

Minuteman Nashoba Health Group

#14120-000

Point of Service Option

Description of Benefits

June 1, 2010



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



New Members—Register Now at www.tuftshealthplan.com
for Fast Access to Your Personal Benefit Information

With Administrative Services Provided by

TUFTS  Health Plan

705 Mount Auburn Street
Watertown MA 02472-1508

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE

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

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

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

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

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN

705 Mount Auburn Street
P.O. Box 9170
Watertown, Massachusetts 02471-9170

Hours: Monday through Thursday 8:00 am - 7:00 pm E.S. T.
Friday 8:00 am - 5:00 pm E.S.T.

IMPORTANT PHONE NUMBERS:

Emergency Care

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

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

Liability Recovery

Call the Liability and Recovery Department at 1-888-880-8699, x. 1098 for questions about coordination of benefits and workers' compensation. For example, call the Liability and Recovery Department if you have any questions about how *Tufts Health Plan (Tufts HP)* coordinates coverage with other health care coverage that you may have. The Liability and Recovery Department is available from 8:30 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 Specialist at 1-800-462-0224. If you are uncertain which department can best address your questions, call Member Services.

Member Services Department

Call the *Tufts HP* Member Services Department at 1-800-462-0224 for general questions, assistance in choosing a *Primary Care Provider (PCP)*, benefit 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 the *Tufts HP* Mental Health Department at 1-800-208-9565.

Services for Hearing Impaired Members

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

Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call 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 Specialist 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.tuftshealthplan.com.

Tufts Health Plan Address And Telephone Directory, continued

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 *Tufts HP* Member Services Department.

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

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ នៃគំរោងថែរក្សាសុខភាពរបស់ 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 «Тафтс» 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: 1-800-868-5850

MassRelay

1-800-720-3480

Plan Information

<i>Plan Name</i>	Minuteman Nashoba Health Group Point of Service Option (POS) Plan
<i>Plan Sponsor</i>	Minuteman Nashoba Health Group
<i>Plan Sponsor Address</i>	c/o Group Benefits Strategies, Inc. 15 Midstate Drive, Suite 110 Auburn, MA 01501
Employer's ID Number (EIN)	04-6001121
<i>Plan Number</i>	14120-000
<i>Tufts HP Effective Date</i>	This plan became effective as of June 1, 1999.
<i>Description of Benefits Effective Date</i>	This <i>Description of Benefits</i> is effective June 1, 2010. It may be amended in accordance with Chapter 7.
<i>Plan Year</i>	June 1 st – May 31 st .
Benefit Year	Calendar Year.
<i>Plan Sponsor and Agent for Service of Legal Process</i>	Minuteman Nashoba Health Group c/o Group Benefits Strategies, Inc. 15 Midstate Drive, Suite 110 Auburn, MA 01501
Type of Plan	Medical and Prescription Benefits
<i>Plan Administration</i>	The <i>Plan</i> is administered by the Tufts Health Plan. The cost of medical benefits is the responsibility of the <i>Plan Sponsor</i> under a self-funded arrangement.
Collective Bargaining Agreement	This <i>Plan</i> is maintained pursuant to an agreement by and among the participating governmental units of the Minuteman Nashoba Health Group. A copy of such agreement may be obtained upon written request from participating governmental units.
<i>Plan Fiscal Year</i>	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>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 Member shall be required to terminate, modify, amend or change the <i>Plan</i> .
Employee Contribution to Benefits	Benefits for <i>Employee</i> only: <ul style="list-style-type: none">• The <i>Employee</i> is required to contribute to the cost of benefits. Benefits for <i>Employee</i> and <i>Dependents</i> : <ul style="list-style-type: none">• The <i>Employee</i> is required to contribute to the cost of benefits.

Point of Service Plan

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 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*.

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

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 *Tufts HP*, each time you need health care services, you may choose to obtain your health care either:

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

Your choice will determine the level of benefits you receive for your health care services:

- ***Authorized Level of Benefits:*** If your care is provided or authorized by your *PCP*, you will be covered at the *Authorized Level of Benefits*. Your *PCP* will authorize you to receive care from other *Tufts HP Providers* unless the care you need is not available within *Tufts HP's* network of *Tufts HP Providers*. In that case, your *PCP*, after obtaining approval from an *Authorized Reviewer*, will refer you to a *Provider* not affiliated with *Tufts HP*. 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* and receive coverage at the *Authorized Level of Benefits*. See Chapter 1, "How Your Point of Service Plan Works," for more information.
- ***Unauthorized Level of Benefits:*** If your care is not provided or authorized by your *PCP*, you will be covered at the *Unauthorized Level of Benefits*. In the case of *Inpatient* mental health and *Inpatient* substance abuse services, if you go to any facility which is not a *Designated Facility*, your coverage will be at the *Unauthorized Level of Benefits*. See "Inpatient Mental Health and Substance Abuse Services" in Chapter 1 for more information.
- ***Covered Services Outside of the 50 United States:*** *Emergency* care services provided to you outside of the 50 United States qualify as *Covered Services*. In addition, *Urgent Care* services provided to you while you are traveling outside of the 50 United States also qualify as *Covered Services*. However, any other service, supply, or medication provided to you outside of the 50 United States is excluded under this plan.

For additional information about these levels of benefits and how to receive covered health care services, please see Chapter 1. If you have any questions, please call *Tufts HP* Member Services at 1-800-462-0224

PLEASE READ THIS *DESCRIPTION OF BENEFITS* CAREFULLY.

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Benefit Overview

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

COINSURANCE

The Member pays 20% of the *Reasonable Charge* for all *Covered Services* provided in the United States that are not provided or authorized by the *Member's PCP*. The *Plan* will cover the remaining charges for *Covered Services*. (The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.) In most instances, there is no *Coinsurance* for *Covered Services* provided or authorized by the *Member's PCP*.

Note: *Emergency care visits at the Unauthorized Level of Benefits are not subject to Coinsurance. Instead, you pay a Copayment for those visits. See the "Copayments" section below for more information.*

COPAYMENTS

• **Emergency Care (Authorized and Unauthorized Levels of Benefits):**

- Emergency room (per Emergency room visit)\$50
- In *Provider's* office (per office visit).....\$10

Note:

An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.

• **Other Covered Services (Authorized Level of Benefits only):**

- Office Visit (per visit)\$10
- *Day Surgery* (per admission) Covered in full.
- *Inpatient Care* (per admission)..... Covered in full.

Note: For certain *Outpatient* services listed as "covered in full" at the *Authorized Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit.

Benefit Overview, continued

DEDUCTIBLE (Unauthorized Level of Benefits Only)

Deductible (Individual)

The Plan has an individual *Deductible* of \$200 per *Member* per calendar year for all *Covered Services* provided at the *Unauthorized Level of Benefits* (or, with respect to *Inpatient* mental health or substance abuse admissions, if the *Covered Services* were not provided and/or authorized by a *Designated Facility*). For more information about what does and does not apply to the *Deductible*, please see the definition of “*Deductible*” in Appendix A.

Deductible (Family)

All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the \$400 Family *Deductible*.

Once the Family *Deductible* has been met during a calendar year, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that calendar year.

OUT-OF-POCKET MAXIMUM (Unauthorized Level of Benefits Only)

Out-of-Pocket Maximum (Individual)

The Plan has an individual *Out-of-Pocket Maximum* of \$2200 per *Member* per calendar year for all *Covered Services* provided at the *Unauthorized Level of Benefits*. Only the *Deductible* and *Coinsurance* count toward the *Out-of-Pocket Maximum*. For more information about your *Out-of-Pocket Maximum*, please see the definition of “*Out-of-Pocket Maximum*” in Appendix A.

Out-of-Pocket Maximum (Family)

All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the \$4400 Family *Out-of-Pocket Maximum*.

Once the Family *Out-of-Pocket Maximum* has been met during a calendar year, all enrolled *Members* in a family will thereafter have satisfied their Individual *Out-of-Pocket Maximums* for the remainder of that calendar year.

PREREGISTRATION PENALTY

You must pay the *Preregistration Penalty* listed below for failure to *Preregister* a hospitalization or hospital transfer in accordance with Chapter 1.

- ***Authorized Level of Benefits:***

There is no *Preregistration Penalty* for a hospitalization or hospital transfer at the *Authorized Level of Benefits*. As long as your *Inpatient* procedure is provided by a *Tufts HP Provider*, you are not responsible for *Preregistering* the hospitalization or transfer. Your *Tufts HP Provider* will *Preregister* the procedure for you.

- ***Unauthorized Level of Benefits:***

You must pay a \$300 *Preregistration Penalty* for failure to *Preregister* a hospitalization or hospital transfer at the *Unauthorized Level of Benefits* in accordance with Chapter 1. For more information, please see “*Preregistration*” in Chapter 1.

Note: This *Preregistration Penalty* cannot be used to meet the *Deductibles* or *Out-of-Pocket Maximums* described earlier in this section.

A *Preregistration Penalty* does not apply to this plan.

Benefit Overview, continued

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

COVERED SERVICE	Authorized Level of Benefits	Unauthorized Level of Benefits	PAGE
	Coverage	Coverage	
Emergency Care			
Treatment in an Emergency room	Emergency room <i>Copayment</i> *	Emergency room <i>Copayment</i> *	3-1
	*Emergency room <i>Copayment</i> waived if admitted as an <i>Inpatient</i> . Observation services will take an <i>Emergency room Copayment</i> .		
Treatment in a <i>Provider’s</i> office	Office Visit <i>Copayment</i> .	Office Visit <i>Copayment</i> .	3-1
You should call <i>Tufts Health Plan</i> within 48 hours after <i>Emergency care</i> is received. If admitted as an <i>Inpatient</i> after receiving <i>Emergency Care</i>, you or someone acting for you must call <i>Tufts Health Plan</i> within 48 hours in order to be covered at the <i>Authorized Level of Benefits</i>.			

Outpatient Care			
Allergy testing and treatment	Office Visit <i>Copayment</i> .	<i>Deductible and Coinsurance</i> .	3-2
Allergy injections	Office Visit <i>Copayment</i> .	<i>Deductible and Coinsurance</i> .	3-2
Cardiac rehabilitation	Covered in full.	<i>Deductible and Coinsurance</i> .	3-2
Chemotherapy	Covered in full.	<i>Deductible and Coinsurance</i> .	3-2
Chiropractic care See “Spinal manipulation”			
Cytology examinations (Pap Smears) (BL)	Covered in full.	<i>Deductible and Coinsurance</i> .	3-2
Diabetes self-management training and educational services	Office Visit <i>Copayment</i> .	<i>Deductible and Coinsurance</i> .	3-2

(AR) – These services may require approval by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.

