:

- **Substance abuse treatment services are covered up to \$500 per calendar year. After this limit is met, only detoxification services are covered.**
- ***Outpatient* substance abuse services require prior authorization. See “*Outpatient* mental health/substance abuse services” in Chapter 1 for more information.**

Important Note: If these *Outpatient* substance abuse services are provided in conjunction with treatment of a *Mental Disorder*, your coverage amount is the applicable coverage described above under “*Outpatient* mental health care services for *Mental Disorders*”.

***Inpatient* and intermediate substance abuse (alcohol and drug) services for substance abuse-related disorders**

(Authorization is required for these services. See “*Inpatient* and intermediate mental health/ substance abuse services” in Chapter 1 for more information.)

- *Inpatient* substance abuse treatment and/or detoxification services are covered in a general hospital or substance abuse facility up to 30 days per calendar year. After 30 days are used, only detoxification services are covered.
- Intermediate substance abuse services. These services are more intensive than traditional *Outpatient* substance abuse services, but less intensive than 24-hour hospitalization. Some examples of Covered intermediate substance abuse services are:
 - day treatment/partial hospital programs; and
 - intensive *Outpatient* programs.

Important: Two substance abuse day treatment/ partial hospital days count as one of the 30 *Inpatient* days you get per calendar year.

Important Note: If these *Inpatient* and intermediate substance abuse services are provided in conjunction with treatment of a *Mental Disorder*, your coverage amount is the applicable coverage described above under “*Inpatient* and intermediate mental health care services for *Mental Disorders*”.

Covered Services, continued

Other Health Services

Ambulance services

- Ground, sea and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance services (e.g., Medflight) when approved by an *Authorized Reviewer*.
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities.
- Non-emergency ambulance transportation for *Medically Necessary* care when the medical condition of the *Member* prevents safe transportation by any other means. Prior approval by an *Authorized Reviewer* is required.

Durable Medical Equipment

Equipment must meet the definition of “*Durable Medical Equipment*” as defined in Appendix A. The following examples of covered and non-covered items are for illustration only. Please call a Member Services Coordinator with questions about whether a particular piece of equipment is covered.

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

Examples of covered items:

- contact lenses or eyeglasses (one pair per prescription change) to replace the natural lens of the eye or following cataract surgery;
- cranial helmets;
- the following equipment when used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes:

- blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind, and
- visual magnifying aids;

- hearing aids (one per ear per prescription change) for *Children* under age 19;
- oral appliances for the treatment of sleep apnea;
- prosthetic devices such as artificial legs, arms, eyes, or breasts;*

*Important Note: Breast prostheses provided in connection with a mastectomy are not subject to the *Durable Medical Equipment* maximum of \$2500 per calendar year.

- scalp hair prostheses made specifically for an individual or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury. (Note: Please see “Scalp hair prostheses or wigs for cancer or leukemia patients” later in this chapter);
- therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease.

Tufts HP will decide whether to purchase or rent the equipment for you. This equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with *Tufts HP* to provide such equipment.

Examples of non-covered items:

- air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers;
- articles of special clothing, and mattress and pillow covers, including hypo-allergenic versions;
- bed pans and bed rails;
- car seats;
- comfort or convenience devices;
- dentures;
- ear plugs;
- elevators, ramps, stair lifts, and scooters;
- exercise equipment;
- foot orthotics and arch supports; , except for therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease;
- heating pads, hot water bottles, and paraffin bath units;
- home blood pressure monitors and cuffs;
- hot tubs, jacuzzis, swimming pools, or whirlpools.

Covered Services, continued

Other Health Services (continued)

Home health care (must be approved by an *Authorized Reviewer*)

The Plan will cover the following services for *Members* who are homebound*:

- home visits by a *Tufts HP* physician;
- inhalation therapy;
- infusion therapy;
- total parenteral nutritional therapy;
- skilled nursing care and physical therapy; and
- the following services, if determined to be a *Medically Necessary* component of skilled nursing or physical therapy:
 - speech therapy;
 - occupational therapy;
 - medical social work;
 - nutritional consultation;
 - the use of *Durable Medical Equipment* (coverage is not subject to limits described in the “*Durable Medical Equipment*” benefit in this chapter); and
 - the services of a part-time home health aide.

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

Note: Home health care services for physical and occupational therapies following an injury or illness are only covered to the extent that those services are provided to restore function lost or impaired, as described under “Short term physical and occupational services” earlier in this chapter. However, those home health care services are not subject to the 60 day limit listed under “Short term physical and occupational services.”

Hospice care services (must be approved by an *Authorized Reviewer*)

The *Plan* will cover the following services for *Members* who are terminally ill (having a life expectancy of 6 months or less):

- physician services;
- nursing care provided by or supervised by a registered professional nurse;
- social work services;
- volunteer services; and
- counseling services (including bereavement counseling services for the *Member’s* family for up to one year following the *Member’s* death).

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

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

Covered Services, continued

Other Health Services (continued)

Injectable medications

Injectable medications that are required for and are an essential part of an office visit to diagnose and treat illness or injury.

Notes:

- Prior authorization and dispensing limitations may apply.
- Medications that are listed on the *Tufts HP* Web site as covered under a *Tufts HP* pharmacy benefit are not covered under the “Injectable medications” benefit. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

Low protein foods

When provided to treat inherited diseases of amino acids and organic acids.

Covered in full up to \$2,500 per calendar year.