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

Benefit Overview, continued

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

COVERED SERVICE	Authorized Level of Benefits	Unauthorized Level of Benefits	PAGE
	Coverage	Coverage	
Outpatient Care, continued			
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 cardiology 	General imaging: Covered in full. MRI/MRA Covered in full. CT/CTA: Covered in full. PET: Covered in full. Nuclear cardiology: Covered in full.	<i>Deductible and Coinsurance.</i>	3-2
Diagnostic screening procedures (for example, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies) (AR)	Diagnostic screening procedure only: Covered in full. Diagnostic screening procedure accompanied by treatment/surgery (for example, polyp removal): Covered in full.	<i>Deductible and Coinsurance.</i>	3-2
Early intervention services for a <i>Dependent Child</i> (BL)	Covered in full up to \$5,200 per calendar year, up to a lifetime maximum of \$15,600.	<i>Deductible and Coinsurance up to \$5,200 per calendar year, up to a lifetime maximum of \$15,600.</i>	3-2
Family planning (procedures, services, and contraceptives)	<u>Office Visit:</u> <u>Office Visit Copayment.</u> <u>Day Surgery:</u> Covered in full.	<i>Deductible and Coinsurance.</i>	3-3

(AR) – These services may require approval by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.

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

Benefit Overview, continued

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

COVERED SERVICE	Authorized Level of Benefits	Unauthorized Level of Benefits	PAGE
	Coverage	Coverage	
Outpatient Care, continued			
Hemodialysis	Covered in full.	<i>Deductible and Coinsurance.</i>	3-3
Human leukocyte antigen testing or histocompatibility locus antigen testing	Covered in full.	<i>Deductible and Coinsurance.</i>	3-3
Immunizations	Covered in full.	<i>Deductible and Coinsurance.</i>	3-3
Infertility services (AR)	Office Visit <i>Copayment.</i> Note: Approved Assisted Reproductive Technology services are covered in full.	<i>Deductible and Coinsurance.</i>	3-4
Laboratory services (AR)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-4
Lead screenings	Covered in full.	<i>Deductible and Coinsurance.</i>	3-4
Mammograms (BL)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-4
Nutritional counseling	Office Visit <i>Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-5
Office visits to diagnose and treat illness or injury	Office Visit <i>Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-5
Oral health services (AR)	Emergency room: Emergency Room Copayment. Office Visit: Office Visit <i>Copayment.</i> Inpatient: Covered in full. Day Surgery: Covered in full.	Emergency room: Emergency Room <i>Copayment.</i> Office Visit for Emergency care: Office Visit <i>Copayment.</i> All other services: <i>Deductible and Coinsurance.</i>	3-5
Outpatient surgery in a Provider’s office	Office Visit <i>Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-6
Patient care services provided as part of a qualified clinical trial (for treatment of cancer)	Office Visit <i>Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-6
Preventive care for <i>Members</i> under age 6	Office Visit <i>Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-7
Preventive care for <i>Members</i> age 6 and older	Office Visit <i>Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-7
Radiation therapy	Covered in full.	<i>Deductible and Coinsurance.</i>	3-7

(AR) – These services may require approval by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.

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

Benefit Overview, continued

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

COVERED SERVICE	Authorized Level of Benefits	Unauthorized Level of Benefits	PAGE
	Coverage	Coverage	
Outpatient Care, continued			
Respiratory therapy and pulmonary rehabilitation services	Covered in full.	<i>Deductible and Coinsurance.</i>	3-7
Short term physical and occupational therapy services (AR) (BL)	<i>Physical therapy services: Office Visit Copayment</i> <i>Occupational therapy services: Office Visit Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-7
Therapy for speech, hearing and language disorders (AR)	<i>Office Visit Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-7
Spinal manipulation (BL)	<i>Office Visit Copayment.</i> (No PCP referral required when services obtained from a Tufts HP Provider.)	<i>Deductible and Coinsurance.</i>	3-8
Vision care services			
Annual routine eye examination (BL)	<i>Office Visit Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-8
Other vision care services	<i>Office Visit Copayment.</i>	<i>Deductible and Coinsurance.</i>	3-8

(AR) – These services may require approval by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.

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

Benefit Overview, continued

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

COVERED SERVICE	Authorized Level of Benefits	Unauthorized Level of Benefits	PAGE
	Coverage	Coverage	
Day Surgery			
<i>Day Surgery (AR)</i>	Covered in full.	<i>Deductible and Coinsurance.</i>	3-8
Inpatient Care			
Bone marrow transplants, hematopoietic stem cell transplants, and human solid organ transplants (AR)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-9
Extended care services (BL) (AR)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-9
Hospital services (acute care) (AR)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-9
Patient care services provided as part of qualified clinical trial (for treatment of cancer)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-10
Reconstructive surgery and procedures (AR)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-10

(AR) – These services may require approval by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.

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

Benefit Overview, continued

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

COVERED SERVICE	Authorized Level of Benefits	Unauthorized Level of Benefits	PAGE
	Coverage	Coverage	
Maternity Care			
<i>Outpatient</i> 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> .	<i>Office Visit Copayment</i> . Note: This <i>Office Visit 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.	<i>Deductible and Coinsurance.</i>	3-10
<i>Inpatient</i> maternity care	Covered in full.	<i>Deductible and Coinsurance.</i>	3-10
Mental Health and Substance Abuse Services			
Mental Health and Substance Services To contact the Tufts HP Mental Health Department, call 1-800-208-9565.			
<i>Outpatient</i> services (AR)	<i>Office Visit Copayment</i> .	<i>Deductible and Coinsurance.</i>	3-12
<i>Inpatient</i> services (AR)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-13
Intermediate care (AR)	Covered in full.	<i>Deductible and Coinsurance.</i>	3-13

(AR) – These services may require approval by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.

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

Benefit Overview, continued

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

COVERED SERVICE	Authorized Level of Benefits	Unauthorized Level of Benefits	PAGE
	Coverage	Coverage	
Other Health Services			
Ambulance services (AR)	Covered in full.	Covered in full.	3-16
Durable Medical Equipment (AR) (BL)	Covered in full up to a maximum of \$2500 per calendar year.*	Deductible and Coinsurance up to a maximum benefit of a \$2500 per calendar year*.	3-16
Home health care (AR)	Covered in full.	Deductible and Coinsurance.	3-18
Hospice care services (AR)	Covered in full.	Deductible and Coinsurance.	3-18
Injectable, infused, or inhaled medications (AR)	Covered in full.	Deductible and Coinsurance.	3-19
Medical supplies	Covered in full.	Deductible and Coinsurance.	3-19
Scalp hair prostheses or wigs for cancer or leukemia patients (BL)	Covered in full up to a maximum benefit of a \$350 per calendar year*.	Deductible and Coinsurance subject to a maximum benefit of \$350 per calendar year*.	3-19
*Authorized and Unauthorized combined.			
Special medical formulas			
Low protein foods (BL)	Covered in full up to \$2500 per calendar year*.	Deductible and Coinsurance. Coverage is provided up to \$2500 per calendar year*.	3-19
*Authorized and Unauthorized combined.			
Nonprescription enteral formulas (AR)	Covered in full.	Covered in full.	3-19
Special medical formulas (AR)	Covered in full.	Covered in full.	3-19

Prescription Drug Benefit

For information about your *Copayments* for covered prescription drugs, see the “Prescription Drug Benefit” section in Chapter 3.

(AR) – These services may require approval by an *Authorized Reviewer* at both *Authorized* and *Unauthorized Levels of Benefits*.
 (BL) – Benefit Limit applies. See “Benefit Limits” section following this section and “Covered Services” in Chapter 3.

Benefit Limits

Durable Medical Equipment

The maximum benefit payable in each calendar year for *Covered Services* (*Authorized* and *Unauthorized Levels* combined) is \$2500 per person. See “*Durable Medical Equipment*” in Chapter 3 for information about the benefits payable for *Covered Services* provided at the *Unauthorized Level of Benefits*.

Important Note: These benefit limits do not apply to breast prostheses following a mastectomy.

Early intervention services

The maximum benefit payable is \$5,200 in each calendar year, up to a lifetime maximum of \$15,600 (*Authorized* and *Unauthorized Levels* combined).

Extended Care Services

The maximum benefit payable in each calendar year is 100 days (*Authorized* and *Unauthorized Levels* combined).

Short-term Physical and Occupational Therapy Services

The maximum benefit payable in each calendar year for physical therapy services is 30 visits (*Authorized* and *Unauthorized Levels of Benefits* combined).

The maximum benefit payable in each calendar year for occupational therapy services is 30 visits (*Authorized* and *Unauthorized Levels of Benefits* combined).

Spinal Manipulation

The maximum benefit payable in each calendar year is 12 visits per person (*Authorized* and *Unauthorized Levels* combined).

Note: Spinal manipulation services for *Members* age 12 and under are not covered.

Chapter 1

How Your Point of Service Plan Works

Eligibility for Benefits

When you need health care services, you may choose to obtain these services:

- from or authorized by your *Tufts HP PCP (Authorized Level of Benefits)*; or
- from any health care *Provider* without your *PCP's* authorization (*Unauthorized Level of Benefits*).

Your choice will determine the level of benefits you receive for your health care services. The *Plan* covers only the services and supplies described as *Covered Services* in Chapter 3.

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

Authorized Level of Benefits

If your care is provided or authorized by your *Tufts HP PCP*, you are entitled to coverage for *Covered Services* at the *Authorized Level of Benefits*. For mental health and substance abuse services, you must obtain approval from a *Tufts HP Mental Health Authorized Reviewer*.

Authorized Level of Benefits

You will be required to pay a *Copayment* for certain *Covered Services* you receive at the *Authorized Level of Benefits*. For more information about your *Copayments*, please see "Benefit Overview" at the front of this *Description of Benefits*. When a *Tufts HP Provider* provides your care, you do not have to submit any claim forms; the *Tufts HP Provider* submits the claim forms to *Tufts HP*. In order to obtain coverage at the *Authorized Level of Benefits*, you must live in or near the *Service Area* so that you can access *Tufts HP Providers*. Otherwise, your coverage will be at the *Unauthorized Level of Benefits*.

If your *PCP* cannot provide the services you need, he or she will refer you to another *Tufts HP Provider*. If the services you need are not available from any *Tufts HP Providers*, your *PCP*, after obtaining approval from an *Authorized Reviewer*, will refer you to a *Provider* not affiliated with *Tufts HP*. Your *PCP* is responsible for completing a referral form and sending it to the specialist prior to your visit for specialty care. In order to expedite matters, sometimes your *PCP* will give you the referral form to deliver to the specialist. Your *PCP* must authorize, in advance, any referral that a specialist may make to another *Provider*. A *PCP* may authorize a standing referral for specialty health care provided by a *Tufts HP Provider*.

Important Notes:

- There are special rules for receiving *Inpatient* mental health and *Inpatient* substance abuse services at the *Authorized Level of Benefits*. Those rules are described under "*Inpatient Mental Health and Substance Abuse Services*" later in this chapter.
- A referral to a specialist must be obtained from your *PCP* **before** you receive any *Covered Services* from that specialist. If you do not obtain a referral **prior** to receiving services, the services will be covered at the *Unauthorized Level of Benefits*.

Authorized Level of Benefits, continued

Selecting a PCP

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

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

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

You do not need to select a *PCP* in order to receive coverage at the *Authorized Level of Benefits* for *Inpatient* mental health and *Inpatient* substance abuse services. You will receive coverage for these services at the *Authorized Level of Benefits* as long as the services are provided or authorized by a *Designated Facility*. See "*Inpatient* Mental Health and Substance Abuse Services" later in this chapter.

Notes:

- Under certain circumstances required by law, if your *Provider* is not in the *Tufts HP* network, you will be covered for a short period of time for services provided by your *Provider*. A Member Specialist can give you more information. Please see "Continuity of Care" later in this chapter.
- For additional information about a *PCP* or specialist, the Massachusetts Board of Registration in Medicine provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 654-9800 or www.massmedboard.org.

Changing Your PCP

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

Canceling Appointments

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

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*, our 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 Member Services.

Authorized Level of Benefits, continued

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

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

- *Emergency* care in an Emergency room or *Provider's* office. (**Note:** If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts HP Provider* within 48 hours after receiving care. Notification from the attending physician satisfies this requirement.)
- Mammograms at the following intervals:
 - one baseline at 35-39 years of age;
 - one every year at age 40 and older; or
 - as otherwise *Medically Necessary*.
- Care in a limited service medical clinic, if available.
- Care in an urgent care center, if available.
- Pregnancy terminations.
- Routine eye exam.
- Medical treatment provided by an optometrist.
- 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; and
 - routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Unauthorized Level of Benefits

Unauthorized Level of Benefits

If your care is not provided or authorized by your *PCP*, you are entitled to coverage for *Covered Services* at the *Unauthorized Level of Benefits*. Each time you need to receive medical care, you may choose to receive that care without the authorization of your *PCP*.

If you obtain such unauthorized care (or if you have not chosen a *PCP*), you pay a *Deductible* for your *Covered Services* at the *Unauthorized Level of Benefits* in each calendar year. After that, you pay *Coinsurance* for all *Covered Services* you receive at the *Unauthorized Level of Benefits* up to the *Out-of-Pocket Maximum*. The *Deductible*, *Coinsurance* and *Out-of-Pocket Maximum* amounts are listed in "Benefit Overview" at the front of this *Description of Benefits*. After you have reached the *Out-of-Pocket Maximum*, you are covered in full for the *Reasonable Charge* for all *Covered Services* in that calendar year. You pay any excess above the *Reasonable Charge*. Finally, you must submit a claim form for each unauthorized service that is provided by a *Non-Tufts HP Provider*. For information on filing claim forms, see Chapter 6.

Preregistration by You

If you receive *Inpatient* services which are not authorized by your *PCP*, you must *Preregister* these services with *Tufts HP*. If you do not *Preregister*, you will be subject to a *Preregistration Penalty*. See "*Preregistration*" later in this chapter for more information.

Covered Services Outside of the 50 United States

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

Continuity of Care

If you are an existing *Member*

If your *Provider* is involuntarily disenrolled from *Tufts Health Plan* for reasons other than quality or fraud, you may continue to see your *Provider* for *Covered Services* at the *Authorized Level of Benefits* in the following circumstances:

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

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

To choose a new *PCP*, call a Member Specialist at 1-800-462-0224. The Member Specialist will help you to select one from the *Tufts Health Plan Directory of Health Care Providers*. You can also visit the *Tufts Health Plan* Web site at www.tuftshealthplan.com to choose a *PCP*.

If you are enrolling as a new *Member*

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

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *Authorized Level of Benefits* from that *Provider* 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* and receive *Covered Services* at the *Authorized Level of Benefits* through your first postpartum visit.
- you are terminally ill. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *Authorized Level of Benefits* as long as necessary.

Conditions for coverage of continued treatment

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

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

Inpatient Mental Health and Substance Abuse Services

Tufts HP's Designated Facility Program

Authorized Level of Benefits: If you require *Inpatient* or intermediate mental health or substance abuse services and wish to receive coverage for these services at the *Authorized Level of Benefits*, 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. You are not responsible for *Preregistering* your admission at a *Designated Facility*.

Unauthorized Level of Benefits: If you wish to receive *Inpatient* or intermediate mental health or substance abuse services at a *Provider* which is not a *Designated Facility*, your coverage will be at the *Unauthorized Level of Benefits*. This is the case even if your *PCP* authorizes your care at a non-*Designated Facility*. *Inpatient* mental health or *Inpatient* substance abuse services not provided by a *Designated Facility* will only be covered at the *Unauthorized Level of Benefits*. Coverage at the *Unauthorized Level of Benefits* means that you pay a *Deductible* and *Coinsurance* and are responsible for *Preregistering* your admission. In order to receive care for *Inpatient* or intermediate mental health or substance abuse services at the *Unauthorized Level of Benefits*, you must receive prior approval from an *Authorized Reviewer*. Please call the *Tufts HP* Mental Health Department at 1-800-208-9565 for more information on how to receive this authorization.

The Designated Facilities

Tufts HP's Designated Facilities are listed in the *Directory of Health Care Providers*. 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). The *Directory of Health Care Providers* also lists any other special rules for a particular *Designated Facility*.

Emergency Admission to a non-Designated Facility

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

Emergency Care

To Receive Emergency Care

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

Outpatient Care

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

If you receive *Emergency Covered Services* from a Non-Tufts HP Provider, the *Plan* will pay up to the *Reasonable Charge*. You pay the applicable *Copayment* and any difference between what the *Plan* paid and what the Non-Tufts HP Provider charged for the service.

Note: 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 *PCP* so he or she can provide or arrange for any follow-up care that you may need.

Inpatient Care

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

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

Also, if you are admitted as an *Inpatient* to a hospital that is not a *Tufts HP Hospital* after receiving *Emergency* care, an *Inpatient Copayment* will apply. In addition, you must *Preregister* the admission or you will be charged a *Preregistration Penalty*. *Preregistration* guidelines are described later in this chapter.

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 ensure that the financial reimbursement system used 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 *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*.

You should feel free to discuss with your *Provider* specific questions about how he or she is paid.

Member Identification Card

Introduction

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

Reporting errors

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

Identifying yourself as a *Tufts HP Member*

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

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

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

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

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

Membership requirement

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

Membership identification number

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

Utilization Management

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. It is also referred to as “pre-service review”.

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*. Retrospective review is also referred to as “post-service review”.

TIMEFRAMES FOR TUFTS HP TO REVIEW YOUR REQUEST FOR COVERAGE

Type of Review	Timeframe for Determinations*
Prospective (Pre-service) review	15 days
Concurrent review	Determination is made prior to treatment being reduced or terminated to allow you to appeal the determination.
Retrospective (Post-service) review	30 days
Urgent care review	72 hours

*Timeframes for determinations may be extended under some circumstances.

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

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

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

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

- Mental health or substance abuse utilization review decisions: 1-800-208-9565;
- All other utilization review decisions: 1-800-462-0224.

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; and
- severe traumatic injury.

Utilization Management, continued

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, in its sole discretion, that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary*;
- the alternative services and supplies are provided directly to the *Member* with the condition;
- 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.

Preregistration

Introduction

Preregistration is *Tufts HP's* process of verifying *PCP* authorization and/or any other authorization required for all Inpatient admissions and transfers. *Tufts HP's* review team will verify eligibility at that time and assign an anticipated length-of-stay guideline for an approved Inpatient admission. In certain cases, the review team will also evaluate your proposed medical care, verify medical necessity or recommend an alternative treatment setting.

Preregistration does not guarantee payment. The *Plan* is not obligated to pay claims that have been *Preregistered* for persons who are not *Members* on the date of service, who fail to meet other eligibility criteria, who receive care that is determined not to be *Medically Necessary*, or if the claim is not for a *Covered Service*.

When Care is Authorized by Your *Tufts HP PCP*

When your *Tufts HP PCP* (or, in the case of *Inpatient* mental health or *Inpatient* substance abuse, a *Designated Facility*) is directing your care, he or she is responsible for *Preregistering* your Inpatient admission or transfer. In this case, you do not need to *Preregister* the admission or transfer.

When Care is Not Authorized by Your *Tufts HP PCP*

When your care is not authorized by your *Tufts HP PCP* (or, when you receive care for *Inpatient* mental health or *Inpatient* substance abuse at a non-*Designated Facility*), you, the *Member*, are responsible for *Preregistering* any *Inpatient* admission or transfer.

If you do not *Preregister*, **you will have to pay a *Preregistration Penalty*** in addition to the *Deductible* and *Coinsurance*. (Please see “Benefit Overview” at the front of this *Description of Benefits* for the amount of the *Preregistration Penalty*.) Please carefully read the following description of the *Preregistration* process that you must complete when your *Tufts HP PCP* is not directing your care. For more information about coverage for *Inpatient* mental health and substance abuse services, see “*Inpatient Mental Health and Substance Abuse Services*” earlier in this chapter.

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

Preregistration, continued

How to *Preregister*

Call (617) 972-9550 or 1-800-672-1515.

Tufts HP's Precertification department is available Monday through Friday from 8:30a.m. to 5:00 p.m. to accept *Preregistration* information. You, or someone acting on your behalf, will be asked to provide the following information:

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

When to *Preregister*

For Elective Hospitalization or Transfers

Elective hospitalizations or transfers must be *Preregistered* at least five (5) days prior to hospitalization or transfer. After you call *Tufts HP* to *Preregister*, *Tufts HP's* review team may consult with your *Provider* and will notify you or your *Provider* of the *Preregistration* determination and the anticipated length-of-stay guideline or will recommend alternative treatment setting.

For an Urgent Admission

Urgent admissions should be *Preregistered* immediately prior to hospitalization. An urgent admission is one which requires prompt medical intervention but one in which there is a reasonable opportunity to *Preregister* prior to, or at the time of, admission.

For an *Emergency* Admission

Emergency admission should be registered within 48 hours following admission. For a definition of *Emergency*, see Appendix A.

For Deliveries

Once you know the due-date for delivery of your newborn *Child*, you may *Preregister* your delivery at any time prior to your due-date.

For Newborn *Children*

- In cases where the newborn *Child* leaves the hospital with the mother after delivery, there is no need to *Preregister* the newborn *Child*.
- In cases where the newborn *Child* remains in the hospital after the mother is discharged after delivery and the newborn *Child's* care is not provided or authorized by the newborn *Child's* PCP, you must call *Tufts HP* immediately and *Preregister* the newborn *Child*. (In order to be covered for any *Medically Necessary* care, the newborn *Child* must be enrolled in the *Plan* within 30 days after birth. See Chapter 2 for more information. For a description of the Level of Benefits applicable to the newborn *Child's* care, see Chapter 1.)

Preregistration, continued

After You Preregister

After you call *Tufts HP* with the necessary *Preregistration* information, *Tufts HP* will notify your *Provider* or the hospital of the decision made by the review team.