Medical supplies

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

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

Notes:

- These medical supplies must be obtained from a vendor that has an agreement with *Tufts HP* to provide such supplies.
- Contact a Member Services Coordinator with coverage questions.

Nonprescription enteral formulas (prior approval by an *Authorized Reviewer* may be required)

Coverage is provided:

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

Scalp hair prostheses or wigs for cancer or leukemia patients

Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. Covered in full up to a maximum benefit of \$350 per calendar year.

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

Special Medical Formulas (prior approval by an *Authorized Reviewer* may be required)

For the treatment of:

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

Covered Services, continued

Prescription Drug Benefit

Introduction

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

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

How Prescription Drugs Are Covered

Prescription drugs will be considered *Covered Services* only if they comply with the “*Tufts HP* Pharmacy Management Programs” section described below and are:

- listed below under “What is Covered”;
- provided to treat an injury, illness, or pregnancy;
- *Medically Necessary*; and
- written by a *Tufts HP* participating physician, except in cases of authorized referral or in *Emergencies*.

For a current list of covered drugs, please go to our Web site at www.tuftshealthplan.com, or call a Member Services Coordinator. For a list of non-covered drugs, please see Appendix C.

The “Prescription Drug Coverage Table” below describes your prescription drug benefit amounts.

- Tier-1 drugs have the lowest *Copayment*; many generic drugs are on Tier-1.
- Tier-2 drugs have the middle *Copayment*.
- Tier-3 drugs have the highest *Copayment*.

Covered Services, continued

Prescription Drug Benefit, Continued

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 HP* designated retail pharmacy.

Tier-1 drugs:

\$5 for up to a 30-day supply
\$10 for a 31-60 day supply
\$15 for a 61-90 day supply

Tier-2 drugs:

\$10 for up to a 30-day supply
\$20 for a 31-60 day supply
\$30 for a 61-90 day supply

Tier-3 drugs:

\$25 for up to a 30-day supply
\$50 for a 31-60 day supply
\$75 for a 61-90 day supply

Note: If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorizes the generic equivalent, you will pay the applicable Tier *Copayment plus* the difference in cost between the brand-name drug and the generic drug.

DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY:

Most maintenance medications, when mailed to you through a *Tufts HP* designated mail services pharmacy.

Tier-1 drugs:

\$10 for up to a 90-day supply

Tier-2 drugs:

\$20 for up to a 90-day supply

Tier-3 drugs:

\$50 for up to a 90-day supply

What is Covered

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

- Prescribed drugs including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under “What is Not Covered” (see “Important Notes” below).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Retin-A ® and similar prescription drug products for individuals through the age of 25.
- Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law*;
***Note:** This Prescription Drug Benefit only describes coverage for oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law. See “Family planning” earlier in this chapter for information about other contraceptive drugs and devices that qualify as *Covered Services*.
- Fluoride for *Children*.
- Injectables and biological serum included on the list of covered drugs on the *Tufts HP* Web site. For more information, call Member Services or see our Web site at www.tuftshealthplan.com.
- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
 - in one of the standard reference compendia;
 - in the medical literature; or
 - by the Commissioner of Insurance.
- Compounded medications, if at least one active ingredient requires a prescription by law.

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

Covered Services, continued

Prescription Drug Benefit, continued

What is Not Covered

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

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the “*What is Covered*” section above).
- Drugs that are listed in Appendix C.
- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for *Children*).
- Topical and oral fluorides for adults.
- Cervical caps, IUDs, Levonorgestrel (Norplant®), Depo-Provera (these are covered under your “Family planning” benefit earlier in this chapter).
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under “Preventive health care” earlier in this chapter.
- Prescriptions written by physicians who do not participate in *Tufts HP*, except in cases of authorized referral or *Emergency* care.
- Prescriptions filled at pharmacies other than *Tufts HP* designated pharmacies, except for *Emergency* care.
- Smoking cessation agents.
- Drugs for asymptomatic onchomycosis, except for Members with diabetes, vascular compromise, or immune deficiency status.
- Retin-A ® and similar prescription drug products for individuals 26 years of age or older, unless *Medically Necessary*.
- Drugs which are dispensed in an amount or dosage that exceeds *Tufts HP*’s established dispensing limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once they become available over-the-counter. In this case, the specific medication is not covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

Covered Services, continued

Prescription Drug Benefit, continued

Tufts HP Pharmacy Management Programs

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

Dispensing Limitations Program:

Tufts HP limits the quantity of selected medications that *Members* can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:

Tufts HP restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from *Tufts HP* for such drugs.

Special Designated Pharmacy Program:

Tufts HP has designated special pharmacies to supply a select number of medications including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C and growth hormone deficiency. These pharmacies specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services to *Members*. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time.

Non-Covered Drugs with Suggested Alternatives:

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

New-To-Market Drug Evaluation Process:

Tufts HP's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. *Tufts HP* then makes a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.

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

IMPORTANT NOTES:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the "*Tufts HP* Pharmacy Management Programs" described above, he or she may submit a request for coverage. *Tufts HP* will approve the request if it meets the guidelines for coverage. For more information, call a Member Services Coordinator.
- The *Tufts Health Plan* Web site has a list of covered drugs with their tiers. *Tufts HP* may change a drug's tier during the year. For example, if a brand drug's patent expires, *Tufts HP* may move the brand drug from Tier-2 to Tier-3 when the generic drug becomes available. Many generic drugs are available on Tier-1.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check our Web site at www.tuftshealthplan.com, or call a Member Services Coordinator.

Covered Services, continued

Prescription Drug Benefit, continued

Filling Your Prescription

Where to Fill Prescriptions:

Fill your prescriptions at a *Tufts Health Plan* designated pharmacy. *Tufts HP* designated pharmacies include:

- for the majority of prescriptions, most of the pharmacies in Massachusetts and additional pharmacies nationwide; and
- for a select number of drug products, a small number of special designated pharmacy providers. (For more information about *Tufts Health Plan's* special designated pharmacy program, see “*Tufts HP 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 HP* participating physician, except in cases of authorized referral or in *Emergencies*.
- When you fill a prescription, provide your Member ID to any *Tufts HP* designated pharmacy and pay your *Copayment*.
- 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 HP* designated pharmacy, call the *Tufts Health Plan* Member Services Department.

Important: Your prescription drug benefit is honored only at *Tufts HP* designated pharmacies. In cases of *Emergency*, please call the *Tufts HP* Member Services Department for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:

If you are required to take a maintenance medication, *Tufts HP* offers you two choices for filling your prescription:

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

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

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of *Tufts HP's* Dispensing Limitations program; or
- medications that are part of *Tufts HP's* Special Designated Pharmacy program

NOTE: Your *Copayments* for covered prescription drugs are shown in the “Prescription Drug Coverage Table” earlier in this section.

Exclusions from Benefits

List of exclusions

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

- A service, supply or medication which is not *Medically Necessary*.
- A service, supply or medication which is not a *Covered Service*.
- A service, supply or medication received outside the *Tufts HP Service Area*, except as described under “How the *Plan Works*” in Chapter 1.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person’s, personal comfort or convenience.
- Custodial care.
- Services related to non-covered services.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

This exclusion does not apply to:

- bone marrow transplants for breast cancer;
- patient care services provided pursuant to a qualified clinical trial for the treatment of cancer; or
- off-label uses of prescription drugs for the treatment of cancer or HIV/AIDS, if you have a Prescription Drug Benefit, which meet the requirements of applicable law.

If the treatment is *Experimental or Investigative*, the *Plan* will not pay for any related treatments which are provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.

- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter.
- Services provided by your relative (by blood or marriage) unless the relative is a *Tufts HP Provider* and the services are authorized by your *PCP*. If you are a *Tufts HP Provider*, you cannot provide or authorize services for yourself or be your own *PCP* for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers’ compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.
- Charges incurred when the *Member*, for his or her convenience, chooses to remain an *Inpatient* beyond the discharge hour.
- Facility charges or related services if the procedure being performed is not a *Covered Service*, except as provided under “Oral health services” earlier in this chapter.

Exclusions from Benefits, continued

- Preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under “Oral health services” earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea, as described earlier in this chapter), including those for TMJ disorders. TMJ disorder-related therapies are not covered except as provided under “Temporomandibular Joint (TMJ) Disorder Treatment” earlier in this chapter.
- Surgical removal or extraction of teeth, except as provided under “Oral health services” earlier in this chapter.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under “Reconstructive surgery and procedures” earlier in this chapter.
- Rhinoplasty, except as provided under “Reconstructive surgery and procedures” earlier in this chapter; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.
- Hair removal, except when *Medically Necessary* to treat an underlying skin condition.
- Costs associated with home births.
- Infertility services for *Members* who do not meet the definition of infertility as described in the “Outpatient Care” section earlier in this chapter; experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days) sperm or embryo cryopreservation unless the *Member* is in active infertility treatment; costs associated with donor recruitment and compensation; infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; and donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
Note: *Tufts HP* may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a *Member’s* future fertility. Prior approval by an *Authorized Reviewer* is required.
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an *Authorized Reviewer*, is provided at a *Tufts HP* ART center, and the *Member* is the sole recipient of the donor’s eggs.
- Preimplantation genetic testing and related procedures performed on gametes or embryos.
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- Human organ transplants, except as described earlier in this chapter.
- Services provided to a non-*Member*, except as described earlier in this chapter for:
 - organ donor charges under “Human organ transplants”;
 - bereavement counseling services under “Hospice care services”; and
 - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or banking of donor sperm or inseminated eggs, under “Infertility services” (to the extent such costs are not covered by the donor’s health coverage, if any).
- Acupuncture; biofeedback, except for treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; *Inpatient* and *Outpatient* weight-loss programs and clinics; relaxation therapies; massage therapies; services by a personal trainer; exercise classes; cognitive rehabilitation programs; cognitive retraining programs. Also excluded are diagnostic services related to any of these procedures or programs.
- Blood, blood donor fees, blood storage fees, or blood substitutes; blood products except for: factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease, and intravenous immunoglobulin (Gamimune, Gammagard SD, Gammar-IV, Iivegam, Sandoglobulin, Venoglobulin-I/S, Cytogram, Polygam) for treatment of severe immune disorders, certain neurologic conditions, infectious conditions and bleeding disorders.
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

Exclusions from Benefits, continued

- Examinations, evaluations or services for educational purposes or developmental purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in this chapter. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities, behavioral problems, and 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.
- Eyeglasses, lenses or frames, except as described under "*Durable Medical Equipment*" earlier in this chapter; refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described earlier in this chapter, the *Plan* will not cover contact lenses or contact lens fittings.
- Hearing aids, except for one hearing aid per ear per prescription change for *Children* under age 19, as described under "*Durable Medical Equipment*" earlier in this chapter.
- Private duty nursing.
- Methadone treatment or methadone maintenance.
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for Members diagnosed with diabetes.