Changes to *Preregistration* Information

Preregistration is valid only for the diagnosis, admission date and medical facility specified at the time of *Preregistration*. *Tufts HP* must be notified of any delays, changes or cancellations of your proposed admission. A separate *Preregistration* must be obtained for a new admission date, readmission, hospitalization or transfer for conditions other than those designated during the initial *Preregistration*.

If you do not notify *Tufts HP* of changes, you will be required to pay a *Preregistration Penalty* for that admission. See “Benefit Overview” at the front of this *Description of Benefits* for the amount of the *Preregistration Penalty*.

Extension of Hospitalization

Tufts HP staff monitors all *Inpatient* hospitalizations. When it is *Medically Necessary* to extend hospitalization beyond the originally determined length-of-stay, *Tufts HP* will request additional clinical information from your attending *Provider* or hospital so that additional *Medically Necessary* hospital days may be authorized.

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

Chapter 2

Eligibility, Enrollment, & Continuing Eligibility

Eligibility

Waiting Period

The waiting period is the period of continuous full-time employment that 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.

Subscribers

You are eligible to enroll as a *Subscriber* when you are in the class of eligible employees established by the *Plan* and you are a permanent full-time *Employee* working the minimum number of hours per week as described below.

Dependents

Dependents are eligible under *Family Coverage* if they meet the definition of *Dependent* in Appendix A.

Proof of Eligibility

Tufts HP may ask you for proof of your 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.

Minimum Hours

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

Enrollment

When to enroll

You may enroll yourself and your eligible *Dependents*, if any, for this coverage only during the annual *Open Enrollment Period* or within 30 days of the date you or your *Dependent* is first eligible for this coverage.

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

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

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

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

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

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

Enrollment, continued

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.

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 your <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's</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* that 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 Specialist for help.
2	Call the <i>Provider</i> 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 Specialist 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.

Continuing Eligibility for *Dependents*, continued

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> 19 th birthday. Call a Member Specialist 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> 19 th 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*, that is the earlier of one year after the date the student last went to class, or the date on which the *Student Dependent's* coverage would have otherwise ended. A physician's certification of the serious illness or injury is required; 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.

Note: This coverage meets or exceeds the requirements of "Michelle's Law", a federal law related to continuing coverage for student dependents.

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.

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

Continuing Eligibility for *Dependents*, continued

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 coverage under an individual contract. See Chapter 5 for more information.

Keeping the *Plan's* records current

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

- birth, adoption, changes in marital status, or death;
- your 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

Covered Services

When health care services are *Covered Services*

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

- listed as *Covered Services* in this chapter;
- *Medically Necessary*;
- consistent with applicable law;
- consistent with *Tufts Health Plan's* Clinical Coverage Guidelines in effect at the time the services or supplies are provided. This information is available to you on our Web site at www.tuftshealthplan.com or by calling Member Services;
- obtained within the 50 United States. The only exceptions to this rule are for *Emergency* care services, and for *Urgent Care* services provided to you while you are traveling, which are *Covered Services* when provided outside of the 50 United States;
- provided to treat an injury, illness, pregnancy, except for preventive care;
- with respect to care at the *Authorized Level of Benefits*, provided or authorized in advance by your *PCP*, except in an *Emergency*; and
- approved by an *Authorized Reviewer*, in some cases.

Important Notes:

- *Authorized Reviewer approval*: All claims for services (whether or not the services were provided by a *Tufts HP Provider*) are subject to retrospective review by an *Authorized Reviewer*. *Authorized Reviewers* review claims to be sure that the claims are for *Covered Services* only. A *Covered Service* is one that is described in this chapter. The *Plan* will only pay claims that are for *Covered Services*.
- Certain services require the prior approval of an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*. Please see Chapter 1 for information about how this prior approval is obtained at the *Authorized Level of Benefits*. If you wish to receive these services at the *Unauthorized Level of Benefits*, you are responsible for obtaining this prior approval from *Tufts HP*. If prior approval is not received, *Tufts HP* will not cover those services. Please contact Member Services, or, for mental health and substance abuse services, the Tufts HP Mental Health Department at 1-800-208-9565, for more information.
- *Preregistration*: You must *Preregister Inpatient* services provided at the *Unauthorized Level of Benefits*. Please see "*Preregistration*" in Chapter 1 for more information.
- At the *Authorized Level of Benefits*, for certain *Outpatient* services listed as "covered in full" in the "Benefit Overview", you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit.

Covered Services, continued

Emergency care

In an *Emergency*, you should call 911 for Emergency medical assistance (or the local number for Emergency medical services) and seek care at the nearest Emergency facility. No *PCP* referral is required for receiving *Emergency* care. However, you or someone acting for you should call your *PCP* or *Tufts HP* within 48 hours after receiving care. You are encouraged to contact your *Primary Care Provider* so your *PCP* can provide or arrange for any follow-up care that you may need.

Emergency care

- Care for an *Emergency* in an Emergency room.
- Care for an *Emergency* in a *Provider's* office.

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 *Reasonable 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.
- An Emergency Room *Copayment* may apply if you register in an Emergency room but leave that facility without receiving care.

Outpatient care

Allergy testing and treatment

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

Cardiac rehabilitation services

Coverage is provided for the cost of *Outpatient* treatment of documented cardiovascular disease that is initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

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

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

Chemotherapy

Chiropractic care

See "Spinal manipulation".

Cytology examinations (Pap Smears)

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

Diabetes self-management training and educational services

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

Important Notes:

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

Covered Services, continued

Outpatient care (continued)

Diagnostic imaging

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

Important Note: Prior approval by an *Authorized Reviewer* may be required for MRI/MRA, CT/CTA, PET, and nuclear cardiology at both the *Authorized* and *Unauthorized Levels of Benefits*. Please contact Member Services and see “Important Notes” on page 3-1 for information about when you are responsible for obtaining this approval.

Diagnostic screening procedures

Including, for example, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies.

Important Note: Prior approval by an *Authorized Reviewer* may be required at both the *Authorized* and *Unauthorized Levels of Benefits*. Please contact Member Services and see “Important Notes” on page 3-1 for information about when you are responsible for obtaining this approval.

Early intervention services

Services provided by early intervention programs. *Medically Necessary* early intervention services include, but are not limited to, occupational therapy, physical therapy, speech therapy, nursing care, and psychological counseling.

These services are covered for *Members* from birth until their third birthday.

Notes:

- The \$5,200 calendar year, year maximum for early intervention services applies to the *Authorized* and *Unauthorized Levels of Benefits* combined.
- The \$15,600 lifetime benefit maximum for early intervention services applies to the *Authorized* and *Unauthorized Levels of Benefits* combined.

Covered Services, continued

Outpatient care (continued)

Family planning

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

- **Procedures**
 - sterilization; and
 - pregnancy terminations.
- **Services**
 - medical examinations;
 - consultations;
 - birth control counseling; and
 - genetic counseling.
- **Contraceptives**
 - cervical caps;
 - Intrauterine devices (IUDs);
 - implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants);
 - Depo-Provera or its generic equivalent; and
 - any other *Medically Necessary* contraceptive device that has been approved by the United States Food and Drug Administration*.

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

Hemodialysis

Includes *Outpatient* hemodialysis (including home hemodialysis) and *Outpatient* peritoneal dialysis (include home peritoneal dialysis).

Human leukocyte antigen (HLA) testing

Human leukocyte antigen (HLA) testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a *Member's* bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens.

Immunizations

Covered Services, Continued

Outpatient care (continued)

Infertility services

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

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

Infertility services include:

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

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

(II.) the following procedures when approved in advance by an *Authorized Reviewer* (see “Important Notes” on page 3-1 for more information):

- artificial insemination (intrauterine or intracervical) with donor sperm and/or gonadotropins; 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 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;
- when approved in advance by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits* (see “Important Note” on page 3-1 for more information about when you are responsible for obtaining this approval); and
- with respect to the procurement and processing of donor sperm, eggs, or inseminated eggs, or the banking of donor sperm or inseminated eggs, to the extent such costs are not covered by the donor's health care coverage, if any.

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

Laboratory tests

Including, but not limited to, blood tests, urinalysis, throat cultures, glycosylated hemoglobin (HbA1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles. **Important Note:** Some laboratory tests (e.g., genetic testing) may require the approval of an *Authorized Reviewer*. This approval is required at both the *Authorized* and *Unauthorized Levels of Benefits*. See “Important Notes” on page 3-1 for information about when you are responsible for obtaining this approval.)

Lead screenings

Mammograms

Provided at the following intervals (no *PCP* referral required):

- one baseline at 35-39 years of age;
- one every year at age 40 and older; or
- when otherwise *Medically Necessary*.

Italicized words are defined in Appendix A.

Covered Services, continued

Outpatient care (continued)

Nutritional counseling

For an individual consultation and up to seven (7) follow-up visits with a registered dietician per calendar year (*Authorized and Unauthorized Levels* combined).

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” later in this chapter); or
- diabetes self-management training and educational services (see that benefit earlier in this chapter).

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.

Oral health services

The following oral health services are covered.

Reminder: If you wish to have an advance determination made as to whether a contemplated service is a *Covered Service*, please call the *Tufts HP* Member Services Department.

- *Emergency* care
X-rays and *Emergency* oral surgery in a *Provider’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.

- *Non-Emergency* care

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

- Hospital, physician, and surgical charges for the following conditions:
 - Surgical treatment of skeletal jaw deformities; or
 - Surgical treatment for Temporomandibular Joint Disorder (TMJ).
- In certain specific instances, the costs of *Inpatient* services and *Day Surgery* for certain additional oral health services are covered. In order for these services (described in the chart below) to be covered, the following clinical criteria must be met:
 - the *Member* cannot safely and effectively receive oral health services in an office setting because of a specific and serious nondental organic impairment (for example, hemophilia), AND
 - the *Member* requires these services in order to maintain his/her health (and the services are not cosmetic or *Experimental*).

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

Note: *Non-Emergency* oral health services are not covered when performed in an office setting.

Covered Services, continued

Outpatient care (continued)

Outpatient surgery in a *Provider's* office

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.

Preventive care for *Members* under age 6

Preventive care services from the date of birth until age 6, including:

- physical examination, including limited developmental testing with interpretation and report;
- history;
- measurements;
- sensory screening;
- neuropsychiatric evaluation; and
- developmental screening and assessment at the following intervals:
 - 6 times during the first year after birth,
 - 3 times during the second year after birth, and
 - annually from age 2 until age 6.

Coverage is also provided for:

- hereditary and metabolic screening at birth;
- appropriate immunizations and tuberculin tests;
- hematocrit, hemoglobin, or other appropriate blood tests;
- urinalysis as recommended by a *Provider*, and
- newborn auditory screening tests, as required by applicable law.

Preventive care for *Members* age 6 and older

- routine physical examinations, including appropriate immunizations and lab tests;
- routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam and hormone replacement therapy services; and
- hearing examinations and screenings.

Radiation therapy

Respiratory therapy and pulmonary rehabilitation services

Short term physical and occupational therapy services

(Services may require the approval of an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*. See "Important Notes" on page 3-1 for more information about when you are responsible for obtaining this approval.)

Short term physical and occupational therapy services are covered only when provided to restore function lost or impaired as the result of an accidental injury or illness. 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.

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

- provided by a licensed physical therapist; and
- in compliance with *Tufts Health Plan's Medical Necessity* guidelines, and, if applicable, prior authorization guidelines.

Covered Services, continued

Outpatient care (continued)

Therapy for speech, hearing and language disorders

(Services may require the approval of an Authorized Reviewer at both the Authorized and Unauthorized Levels of Benefits. See "Important Notes" on page 3-1 for more information about when you are responsible for obtaining this approval.)

Diagnosis and treatment when *Medically Necessary*.

Spinal manipulation (No PCP referral required when services obtained from a *Tufts HP Provider*.)

Manual manipulation of the spine.

Notes:

- Coverage is provided up to the maximum benefit listed in "Plan and Benefit Information" at the front of this *Description of Benefits*. You pay all subsequent charges in that *Benefit Year*.
- Spinal manipulation services for *Members* age 12 and under are not covered.

Vision care services

- **Routine eye examination.**

Coverage is provided for one routine eye examination per calendar year. Any follow-up care must be authorized by your PCP in order to be covered at the *Authorized Level of Benefits*. **Note:** You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network in order to obtain coverage for these services at the *Authorized Level of Benefits*. Please go to www.tuftshealthplan.com or contact Member Services for more information. Except as described below, in order to be covered at the *Authorized Level of Benefits* for services to treat a medical condition of the eye, you must obtain a referral from your PCP for services from a *Tufts HP Provider*.

- **Other Vision Care Services.**

Coverage is provided for eye examinations and necessary treatment of a medical condition (no PCP referral is required at the *Authorized Level of Benefits* for medical treatment provided by an optometrist).

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* at both the *Authorized* and *Unauthorized Levels of Benefits*. Please contact Member Services and see "Important Notes" on page 3-1 for more information about which *Day Surgeries* require this approval and when you are responsible for obtaining this approval.)

Covered Services, continued

Inpatient care

Bone marrow transplants, hematopoietic stem cell transplants, and human solid organ transplants

Authorized Reviewer approval is required before you receive a bone marrow transplant, a hematopoietic stem cell transplant, or a solid organ transplant (regardless of whether the procedure is authorized by your *PCP*). Call the *Tufts HP Member Services Department* for more information. Coverage is provided for the cost of:

- Bone marrow transplants for *Members* diagnosed with breast cancer that has progressed to metastatic disease; and
- Hematopoietic stem cell transplants and human solid organ transplants which are generally accepted in the medical community for *Members* who are the stem cell or solid organ recipients. When the recipient is a *Member*, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health insurance: evaluation and preparation of the donor, and surgical intervention and recovery services when those services relate directly to donating the stem cells or solid organ to the *Member*.

Notes:

- The *Plan* does not cover donor charges of *Members* who donate stem cells or 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 care*" earlier in this chapter for more information.
- Prior approval by an *Authorized Reviewer* is required at both the *Authorized* and *Unauthorized Levels of Benefits*. See "Important Notes" on page 3-1 for more information about when you are responsible for obtaining this approval.

Extended care services

In each calendar year, *Inpatient* extended care services are covered up to the maximum benefit listed under "Benefit Overview". Extended care services are *Skilled* nursing and rehabilitation or chronic disease hospital services which are provided in a Medicare-certified:

- skilled nursing facility;
- rehabilitation hospital; or
- chronic hospital.

Custodial Care is excluded from coverage.

Note: Extended care services require the prior approval of an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*. See "Important Notes" on page 3-1 for more information about when you are responsible for obtaining this approval.

Covered Services, continued

Inpatient care (continued)

Hospital services (acute care)

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

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

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

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; and
- 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 autoimmune 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*). This prior approval by an *Authorized Reviewer* is required at both the *Authorized* and *Unauthorized Levels of Benefits*. See "Important Notes" on page 3-1 for more information about when you are responsible for obtaining this approval.

Covered Services, continued

Maternity care (Outpatient and Inpatient)

Outpatient

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

Note: *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*.

Important: This 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.

Inpatient

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

Includes *Inpatient* care in hospital for mother and newborn *Child* for at least 48 hours following a vaginal delivery and 96 hours following a caesarean delivery.

Notes:

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

(For information about *Preregistration* of a newborn *Child*, see Chapter 1.)

(continued on next page)

Covered Services, continued
Maternity care (Outpatient and Inpatient), continued

Benefits for Newborn Children at Time of Delivery:

Member's Delivery is Performed by her PCP

If a mother is a *Member* whose delivery was performed by her *PCP*, the *Plan* will cover *Medically Necessary* care as follows:

When newborn Child is enrolled: If the newborn *Child* is enrolled in the *Plan* as described under "Adding Dependents" in Chapter 2, the *Plan* will cover:

- Routine Nursery Care at the *Authorized Level of Benefits*; and
- *Medically Necessary* care other than *Routine Nursery Care*: (1) at the *Authorized Level of Benefits*, if the newborn *Child* has a *Tufts HP PCP* who is providing or has authorized the services; and (2) at the *Unauthorized Level of Benefits*, if that care is not provided or authorized by the newborn *Child's Tufts HP PCP* (*Preregistration* is required).

When newborn Child is not enrolled: If the newborn *Child* is not enrolled under the *Plan* as described under "Adding Dependents" in Chapter 2, the *Plan* will cover (1) *Routine Nursery Care* at the *Authorized Level of Benefits*; and (2) will not cover care other than *Routine Nursery Care*.

Non-Member's Delivery

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

When newborn Child is enrolled: If the newborn *Child* is enrolled under the *Plan* as described under "Adding Dependents" in Chapter 2, the *Plan* will cover:

- *Routine Nursery Care* at the *Unauthorized Level of Benefits*; and
- *Medically Necessary* care other than *Routine Nursery Care* (1) at the *Authorized Level of Benefits*, if that care is provided at a *Tufts HP Hospital*; and (2) at the *Unauthorized Level of Benefits*, if that care is not provided at a *Tufts HP Hospital* (*Preregistration* is required).

When newborn Child is not enrolled: If the newborn *Child* is not enrolled in the *Plan* as described under "Adding Dependents" in Chapter 2, the *Plan* will not pay for any care for the newborn *Child*.

Covered Services, continued

Mental Health and Substance Abuse Services (Outpatient, Inpatient, and Intermediate)

Outpatient* mental health and substance abuse services for *Mental Disorders

Services to diagnose and treat *Mental Disorders* (including diagnosis, detoxification and treatment of substance abuse disorders), given by the following *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.

Important 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 approval by a *Tufts HP* Mental Health *Authorized Reviewer* is required for psychological testing and neuropsychological assessment services at both the *Authorized* and *Unauthorized Levels of Benefits*. Please contact the *Tufts HP* Mental Health Department at 1-800-208-9565 for more information on how to obtain this approval.
- *Outpatient* mental health and substance abuse services for *Mental Disorders* require prior approval at the *Authorized Level of Benefits*. Please contact the *Tufts HP* Mental Health Department at 1-800-208-9565 for more information on how to obtain this authorization.

Covered Services, continued

Mental Health and Substance Abuse Services (Outpatient, Inpatient, and Intermediate) **(continued)**

Inpatient and intermediate mental health and substance abuse services for Mental Disorders

- *Inpatient* mental health and substance abuse services for *Mental Disorders* (including substance abuse disorders) in:
 - a general hospital;
 - a mental health hospital; or
 - a substance abuse facility.
- Intermediate mental health and substance abuse services. These services are more intensive than traditional *Outpatient* mental health and substance abuse services, but less intensive than 24-hour hospitalization.

Some examples of *Covered* intermediate mental health and substance abuse 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.

Note:

- *Inpatient* and intermediate mental health and substance abuse services must be obtained at a *Tufts HP Designated Facility* in order to be covered at the *Authorized Level of Benefits*. See “*Inpatient Mental Health and Substance Abuse Services*” in Chapter 1 for more information. To receive care at the *Unauthorized Level of Benefits*, you must receive prior authorization from an *Authorized Reviewer*. Please contact the *Tufts HP* Mental Health Department at 1-800-208-9565 for more information on how to receive this authorization.

Covered Services, continued

Other Health Services

Ambulance services

- Ground, sea and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance 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 another other means. Prior authorization by an *Authorized Reviewer* is required.

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

Covered Services, continued

Durable Medical Equipment

Equipment must meet the following definition of “*Durable Medical Equipment*”.

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

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

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

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

Note: Certain *Durable Medical Equipment* may require *Authorized Reviewer* approval. This prior approval is required at both the *Authorized* and *Unauthorized Levels of Benefits*. See “Important Notes” on page 3-1 for more information about when you are responsible for obtaining this approval.

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

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

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

- contact lenses or eyeglass lenses (one pair per prescription change) to replace the natural lens of the eye or following cataract surgery. Note: Eyeglass frames provided in association with these lenses are covered up to a maximum of \$69 per calendar year;
 - cranial helmets;
 - the following equipment when used to diagnose or treat diabetes mellitus Type 1 (insulin-dependent diabetes), diabetes mellitus Type 2 (insulin or non-insulin dependent diabetes), or gestational diabetes:
 - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind,
 - therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease; and
 - visual magnifying aids;
 - gradient stockings (up to three pairs per calendar year);
 - 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).
 - power/motorized wheelchairs.

Tufts HP will decide whether to rent or purchase *Durable Medical Equipment* for use by the *Member*. At the *Authorized Level of Benefits*, this equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with *Tufts HP* to provide such equipment.

(continued on next page)

Covered Services, continued

Other Health Services (continued)

Durable Medical Equipment, continued

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

- air conditioners, dehumidifiers, HEPA filters and other filters, and portable nebulizers;
- articles of special clothing, and mattress and pillow covers, including hypo-allergenic versions;
- bed-related items, including bed trays, bed pans, bed rails, over-the-bed tables, and bed wedges;
- car seats;
- car/van modifications;
- comfort or convenience devices;
- dentures;
- ear plugs;
- exercise equipment and saunas;
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts or stair climbers;
- foot orthotics and arch supports;
- heating pads, hot water bottles, and paraffin bath units;
- home blood pressure monitors and cuffs;
- hot tubs, jacuzzis, swimming pools, or whirlpools.
- mattresses except for mattresses used in conjunction with a hospital bed and ordered by a *Provider*. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g., Tempur-Pedic® or Posturepedic® mattresses) are not covered.

Covered Services, continued

Other Health Services (continued)

Home health care

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

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

Prior approval by an *Authorized Reviewer* is required at both the *Authorized* and *Unauthorized Levels of Benefits*. See “Important Notes” on page 3-1 for more information about when you are responsible for obtaining this approval.