Note: This exclusion also does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:

- are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
 - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.
- Transportation, including transportation by chair car or taxi, except as described in “Ambulance services” earlier in this chapter; lodging related to receiving any medical service.

Chapter 4

When Coverage Ends

Overview

Reasons coverage ends

Coverage ends when any of the following occurs:

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

Benefits after termination

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

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

Continuation and conversion

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

When a *Member* is No Longer Eligible

Loss of eligibility

Your coverage ends on the date you no longer meet your group's eligibility rules.

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

Dependent Coverage

- An enrolled *Dependent's* coverage ends when the *Subscriber's* coverage ends. Coverage of any *Child* of an enrolled *Dependent Child* ends when the enrolled *Dependent Child's* coverage ends.
- An enrolled *Dependent Child's* coverage ends when the *Child* reaches age 19, unless the *Child* is a *Student Dependent* or a *Disabled Dependent*. See Chapter 2, "Continuing Eligibility for *Dependents*", for more information.

If you move out of *Tufts HP's Service Area*

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

Before you move, tell your *Plan Sponsor* or call a Member Services Coordinator to notify *Tufts HP* of the date you are moving. If you keep a residence in the *Service Area* but have been out of the *Service Area* for more than 90 days, coverage ends 90 days after the date you left the *Service Area*.

For more information about coverage available to you when you move out of the *Service Area*, contact a Member Services Coordinator.

When a *Member* is No Longer Eligible, continued

You choose to drop coverage

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

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

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

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

Membership Termination for Misrepresentation or Fraud

Policy

Your coverage may be terminated for misrepresentation or fraud.

Acts of misrepresentation or fraud

Examples of misrepresentation or fraud include:

- false or misleading information on your member application form;
- enrolling as a *Spouse* someone who is not your *Spouse*;
- receiving benefits for which you are not eligible; or
- allowing someone else to use your Member ID card.

Date of termination

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

Payment of claims

After all claims for *Plan* benefits for services rendered after the termination date have been received, the *Plan Sponsor* will refund your contribution to coverage, if any, applicable to any period after the termination date minus any *Plan* payments made for services rendered after the termination date. If the *Plan Sponsor* paid more claims than it received in your contributions, it has the right to collect the excess from you.

Termination of the *Group Contract*

End of *Tufts HP's* and the *Plan Sponsor's* relationship

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

- the *Plan Sponsor's* contract with *Tufts HP* terminates;
- the *Plan Sponsor's* fails to pay its obligation;
- *Tufts HP* stops operating; or
- the *Plan Sponsor* stops operating.

Obtaining a Certificate of Creditable Coverage

Certificates of Creditable Coverage will be mailed to each *Subscriber* and/or *Dependent* upon termination in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting the *Tufts HP* Member Services Department at 1-800-462-0224.

Chapter 5

Continuation of Coverage

Federal Continuation Coverage (COBRA)

Introduction

This topic contains an overview of continuation coverage under federal COBRA law. For more information, please contact your *Employer*.

Rules for federal COBRA continuation

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible to continue coverage after group coverage ends if:

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

Note: Same-sex marriages legally entered into in Massachusetts are not recognized under federal law. Federal COBRA continuation provisions therefore do not apply to same-sex *Spouses*. However, the *Plan Sponsor* provides continuation coverage similar to federal COBRA continuation under this *Plan* for same-sex spouses.

Qualifying events

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

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

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

When federal COBRA coverage is effective

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

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

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

Cost of Coverage

In most cases, you are responsible for payment of 102% of the cost of coverage for the federal COBRA continuation coverage. For more information, contact your former *Employer*.

Duration of Coverage

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

Federal Continuation Coverage (COBRA), continued

FEDERAL COBRA - DURATION OF COVERAGE CHART		
Qualifying Event(s)	Qualified Beneficiaries	Maximum Period of Coverage
<ul style="list-style-type: none"> Termination of <i>Subscriber's</i> employment for any reason other than gross misconduct. Reduction in the <i>Subscriber's</i> work hours. 	<i>Subscriber, Spouse, and Dependent Children</i>	18 months*
<i>Subscriber's</i> divorce, legal separation, entitlement to Medicare, or death.	<i>Spouse and Dependent Children</i>	36 months
<i>Subscriber's</i> or <i>Spouse's</i> enrolled <i>Dependent</i> ceases to be a <i>Dependent Child</i> .	<i>Dependent Child</i>	36 months
<p>*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.</p>		

When coverage ends

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

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

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) allows for continuation of health insurance coverage for individuals who voluntarily or involuntarily leave employment positions to undertake military services.

Under USERRA:

- 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.

For more information, please contact your *Plan Sponsor*.

Nongroup Coverage

Introduction

This topic covers eligibility for and benefits of *Nongroup Coverage* in *Tufts HP*.

Eligibility

If your group coverage ends, you may be eligible to enroll in *Nongroup Coverage*.

Benefits

If you live in Massachusetts (except Martha's Vineyard and Nantucket), you may enroll in a *Tufts HP Nongroup HMO* product. Please note that *Nongroup Coverage* may differ from group coverage. *Annual Coverage Limitations* from the prior group coverage will not continue under *Nongroup Coverage*.