****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 Therapy services” earlier in this chapter. However, those home health care services are not subject to the 60-day period for significant improvement requirement listed under “Short Term Physical and Occupational Therapy services.”

Hospice care services

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

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

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

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

Important Note: Prior approval by an *Authorized Reviewer* is required at both the *Authorized* and *Unauthorized Levels of Benefits*. See “Important Notes” on page 3-1 for more information about when you are responsible for obtaining this approval.)

Covered Services, continued

Other Health Services (continued)

Injectable, infused, or inhaled medications

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

Notes:

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

Medical supplies

The Plan covers the cost of certain types of medical supplies, including:

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

Contact a Member Specialist with coverage questions.

Scalp hair prostheses or wigs for cancer or leukemia patients

Coverage is provided for scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer.

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

Covered up to a maximum benefit of \$350 per calendar year (*Authorized* and *Unauthorized Levels* combined).

Special medical formulas

Included in this benefit are the following special medical formulas, nonprescription enteral formulas, and low protein foods, when prescribed by a *Provider* for the treatments described below:

Low protein foods:

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

Covered up to a maximum benefit of \$2,500 per calendar year (*Authorized* and *Unauthorized Levels* combined).

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* for: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure.

Covered Services, Continued

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

Coverage is provided:

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

Important Note: Coverage for nonprescription enteral formulas and special medical formulas may require prior approval by an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*. See “Important Notes” on page 3-1 for more information about when you are responsible for obtaining this approval.

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; and
- *Medically Necessary*.

For a current list of covered drugs, please go to our Web site at www.tuftshealthplan.com, or call a Member Specialist. 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 level *Cost Sharing Amount*; many generic drugs are on Tier-1.
- Tier-2 drugs have the middle level *Cost Sharing Amount*.
- Tier-3 drugs have the highest level *Cost Sharing Amount*.

Covered Services, continued

Prescription Drug Benefit, (continued)

PRESCRIPTION DRUG COVERAGE TABLE	
Description	Coverage
<p>DRUGS OBTAINED AT A RETAIL PHARMACY:</p> <p>Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a <i>Tufts HP</i> designated retail pharmacy.</p>	<p><u>Tier-1 drugs:</u> \$5 for up to a 30-day supply \$10 for a 31-60 day supply \$15 for a 61-90 day supply</p> <p><u>Tier-2 drugs:</u> \$10 for up to a 30-day supply \$20 for a 31-60 day supply \$30 for a 61-90 day supply</p> <p><u>Tier-3 drugs:</u> \$25 for up to a 30-day supply \$50 for a 31-60 day supply \$75 for a 61-90 day supply</p>
<p>DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY:</p> <p>Most maintenance medications, when mailed to you through a <i>Tufts HP</i> designated mail services pharmacy.</p>	<p><u>Tier-1 drugs:</u> \$10 for up to a 90-day supply</p> <p><u>Tier-2 drugs:</u> \$20 for up to a 90-day supply</p> <p><u>Tier-3 drugs:</u> \$50 for up to a 90-day supply</p>

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

Covered Services, continued **Prescription Drug Benefit** (continued)

What is Covered

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

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under “What is Not Covered” (see “Important Notes” below).
- Insulin, insulin pens, insulin needles and syringes; lancets; blood glucose, urine glucose, and ketone monitoring strips; and oral diabetes medications that influence blood sugar levels.
- Acne medications 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 in the list of covered drugs on the *Tufts HP* Web site. *Medically Necessary* hypodermic needles and syringes required to inject these medications are also covered. For more information, call Member Services or see our Web site at www.tuftshealthplan.com.
- 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.
- Over-the-counter drugs included in 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.
- Smoking cessation agents.

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.
- Medications for the treatment of idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants, Depo-Provera or its generic equivalent, (these are covered under your “*Outpatient care*” benefit earlier in this chapter),
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- 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 filled at pharmacies other than *Tufts HP* designated pharmacies, except for *Emergency* care.
- Smoking cessation agents.
- Drugs for asymptomatic onychomycosis, except for *Members* with diabetes, vascular compromise, or immune deficiency status.
- Acne medications for individuals 26 years of age or older, unless *Medically Necessary*.
- 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 may not be covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.
- Prescription medications when packaged with non-prescription products.
- Oral non-sedating antihistamines.

Effective January 1, 2011, we may no longer cover prescription medications when medications with the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication are available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. Some examples of these excluded medications are: Topical acne medications with benzoyl peroxide $\leq 10\%$; H₂ blockers with nizatidine, famotidine, cimetidine, or ranitidine; and oral non-sedating antihistamines. For a complete list of these excluded medications, 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 *Provider* to obtain prior approval from *Tufts HP* for such drugs.

Step Therapy PA Program

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

Special Designated Pharmacy Program (Mail Order):

Tufts HP has designated special pharmacies to supply a select number of medications via mail order, including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C, growth hormone deficiency, rheumatoid arthritis, and cancers treated with oral medications. 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 via mail order.

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 *Provider* 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 Member Services.
- 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 change the drug's status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) moving the brand drug to our list of non-covered drugs in Appendix C when a generic alternative becomes available. Many generic drugs are available on Tier-1.

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

Covered Services, continued

Prescription Drug Benefit, (continued)

Filling Your Prescription

Where to Fill Prescriptions:

You can fill your prescriptions at any *Tufts HP* designated pharmacy. *Tufts HP* designated pharmacies include:

- for the majority of prescriptions, many 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:

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

Important: Your prescription drug benefit will only be honored at a *Tufts HP* designated pharmacy. In cases of *Emergency*, please call the *Tufts HP* Member Services Department at 1-800-462-0224 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 *Cost Sharing Amounts* 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, or medications:

- A service, supply or medication that is not *Medically Necessary*.
- A service, supply or medication that is not a *Covered Service*.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- A service, supply, or medication that is obtained outside of the 50 United States. The only exception to this rule is for *Emergency* care services, and for *Urgent Care* services provided to you while traveling, which qualify as *Covered Services* when provided outside of the 50 United States.
- *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.
- The following exclusions apply to services provided by the relatives of a *Member*:
 - Services provided by a relative who is not a *Provider* are not covered.
 - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Provider*, are not covered.
 - If you are a *Tufts Health Plan Provider*, you cannot provide or authorize services for yourself, be your own *PCP*, or be the *PCP* of a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. 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; orthodontia, even when it is an adjunct to other surgical or medical procedures; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under “Oral Health Services” earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea, as described in Chapter 3), including those for TMJ disorders. TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies, are not covered.
- 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; costs associated with the services provided by a doula.
- Circumcisions performed in any setting other than a hospital, *Day Surgery*, or a *Provider’s* office.
- Infertility services for *Members* who do not meet the definition of infertility as described in the “*Outpatient care*” section earlier in this chapter; experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days) sperm or embryo cryopreservation unless the *Member* is in active infertility treatment; costs associated with donor recruitment and compensation; Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; and donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
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* 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.
- Manual breast pumps; the purchase of an electric or hospital-grade breast pump.
- Human organ transplants, except as described earlier in this chapter.
- Services provided to a non-*Member*, except as described earlier in this chapter for:
 - organ donor charges under “Human organ transplants”;
 - bereavement counseling services under “Hospice care services”; or
 - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or 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 the treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; spinal manipulation services for *Members* age 12 and under; *Inpatient* and *Outpatient* weight-loss programs and clinics; relaxation therapies; massage therapies, except as described under “Short term physical and occupational therapy services”; 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.

Exclusions from Benefits, continued

- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the “Note” below.
Note: The following blood services and products are covered:
 - blood processing;
 - blood administration;
 - Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval by an *Authorized Reviewer* is required);
 - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an *Authorized Reviewer* is required).
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- 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. Routine eye exams. Except as described earlier in this chapter, the *Plan* will not pay for 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
- Methadone treatment or methadone maintenance related to substance abuse disorders.
- Private duty nursing (block or non-intermittent nursing).
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.
Note: This exclusion also does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member’s* treating doctor, and the shoes and inserts:
 - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
 - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in “Ambulance services” earlier in this chapter.

Chapter 4

When Coverage Ends

Overview

Reasons coverage ends

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

- you lose eligibility because you no longer meet the group's or *Tufts HP's* eligibility rules, including the requirement for minimum hours described in Chapter 2;
- 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
- your *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 are receiving *Inpatient* or *Outpatient* care when your coverage ends; or
- you have a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends.

Continuation

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

When a *Member* is No Longer Eligible

Loss of eligibility

Your coverage ends on the date you no longer meet your *Plan'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.

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

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

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

Membership Termination for Misrepresentation or Fraud

Policy

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

Acts of misrepresentation or fraud

Examples of misrepresentation or fraud include:

- false or misleading information on your member application form;
- enrolling as a *Spouse* someone who is not your *Spouse*;
- receiving benefits for which you are not eligible;
- keeping for yourself payments made by the *Plan* that were intended to be used to pay a *Provider*, 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

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

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

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

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

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

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

Termination of the *Group Contract*

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

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

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

Qualifying Events

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

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

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

When federal COBRA coverage is effective

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

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

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

Cost of Coverage

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

Duration of Coverage

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

Federal Continuation Coverage (COBRA), continued

FEDERAL COBRA - DURATION OF COVERAGE		
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. You may be responsible for payment of up to 150% of the cost of COBRA coverage for this additional period of up to 11 months.</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 *Group* ceases to maintain any group health plan.
- after the COBRA election, the qualified beneficiary obtains coverage with another employer group health plan that does not contain any exclusion or pre-existing condition of such beneficiary. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- after the COBRA election, the qualified beneficiary becomes entitled to federal Medicare benefits. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Under USERRA:

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

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

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

Coverage under an Individual Contract

If you live in Massachusetts:

If your *Group* coverage ends, you may be eligible to enroll in coverage under an individual contract offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority ("the Connector"). For more information, call *Tufts Health Plan* Member Services or contact the Connector either by phone (1-877-MA-ENROLL) or on its Web site (www.mahealthconnector.org).

If you live outside Massachusetts:

If your *Group* coverage ends, you are not eligible to enroll in coverage under an individual contract offered either directly by *Tufts Health Plan* or through the Commonwealth Health Insurance Connector Authority. Please contact your state insurance department for information about coverage options that may be available to you in the state where you reside.

For more information

Please call the *Tufts HP* Member Services Department.

Chapter 6

How to File a Claim and *Member Satisfaction*

How to File a Claim

Tufts HP Providers

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

Non-Tufts HP Providers

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

Hospital Admission or Day Surgery

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

Outpatient Medical Expenses

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

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

To Obtain Claim Forms

Claim forms are available from your *Plan Administrator* or by calling the *Tufts HP* Member Services Department at 1-800-462-0224.