If you live outside Massachusetts, you are not eligible for *Nongroup Coverage*. Please contact your state insurance department for information about coverage options that may be available to you in the state where you reside.

For more information

Please call the *Tufts HP* Member Services Department.

Chapter 6

Member Satisfaction

Overview

Introduction

This chapter contains information about:

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

Address and telephone number

If you write to *Tufts HP*, send the letter to the Appeals and Grievances Department at this address:

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

If you need to call *Tufts HP* about a concern or appeal, contact a Member Services Coordinator at 1-800-462-0224.

Member Satisfaction Process

Process Summary

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

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

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

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

All calls should be directed to *Tufts HP*'s Member Services at **1-800-462-0224**.

Internal Inquiry

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

Member Satisfaction Process, continued

Member Grievance Process

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

It is important that you contact *Tufts HP* as soon as possible to explain your concern. Call a *Tufts HP* Member Services Coordinator, who will document your concern and forward it to a Grievance Analyst in the Appeals and Grievances Department. Grievances may be filed either verbally or in writing. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

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

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

Administrative Grievances

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

Administrative Grievance Timeline

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

Clinical Grievances

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

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

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

Member Satisfaction Process, continued

Internal Member Appeals

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

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

- your complete name and address;
- your ID number and suffix;
- a detailed description of your concern; and
- copies of any supporting documentation.

Within five (5) business days of the receipt of your written appeal, a *Tufts HP* Appeals Analyst will send an acknowledgment of receipt to you and if appropriate, a request for authorization for the release of medical and treatment information. Within 48 hours of receipt of a verbal appeal, a *Tufts HP* Appeals Analyst will summarize your request for an appeal and send a copy to you. This summary will serve as the acknowledgment of receipt of your appeal and if appropriate, will include a request for authorization for the release of medical and treatment information.

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

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

If the case involves an adverse determination (*Medical Necessity* determination), and you would like to address the Committee, you should contact the Appeals Analyst who is handling your appeal. If you ask to attend the meeting, *Tufts HP* will notify you of the date and time. You will have access to any medical information and records relevant to your appeal which are in the possession and control of *Tufts HP*. The time limits of this process will be waived or extended by a mutual written agreement between you or your authorized representative and *Tufts HP*.

The Appeals Analyst will notify you in writing of *Tufts HP's* decision on your appeal, within no more than thirty (30) calendar days of the receipt of your appeal. The decision letter will include the specific reasons for the decision and references to the pertinent plan provisions on which the decision is based.

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

Member Satisfaction Process, continued

Expedited Appeals

You can request an expedited appeal in situations when your health or well-being is at risk, or coverage for your Inpatient care has been denied, by calling a *Tufts HP* Member Services Coordinator. If your request does not meet the guidelines for an expedited appeal, *Tufts HP* will explain your right to use the standard appeal process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a medical director and/or practitioner in a same or similar specialty that typically manages the medical condition, procedure or treatment under review. The medical director and/or practitioner will not have previously reviewed your case.

Tufts HP will notify you by telephone within one (1) business day after receiving the information necessary to conduct your appeal, but no later than 72 hours after *Tufts Health Plan's* receipt of the request.

If you have questions

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

Bills from Providers

Medical Expenses

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

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

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

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

Please note: You must contact *Tufts Health Plan* regarding your bill(s) or send your bill(s) to *Tufts HP* within twelve months from the date of service. If you do not, the bill cannot be considered for payment.

If you receive *Covered Services* from a non-*Tufts HP Provider*, you will be reimbursed up to the *Usual and Customary Charge* for the services.

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

Pharmacy Expenses

If you obtain a prescription from 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 Coordinator or through our Web site at www.tuftshealthplan.com.

Limitation on Actions

You cannot file a lawsuit against *Tufts HP* for failing to pay or arrange for or administer *Covered Services* unless you have completed the *Tufts HP Member Satisfaction Process* and file the lawsuit within two years from the time the cause of action arose.

Chapter 7

Other Plan Provisions

Subrogation

The *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. For example, you may recover some or all of the costs of your health care from your own or someone else's auto or homeowner's insurer, or the person who caused your illness or injury.

In that case, the *Plan* has subrogation rights for the costs of health care services provided to treat your illness or injury. The *Plan* has the right to recover those costs in your name, with or without your consent, directly from that person or company. This is called the *Plan's* right of subrogation. The *Plan's* rights of recovery have priority. The *Plan* can recover against the total amount of any recovery, regardless of whether:

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

Workers' compensation

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

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The *Plan* will not provide coverage for any injury or illness for which it determines that benefits are available under any workers' compensation coverage or equivalent employer liability, or indemnification law.

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

The *Plan's* right of reimbursement

In addition to the rights described above, if you recover money by suit, settlement, or otherwise, you are required to reimburse the *Plan* for the cost of health care services, supplies, medications, and expenses for which the *Plan* paid, or will pay. The *Plan* has 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 reimburse you fully for the illness or injury.

Assignment of benefits

You hereby assign to the *Plan* any benefits you may be entitled to receive from a person or company that caused, or is legally responsible to reimburse you for, your illness or injury. Your assignment is up to the cost of health care services and supplies, and expenses, that the *Plan* paid or will pay for your illness or injury.

Member cooperation

You agree:

- to notify *Tufts HP* of any events which may affect the *Plan's* rights of recovery under this section, such as:
 - injury resulting from an automobile accident, or
 - job-related injuries that may be covered by workers' compensation;
- to cooperate with the *Plan* and *Tufts HP* by:
 - giving the *Plan* and *Tufts HP* information and help, and
 - signing documents to help the *Plan* get reimbursed;
- that the *Plan* and *Tufts HP* may:
 - investigate,
 - request and release information which is necessary to carry out the purpose of this section to the extent allowed by law, and
 - do the things the *Plan* and *Tufts HP* decides are appropriate to protect the rights of recovery.

Subrogation, continued

Subrogation Agent

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

Coordination of Benefits

Application and Purpose

The coordination of benefits (COB) program applies when you are also covered by other plans for hospital, medical, dental or other health care expenses. These plans include personal injury insurance and medical benefits provisions of motor vehicle policies. The COB program prevents duplication of payments for the same health care services. *Tufts HP* will coordinate all benefits described in this *Description of Benefits* with other plans for the *Plan*, consistent with applicable law.

How COB works

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

(1) No COB Rule

If only one of the plans has COB rules, the plan with no rules is the primary plan. If one of the plans has rules which are permitted by law and the other plan has rules not permitted by law, the latter plan is primary.

(2) COB Rule

When all plans which cover you have COB rules consistent with law, the rules listed below apply:

• Employee/Dependent Rule

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

• Birthday Rule

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

• Children of Separated/Divorced Parents Rule

If two or more plans cover a *Dependent Child* whose parents are separated or divorced, the order of payment is:

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

• Court Decree Rule

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

• Active/Inactive Rule

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

• Longer/Shorter Rule

If none of the above rules determines which plan is primary, the plan which has covered a person longer, as defined by law, is primary.

These rules do not apply to Medicare COB. Call *Tufts HP's* COB Department at 1-888-880-8699, x. 1098 for more information on Medicare COB.

Coordination of Benefits, continued

Right to receive and release necessary information

When you enroll, you must include information on your member application about other health coverage you have. After you enroll, you must notify *Tufts HP* of new coverage or termination of other coverage. *Tufts HP* may ask for and give out information needed to coordinate benefits.

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

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

Right to recover overpayment

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

For more information

For more information about COB, contact the *Tufts HP* COB Department at 1-888-880-8699, x. 1098. You can also call a Member Services Coordinator and have your call transferred to the *Tufts HP* COB Department.

Medicare Eligibility

Medicare eligibility

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

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

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

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

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

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

Use and Disclosure of Medical Information

For information about how *Tufts HP* uses and discloses your medical information, please contact a Member Services Coordinator. Information is also available on the *Tufts HP* Web site at www.tuftshealthplan.com.

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

Relationships between *Tufts HP* and *Providers*

Tufts HP* and *Providers

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

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

Circumstances Beyond *Tufts Health Plan's* Reasonable Control

Circumstances beyond *Tufts HP's* reasonable control

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

Group Contract

Acceptance of the terms of the *Plan*

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

Payments

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

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

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

Notice

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

Notice to *Tufts HP*: *Members* should address all correspondence to:
Tufts Health Plan, Member Services, P.O. Box 9166, Watertown, MA 02471-9166.

Enforcement of terms

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

Appendix A

Glossary of Terms

Terms and Definitions

Adoptive Child

An unmarried *Child* under age 19 is an *Adoptive Child* as of the date he or she:

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

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

Annual Coverage Limitations

Annual dollar or time limitations on *Covered Services*.

Authorized Reviewer

Authorized Reviewers review and approve certain services and supplies to Members. They are *Tufts HP's* Chief Medical Officer (or equivalent), or someone he or she names.

Benefit Year

The 12-month period of time in which benefit limits are calculated.

Child

- The *Subscriber's* or *Spouse's* unmarried natural child or stepchild who is under age 19 and:
 - regularly resides with the *Subscriber* or *Spouse*, or
 - qualifies as a *Dependent* for federal tax purposes; or
- the *Subscriber's* or *Spouse's* *Adoptive Child*; or
- the *Child* of an enrolled child; or
- any other *Child* for whom the *Subscriber* has legal guardianship.

Copayment

Fees you pay for *Covered Services*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise.

Covered Services

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

- described 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 mental health care, by *Providers* with recognized expertise in specialty pediatrics.

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

Covering Physician

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

Terms and Definitions, continued

Custodial Care

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

In cases of mental health care or substance abuse care, Inpatient care or intermediate care provided primarily:

- for maintaining the *Member's* or anyone else's safety; or
- for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute hospital level of care or intermediate care.

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

Day Surgery

Any surgical procedure(s) in an operating room under anesthesia for which the *Member* is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day, or in some instances, within twenty-four hours. For hospital census purposes, the *Member* is an *Outpatient* not an *Inpatient*. Also referred to as "Ambulatory Surgery" or "Surgical Day Care."

Dependent

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

Description of Benefits

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

Designated Facility

A facility licensed to treat *Mental Disorders* and/or substance abuse (alcohol and drug). This facility has an agreement with *Tufts HP* to provide Inpatient or day treatment/partial hospitalization services to *Members* assigned to the facility.

Directory of Health Care Providers

A separate booklet which lists *Tufts HP PCPs* and their affiliated *Tufts HP Hospitals* and certain other *Tufts HP Providers*.

Note: This booklet is updated from time to time to show changes in *Providers* affiliated with *Tufts HP*. For information about the *Providers* listed in the *Directory of Health Care Providers*, you can call *Tufts HP Member Services* or check *Tufts HP's* Web site at www.tuftshealthplan.com.