Where to Send Medical Claim Forms

Send completed claim forms to:

Tufts Health Plan

POS Claims

P.O. Box 9171

Watertown, MA 02471-9171

Separate claim forms should be submitted for each family member. If you have any questions about filing forms, call Member Services at 1-800-462-0224.

Pharmacy Expenses

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

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 Department at **1-800-462-0224**.

Internal Inquiry

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

Member Grievance Process

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

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

- your name and address;
- your *Tufts 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.

Member Satisfaction Process, continued

Administrative Grievance Timeline

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

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 Specialist, 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 and Grievances 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 and Grievances 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.

Member Satisfaction Process, continued

Internal Member Appeals, continued

Once you have signed and returned the authorization for the release of medical and treatment information to *Tufts HP*, the Appeals and Grievances Analyst will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to *Tufts 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.

You will have access to any medical information and records relevant to your appeal that 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 and Grievances 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

Tufts HP recognizes that there are circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard appeals process. *Tufts HP* will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. 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 Specialist for assistance.

Bills from Providers

Occasionally, you may receive a bill from a *Non-Tufts HP 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(s) cannot be considered for payment.

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

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

Limitation on Actions

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

Chapter 7

Other Plan Provisions

Subrogation

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, such as your own or someone else's auto or homeowner's insurer, or the person who caused your illness or injury.

In that case, if the *Plan* pays or will pay 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 the *Member* is entitled to benefits pursuant to any workers' compensation statute or equivalent employer liability, or indemnification law (whether or not the employer has obtained workers' compensation coverage as required by law).

If the *Plan* pays for the costs of health care services or medications for any work-related illness or injury, the *Plan* has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider*. If your *Provider* bills services or medications to the *Plan* for any work-related illness or injury, please contact the *Tufts HP* Liability and Recovery Department at 1-888-880-8699, x. 1098.

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 an amount 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 case, that subcontractor will act as *Tufts HP's* agent.

Constructive Trust

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

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 you make a claim (the primary plan); and (b) which plan has the secondary obligation to provide benefits (the secondary plan). These determinations will be made according to the following rules:

- **No COB Rule**

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.

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

Coordination of Benefits, continued

- **Longer/Shorter Rule**

If none of the above rules determine 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* Liability and Recovery Department at 1-888-880-8699, x. 1098 for more information on Medicare COB.

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 you may be entitled to receive because a party other than the *Plan* may be responsible for all or a portion of the cost of health care services paid or to be paid by the *Plan*.

Right to recover overpayment

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

For more information

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

Medicare Eligibility

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

The *Plan* will pay benefits **before** Medicare:

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

The *Plan* will pay benefits **after** Medicare:

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

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

Use and Disclosure of Medical Information

For information about how *Tufts HP* uses and discloses your medical information, please contact a Member Specialist. 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*; or
- 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

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

Notice

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

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

Enforcement of terms

Tufts HP may choose to waive certain terms of the *Group Contract*, if applicable, including this *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 is filed.

Annual Coverage Limitations

Annual dollar or time limitations on *Covered Services*.

Authorized Level of Benefits

The level of benefits that a *Member* receives when care is provided or authorized by his or her *PCP* (or, with respect to *Inpatient* mental health or *Inpatient* substance abuse care, when care is provided or authorized by a *Designated Facility*). See Chapter 1 for more information.

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, *Deductibles*, *Out-of-Pocket Maximums*, and *Coinsurance* 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.

Coinsurance

The *Member's* share of costs for *Covered Services*.

- For services provided by a *Tufts HP Provider*, the *Member's* share is a percentage of:
 - the applicable *Tufts HP* fee schedule amount for those services; or
 - the *Tufts HP Provider's* charges, whichever is less.

For unauthorized services provided by a *Non-Tufts HP Provider*, the *Member* pays a share of *Reasonable Charges*.

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

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

Copayment

The *Member's* payment for certain *Covered Services* provided or authorized by the *Member's PCP*. The *Member* pays *Copayments* to the *Provider* at the time services are rendered, unless the *Provider* arranges otherwise. *Copayments* are not included in the *Deductible*, *Coinsurance*, or *Out-of-Pocket Maximum*.

Terms and Definitions, continued

Cost Sharing Amount

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

Covered Service

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

- described in Chapter 3 of this *Description of Benefits* (subject to the “Exclusions from Benefits” section in Chapter 3; and
- *Medically Necessary*.

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 Health Safety Net Trust Fund or New York Health Care Reform Act surcharges, or later billed charges under provider network agreements, such as supplemental provider payments or access fee arrangements.

Covering Physician

A physician designated by a *Tufts HP* physician to provide or authorize services to *Members* in the *Tufts HP* physician’s absence.

Custodial Care

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

In cases of 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 covered by 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”.

Deductible

For each calendar year, the amount paid by the *Member* for certain *Covered Services* before any payments are made under this *Description of Benefits*. (Any amount paid by the *Member* for a *Covered Service* rendered during the last 3 months of a calendar year shall be carried forward to the next calendar year’s *Deductible*.)

Copayments do not count toward the *Deductible*. See “Benefit Overview” at the front of this *Description of Benefits* for more information.

The following charges do not count toward the *Deductible*:

- *Emergency care Copayments*;
- any amounts you pay for prescription drugs;
- any amount you pay for a *Preregistration Penalty*;
- any amount you pay for *Covered Services* received at the *Authorized Level of Benefits*; and
- any amount you pay for services, supplies, medications which are not *Covered Services*.

After you have met your *Deductible* in a calendar year, you pay only the following for *Covered Services* not provided or authorized by your *PCP*:

- *Emergency care Copayments*; and
- *Coinsurance* for *Covered Services* not provided or authorized by your *PCP*

See “Benefit Overview” at the front of this *Certificate* for more information.

Terms and Definitions, continued

Dependent

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

Description of Benefits

This document, and any future amendments, which describe the Point of Service Option you have selected under the *Plan*.

Designated Facility for Inpatient Mental Health/ Inpatient Substance Abuse

A facility licensed to treat *Mental Disorders* and/or substance abuse (alcohol and drug). This facility has entered into an agreement with *Tufts HP* to provide Inpatient or day treatment/partial hospitalization services to *Members*. (See Chapter 1 for further information.) Also referred to as "*Designated Facility*".

Developmental

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

Directory of Health Care Providers

A separate booklet which lists *Tufts HP* physicians and their affiliated *Tufts HP Hospital(s)*, and certain other *Tufts HP Providers*.

This directory is updated from time to time to reflect changes in *Providers* affiliated with *Tufts HP*. For information about the *Providers* listed in the *Directory of Health Care Providers*, 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 become a *Member* and are first eligible for *Covered Services*.

Emergency

An illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain, such 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*.

Terms and Definitions, continued

Experimental or Investigative

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

- the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished;
- the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval;
- reliable 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
- evaluation by an independent health technology assessment organization has determined that the treatment is not proven safe and/or effective in improving health outcomes or that appropriate patient selection has not been determined; or
- the peer-reviewed published literature regarding the treatment is predominantly non-randomized, historically controlled, case controlled or cohort studies, or there are few or no well-designed randomized, controlled trials.

Family Coverage

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

Group Contract

The agreement between *Tufts HP* and the *Group* under which *Tufts HP* agrees to provide certain administrative services, and the *Group* agrees to pay *Tufts HP* for these services.

The *Group Contract* includes this *Description of Benefits* and any amendments.

Individual Coverage

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

Terms and Definitions, continued

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 Clinical Coverage 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 given, 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*.

Non-Tufts HP Provider

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

Observation Services

The use of inpatient hospital services to treat and/or evaluate a condition that should result in discharge within 23 hours.

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 *Provider's* office;
- a *Day Surgery* or ambulatory care unit; and
- an *Emergency* room or *Outpatient* clinic.

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

Out-of-Pocket Maximum

The maximum amount of money paid by a *Member* during a calendar year for *Covered Services* which are not provided or authorized by the *Member's PCP*. The *Out-of-Pocket Maximum* consists of the *Deductible* and *Coinsurance*.

It does not include:

- *Emergency care Copayments*;
- any amount you pay for prescription drugs;
- any amount you pay for a *Preregistration Penalty*;
- any amount you pay for *Covered Services* received at the *Authorized Level of Benefits*; or
- costs for health care services that are not *Covered Services* under the *Group Contract*.

Once you have met your *Out-of-Pocket Maximum* in a calendar year, you no longer pay for the following in that calendar year:

- Individual/Family *Deductibles* at the *Unauthorized Level of Benefits*; and
- Any amount you pay for *Covered Services* received at the *Unauthorized Level of Benefits*, except for *Emergency care Copayments*, up to the *Reasonable Charge*. You pay any excess above the *Reasonable Charge*.

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

PCP

See "*Primary Care Provider*".

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*.

Preregistration

Tufts HP's process to verify *PCP* referral authorization and any other authorization required for all *Inpatient* admissions and transfers. *Preregistration* is not a guarantee of payment. See Chapter 1 for further information.

Preregistration Penalty

The amount a *Member* will be required to pay if he or she does not follow the *Preregistration* guidelines described in Chapter 1. The *Preregistration Penalty* amount does not count toward *Coinsurance*, *Deductibles* or the *Out-of-Pocket Maximums*. The *Preregistration Penalty* is shown in "Benefit Overview" at the front of this *Description of Benefits*.

Terms and Definitions, continued

Primary Care Provider (PCP)

The *Tufts HP* physician or nurse practitioner who has an agreement with *Tufts HP* to provide primary care and to authorize, when appropriate, the provision of other *Covered Services* to *Members* (except for *Inpatient* mental health and *Inpatient* substance abuse services). *Members* choose *PCPs* from among those listed in the *Directory of Health Care Providers*, subject to the *PCP's* availability.

Provider

A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, limited service medical clinics (if available), urgent care centers (if available), physicians, doctors of osteopathy; 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

The lesser of:

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

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

Routine Nursery Care

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

Service Area

The geographic area within which *Tufts HP* has developed or arranged for a network of *Providers* to afford *Members* adequate access to *Covered Services*.

Note: For a list of cities and towns in the *Service Area*, call the *Tufts HP* Member Services Department or check *Tufts HP's* Web site at www.tuftshealthplan.com.

Skilled

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

Spouse

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

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*.

Terms and Definitions, continued

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 *Tufts HP Providers* and to provide certain services to the health benefit plans including, but not limited to, processing claims for benefits and performing *Preregistration*. 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 Hospitals* are subject to change.

Terms and Definitions, continued

Tufts Health Plan Provider

A *Provider* who has an agreement with *Tufts HP* to provide *Covered Services* to *Members*. *Tufts HP Providers* are located throughout the *Service Area*.

Unauthorized Level of Benefits

The level of benefits that a *Member* receives when care is not provided or authorized by his or her *PCP*. See “Benefit Overview” at the front of this *Description of Benefits* for more information.

Urgent Care

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

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

You, Your

This term has the following meaning in this *Description of Benefits*, regardless of whether it is capitalized: the *Member*.