Disabled Dependent

The *Subscriber's* unmarried *Child* who:

- became permanently physically or mentally disabled before age 19 (or before losing eligibility as a *Student Dependent*)
- is incapable of supporting himself or herself due to disability;
- lives with the *Subscriber* or *Spouse*; and
- was covered under the *Subscriber's Family Coverage* immediately before reaching age 19 (or before losing eligibility as a *Student Dependent*) or has been covered by other group health coverage since the disability began.

Terms and Definitions, continued

Durable Medical Equipment

Devices or instruments of a durable nature that:

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

Effective Date

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

Emergency

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

- serious jeopardy to the physical and/or 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.

Employee

An individual who is employed by the *Employer* for at least the minimum number of hours specified under the *Plan* and/or who is defined as an *Employee* by M.G.L. Ch. 32B

Employer

A governmental unit which participates in the Minuteman Nashoba Health Group. The Minuteman Nashoba Health Group, the *Plan Sponsor*, contracts with *Tufts HP* for the provision of certain services and the availability of a preferred network to the *Plan* and who is responsible for funding all *Covered Services* under the *Plan* described in this *Description of Benefits*.

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is *Experimental or Investigative* if any of the following is true:

- 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; or
- 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; or
- reliable evidence shows that the treatment: is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or

Terms and Definitions, continued

- reliable evidence shows that prevailing opinion among experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis.

Note: Reliable evidence, as used in this section, shall mean only: published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment; or the written informed consent form used by the treating facility or by another facility studying substantially the same treatment.

Family Coverage

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

Group Contract

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

Individual Coverage

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

Inpatient

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

Medically Necessary

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

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

In determining coverage for *Medically Necessary* services, *Tufts HP* uses guidelines which are:

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

Member

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

Mental 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.

Nongroup Coverage

A separate plan of coverage which may be available to a former *Member*.

Open Enrollment Period

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

Terms and Definitions, continued

Outpatient

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

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

Physician Organization

A *Physician 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.

Plan

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

Plan Sponsor

The person(s) or entity designated by the *Plan* as the *Plan Sponsor* and is responsible for funding all covered services described in this Description of Benefits. The *Plan Sponsor* is the Minuteman Nashoba Health Group. Tufts HP is not the *Plan Sponsor*.

Primary Care Physician (PCP)

The *Tufts HP* physician you have chosen from the *Tufts HP Directory of Health Care Providers* who has an agreement with *Tufts HP* to provide primary care and to coordinate, arrange, and authorize the provision of *Covered Services*.

Provider

A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, physicians, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, licensed speech-language pathologists, and licensed audiologists.

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

Reasonable Charge

See "Usual and Customary Charge".

Routine Nursery Care

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

Service Area

The *Service Area* (sometimes referred to as the "Enrollment Service Area") is the geographical area within which *Tufts HP* has developed a network of *Providers* to afford *Members* adequate access to *Covered Services*. The Enrollment *Service Area* consists of the Primary Service Area and the Extended Service Area.

The Primary *Service Area* is comprised of:

- all of Massachusetts, except Nantucket and Martha's Vineyard; and
- the cities and towns in New Hampshire and Rhode Island in which *Tufts HP PCPs* are located.

The Extended Service Area includes certain towns in Connecticut, New Hampshire, Rhode Island and Vermont which surround the Primary Service Area and are within a reasonable distance to the location of *Primary Care Physicians*.

Notes:

- There are generally no *Tufts HP PCPs* located within the Extended Service Area.
- For a list of cities and towns in the *Service Area*, call *Tufts HP* Member Services or check the Web site at www.tuftshealthplan.com.

Terms and Definitions, continued

Spouse

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

Skilled

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

Student Dependent

The Subscriber's unmarried *Child* who is:

- between age 19 and age 25; and
- enrolled as a full-time student at an accredited educational institution.

Subscriber

The person who is employed by the *Employer* for at least the minimum number of hours specified in Chapter 2; and enrolls in *Tufts Health Plan* and signs the member application form on behalf of himself or herself and any *Dependents*.

Tufts Health Plan or Tufts HP

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

Tufts HP Hospital

A hospital which has an agreement with *Tufts Health Plan* to provide certain *Covered Services* to *Members*. *Tufts HP Hospitals* are independent. They are not owned by *Tufts Health Plan*. *Tufts HP Hospitals* are not *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees.

Tufts HP Provider

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

Urgent Care

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

Usual and Customary Charge

The lesser of the:

- amount charged; or
- amount that *Tufts HP* determines, based upon the fees most often charged by similar *Providers* for the same service in the geographic area in which it is given, to be the reasonable amount for the service.

Also referred to as "Reasonable Charge".

You, Your

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

Appendix B – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2006 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter.

IMPORTANT NOTE: Please see our Web site at www.tuftshealthplan.com for the most current list or call a Member Services Coordinator at 1-800-462-0224.

Brand Name	Suggested Alternatives and Additional Information
Abilify Solution	Abilify tablets (Tier-2, middle <i>Copayment</i>)
AcipHex	Prilosec OTC (OTC, not covered), Nexium or Prevacid (Tier-3, highest <i>Copayment</i>)
Atacand	Benicar, Cozaar, or Diovan (Tier-3, highest <i>Copayment</i>)
Atacand HCT	Benicar HCT, Diovan HCT or Hyzaar (Tier-3, highest <i>Copayment</i>)
Avalide	Benicar HCT, Diovan HCT, or Hyzaar (Tier-3, highest <i>Copayment</i>)
Avapro	Benicar, Cozaar, or Diovan (Tier-3, highest <i>Copayment</i>)
Axid	cimetidine, famotidine, nizatidine, or ranitidine (Tier-1, lowest <i>Copayment</i>)
Beconase AQ	Nasacort AQ, Flonase, Nasonex or Rhinocort Aqua (Tier-2, middle <i>Copayment</i>)
BiDil	isosorbide dinitrate and hydralazine (Tier-1, lowest <i>Copayment</i>)
Bright Beginnings Prenatal Supplement Bars	prenatal vitamins plus iron (Tier-1, lowest <i>Copayment</i>)
Capoten	captopril (Tier-1, lowest <i>Copayment</i>)
Clarinex	loratidine (OTC, not covered); fexofenadine (Tier-1, lowest <i>Copayment</i>); or Zyrtec (Tier-3, highest <i>Copayment</i>)
Clarinex-D 24-Hour	loratidine plus pseudoephedrine (OTC, not covered); fexofenadine (Tier-1, lowest <i>Copayment</i>) plus pseudoephedrine (OTC, not covered); or Zyrtec-D 12-Hour (Tier-3, highest <i>Copayment</i>)
Dynacin	minocycline HCl capsules (Tier-1, lowest <i>Copayment</i>)
EC Naprosyn	enteric-coated naproxen (Tier-1, lowest <i>Copayment</i>)
Evoclin	clindamycin phosphate 1% lotion (Tier-1, lowest <i>Copayment</i>)
Flagyl, Flagyl ER	metronidazole tablets (Tier-1, lowest <i>Copayment</i>)
Genotropin	Humatrope, Norditropin, Nutropin, Protropin, Saizen (Tier-2, middle <i>Copayment</i>)
Klonopin	clonazepam (Tier-1, lowest <i>Copayment</i>)
Lagesic	Aceta-Gesic (OTC, not covered)
Lidex , Lidex E	fluocinonide and fluocinonide E (Tier-1, lowest <i>Copayment</i>)
Lopressor	metoprolol (Tier-1, lowest <i>Copayment</i>)
Lupron 1mg/ 0.2mL vial and kit	leuprolide 1mg/0.2 mL vial and kit (Tier-1, lowest <i>Copayment</i>)
Megace ES	megestrol acetate oral suspension (Tier-1, lowest <i>Copayment</i>)
Mevacor	lovastatin (Tier-1, lowest <i>Copayment</i>)
Micardis	Benicar, Diovan or Cozaar (Tier-3, highest <i>Copayment</i>)
Micardis HCT	Benicar HCT, Diovan HCT or Hyzaar (Tier-3, highest <i>Copayment</i>)
Minocin	minocycline HCL capsules (Tier-1, lowest <i>Copayment</i>)
Monodox	doxycycline monohydrate (Tier-1, lowest <i>Copayment</i>)
Myrac	minocycline tablets (Tier-1, lowest <i>Copayment</i>)
Naprelan	naproxen sodium extended release (Tier-1, lowest <i>Copayment</i>)
Niravam	alprazolam (Tier-1, lowest <i>Copayment</i>)
Pepcid (except suspension)	cimetidine, famotidine, nizatidine, or ranitidine (Tier-1, lowest <i>Copayment</i>)
Prevacid Naprapac	naproxen (Tier-1, lowest <i>Copayment</i>) plus Prilosec OTC (OTC, not covered), Nexium or Prevacid (Tier-3, highest <i>Copayment</i>)

Italicized words are defined in Appendix A.

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To contact Member Services, call 1-800-462-0224, or see our Web site at www.tuftshealthplan.com.

Brand Name	Suggested Alternatives and Additional Information
Prilosec	Prilosec OTC (OTC, not covered), Nexium or Prevacid (Tier-3, highest <i>Copayment</i>) Please note: Prilosec is covered for Members age 12 years and under (Tier-3, highest <i>Copayment</i>).
Prinivil	lisinopril (Tier-1, lowest <i>Copayment</i>)
Prinzide	lisinopril/hydrochlorothiazide (Tier-1, lowest <i>Copayment</i>)
Relenza	amantadine (Tier-1, lowest <i>Copayment</i>)
Reprexain	hydrocodone/ibuprofen (Tier-1, lowest <i>Copayment</i>)
Sporanox capsules (itraconazole)	Lamisil tablets (Prior Authorization is required) (Tier-3, highest <i>Copayment</i>)
Tamiflu	amantadine (Tier-1, lowest <i>Copayment</i>)
Teveten	Benicar, Cozaar, or Diovan (Tier-3, highest <i>Copayment</i>)
Teveten HCT	Benicar HCT, Diovan HCT, or Hyzaar (Tier-3, highest <i>Copayment</i>)
Valium	diazepam (Tier-1, lowest <i>Copayment</i>)
Vasotec	enalapril (Tier-1, lowest <i>Copayment</i>)
Vicoprofen	hydrocodone/ibuprofen (Tier-1, lowest <i>Copayment</i>)
Xanax/Xanax XR	alprazolam (Tier-1, lowest <i>Copayment</i>)
Zegrid	Prilosec OTC (OTC, not covered), Nexium or Prevacid (Tier-3, highest <i>Copayment</i>)
Zocor	lovastatin (Tier-1, lowest <i>Copayment</i>), Lipitor, Pravachol, or Crestor (Tier-2, middle <i>Copayment</i>)