Appendix B – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2010 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 or if a generic version of a drug becomes available.

IMPORTANT NOTE: Please see our Web site at www.tuftshealthplan.com for the most current list or call a Member Specialist.

Brand Name	Suggested Alternatives
Abilify Discmelt	Abilify tablets
Abilify Solution	Abilify tablets
Acanya	benzaclin, clindamycin gel + benzoyl peroxide gel
Accupril	quinapril
Accuretic	quinapril/hydrochlorothiazide
AcipHex	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole
Acuvail	Acular, Acular LS, ketorolac
Aczone	benzoyl peroxide gel
Alcet	oxycodone/acetaminophen
Alcortin A Topical Gel	hydrocortisone/iodoquinol cream;
Aloquin	ciclopirox cream, clotrimazole cream (OTC, not covered)
Altace tablets	ramipril capsules
Altprev	lovastatin tablets
Ambien	zolpidem tartrate
Ambien CR	zolpidem tartrate
Amrix	cyclobenzaprine
Atacand	Benicar, Cozaar, or Diovan
Atacand HCT	Benicar HCT, Diovan HCT, Hyzaar
Auralgan	A/B Otic, Benzotic, Aurodex
Avalide	Benicar HCT, Diovan HCT, or Hyzaar
Avapro	Benicar, Cozaar, Diovan
Axid capsules	cimetidine, famotidine, nizatidine, ranitidine
Beconase AQ	fluticasone nasal spray, flunisolide nasal spray, Nasonex
Benzig	benzoyl peroxide
Benzig LS	benzoyl peroxide
Bystolic	atenolol, carvedilol, metoprolol
Calomist	Nascobal, cyanocobalamin
Caphosol	saliva substitute (OTC, not covered)
Capoten	captopril
Capozide	captopril/hydrochlorothiazide
Cleanse and Treat	benzoyl peroxide wash salicylic acid pads (OTC, not covered)
Clobex spray	clobetasol lotion
Combunox	oxycodone/ibuprofen

Appendix C – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Coreg CR	carvedilol
Dazidox	oxycodone tablets
Desonate	desonide cream/lotion
Durezol	diclofenac eye drops, prednisolone acetate
Dynacin	minocycline capsules
EC Naprosyn	enteric-coated naproxen
Edluar	zolpidem tartrate tablets
Epiduo	Differin 0.1% gel, benzoyl peroxide 2.5% gel
Evamist	Elestrin, EstroGel
Extina	ketoconazole cream or shampoo
Factive	ciprofloxacin, ofloxacin, or Avelox
Fenoglide	fenofibrate, Tricor
Fentora	fentanyl citrate lollipop, Actiq
Fexmid	cyclobenzaprine
Fibricor	fenofibrate, Tricor
Flagyl 375 mg, Flagyl ER	metronidazole tablets
Flector	diclofenac tablets
Flonase	flunisolide nasal spray, fluticasone nasal spray, Nasonex
Fortamet	metformin extended-release
Fosamax	alendronate
Fosamax	alendronate plus Vitamin D (Vitamin D is OTC, not covered)
Genotropin	Norditropin, Norditropin Nordiflex
Glumetza	metformin ER
Glycolax	Miralax (OTC, not covered)
Humatrope	Norditropin, Norditropin Nordiflex
Hydro 35/Hydro 40	urea lotion, urea cream
Hylira	Eucerin cream (OTC, not covered)
Inova	benzoyl peroxide wash, Stridex (OTC, not covered)
Invega	risperidone, Seroquel, Zyprexa
itraconazole capsules	terbinafine tablets (prior authorization required)
Kapidex	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole
Keppra XR	Keppra, levetiracetam
Kerafoam	urea lotion/cream
Keralac Nailstik	urea nail gel, Keralac nail gel
Kerol	urea cream/lotion
Kerol ZX	urea liquid/lotion
Ketotifen Fumarate Ophthalmic Drops	Zaditor (OTC, not covered)
Klonopin	clonazepam
Klonopin wafers	clonazepam
Levaquin	ciprofloxacin, ofloxacin, Avelox
Lialda	Apriso, Asaco
Lidamantle HC Medicated Pads	lidocaine-HC cream or lotion
Lipofen	fenofibrate, Tricor
Lopressor	metoprolol
Lotensin	benazepril
Lotensin HCT	benazepril/hydrochlorothiazide
Lovaza	omega-3 fish oil (OTC, not covered)
Lupron 1mg/0.2mL vial and kit	leuprolide 1mg/0.2mL vial and kit

Appendix C – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Luvox CR	fluvoxamine tablets
Magnacet	oxycodone/ acetaminophen tablets
Mavik	trandolapril
Megace ES	megestrol acetate oral suspension
Mevacor	lovastatin
Micardis	Benicar, Cozaar, Diovan
Micardis HCT	Benicar HCT, Diovan HCT, Hyzaar
Minocin	minocycline capsules
Mobic oral suspension	meloxicam oral suspension
Monodox	doxycycline monohydrate
Monopril	fosinopril
Monopril-HCT	fosinopril/hydrochlorothiazide
Moxatag	amoxicillin 500 mg, amoxicillin 875 mg
Naprelan	naproxen sodium extended-release
Nasacort AQ	flunisolide nasal spray, fluticasone nasal spray, Nasonex
Nasarel	flunisolide nasal spray, fluticasone nasal spray, Nasonex
Neobenz Micro/Kit/Wash	benzoyl peroxide
Neobenz Micro SD	benzoyl peroxide
Neotic	A-B Otic, Aurodex, Benzotic
Nexium	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole PLEASE NOTE: Nexium suspension is covered for <i>Members</i> 12 years of age or younger.
Niravam	alprazolam
Noxafil	fluconazole
Numoisyn	saliva substitute (OTC, not covered), Salivart
Nutropin	Norditropin, Norditropin Nordiflex
Nutropin AQ	Norditropin, Norditropin Nordiflex
Olux-E	Olux foam, clobetasol propionate emollient cream
Olux-Olux E	Olux foam, clobetasol propionate emollient cream
Omnaris	Astelin, fluticasone nasal spray, Nasalcrom (OTC, not covered)
Omnitrope	Norditropin, Norditropin Nordiflex
Opana	hydromorphone tablets, oxycodone tablets
Opana ER	oxycodone ER
Oracea	doxycycline
Otosporin	Star-Otic (OTC, not covered)
Pacnex	benzoyl peroxide cleanser
Pataday	Zaditor (OTC, not covered), Patanol
Patanase	Astelin, fluticasone nasal spray, flunisolide nasal spray
Pepcid (except suspension)	cimetidine, famotidine, nizatidine, or ranitidine tablets
Peranex HC	lidocaine-hydrocortisone-aloe kit
polyethylene glycol 3350 oral powder	Miralax (OTC, not covered)
Pravachol	Pravastatin
Prevacid	lansoprazole, omeprazole, Prilosec OTC (OTC, not covered)
Prevacid Solutab	lansoprazole, omeprazole, Prilosec OTC (OTC, not covered)
Prilosec	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole
Prinivil	lisinopril
Prinzide	lisinopril/hydrochlorothiazide
Proscar	Avodart, finasteride 5 mg
Protonix	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole PLEASE NOTE: Protonix suspension is covered for <i>Members</i> 12 years of age or younger.

Appendix C – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Rapaflo	doxazosin, Flomax, Uroxatral
Rhinocort Aqua	flunisolide nasal spray, fluticasone nasal spray, Nasonex
Rosac wash	Clenia cleanser, Avar cleanser
Rosula cleanser	Prascion, Sulfatol
Ryzolt	tramadol
Saizen	Norditropin, Norditropin Nordiflex
Salkera Foam	salicylic acid cream or lotion
Salvax 6% Foam	salicylic acid cream or lotion
Salvax Duo	salicylic acid lotion + urea lotion
Solodyn	minocycline tablets
Soma 250 mg	carisoprodol tablets
Sonata	zaleplon
Sporanox capsules	terbinafine tablets (prior authorization required)
Sular 8.5 mg, 17 mg, 22.5 mg, 34 mg	amlodipine, felodipine, nisoldipine
Sumaxin	sulfacetamide sodium 10%, sulfur 5% Med Pads
Taclonex	betamethasone dipropionate/calcipotriene ointment
Taclonex Scalp	betamethasone dipropionate + calcipotriene solution
Tekturna	lisinopril, enalapril, Benicar, Cozaar, or Diovan
Tekturna HCT	lisinopril/hydrochlorothiazide, enalapril/hydrochlorothiazide, Benicar HCT, Hyzaar, Diovan HCT
Tersi Foam	selenium sulfide shampoo
Teveten	Benicar, Cozaar, or Diovan
Teveten HCT	Benicar HCT, Diovan HCT or Hyzaar
Tev-Tropin	Norditropin, Norditropin Nordiflex
Toviaz	oxybutynin ER, Enablex, Vesicare
Tretin-X	tretinoin cream/gel
Treximet	sumatriptan tablets + naproxen sodium tablets
Triaz Foaming Cloths	benzoyl peroxide cleanser or pads
Trilipix	fenofibrate, Tricor
Trioxin	antipyrine/benzocaine otic, OtiRX
Uloric	allopurinol
Ultram ER	tramadol
Umecta PD Topic Emulsion Adhesive 40%	urea lotion, Umecta Topical Solution
Umecta PD Topical Suspension Adhesive 40%	urea lotion, Umecta Topical Suspension
Uniretic	moexipril/hydrochlorothiazide
Univasc	moexipril
Uramaxin	urea cream, gel, or lotion
urea nail stick 50%	urea nail gel 50%
Valium	diazepam
Vaseretic	enalapril/hydrochlorothiazide
Vasotec	enalapril
Vectical	calcipotriene, Dovonex cream
Veramyst	fluticasone propionate nasal spray, flunisolide nasal spray, Nasonex
Verdeso	desonide cream/lotion
Veregen	podofilox, Aldara, Condylox
Vicoprofen	hydrocodone/ibuprofen
Vusion	miconazole nitrate & zinc oxide (OTC, not covered)

Appendix C – Non-Covered Drugs With Suggested Alternatives, continued

Brand Name	Suggested Alternatives
Xanax	alprazolam
Xanax XR	alprazolam extended-release
Xolegel	ketoconazole cream
Zamicet	hydrocodone bitartrate/APA, Hycet
Zegerid	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole
Zelapar	selegiline tablets
Zestoretic	lisinopril/hydrochlorothiazide
Zestril	lisinopril
Ziana	tretinoin gel and clindamycin gel
Zinotic	Pramotic, Zolene HC
Zinotic ES	chloroxylenol/pramoxine HCl, OtiRX
Zipsor	diclofenac tablets
Zithranol-RR	Drithocrema HP
Zocor	simvastatin
Zoderm Redi-Pads	benzoyl peroxide wash
Zyflo CR	Singulair, Accolate
Zypram Rectal Kit	Analpram HC, hydrocortisone/pramoxine cream