

Minuteman Nashoba Health Group

#16116

**EPO Rate Saver
Choice Copay Option**

Description of Benefits



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



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.

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.

Notice for Grandfathered Health Plans

Tufts Health Plan believes that this coverage is a “grandfathered health plan.” This is a term used under the Patient Protection and Affordable Care Act. This is also called “the Affordable Care Act” or “federal health care reform”. A grandfathered health plan can keep certain basic health coverage already in place when that federal law took effect. Under this grandfathered health plan, your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans. One example is the requirement to have preventive health services without any cost sharing. (An example of cost sharing is a copayment or deductible). Your group can decide whether or not to follow this requirement. (For more information about how your plan covers preventive health services, see the “Benefit Overview” section in your Description of Benefits). However, this grandfathered health plan must follow certain other consumer protections in the Affordable Care Act. Under the Act, certain care is called “essential health benefits”. An example of this is maternity care. This plan cannot apply any annual or lifetime dollar limits on those essential health benefits.

You may have questions about which protections apply to a grandfathered health plan and which ones do not. You may want to know what can make a plan lose its grandfathered health plan status. If so, please call Tufts Health Plan. You can reach us at 1-800-462-0224 or see our Web site at www.tuftshealthplan.com. You can also contact the federal government with these questions.

- Your health plan may be offered through a city or state. If so, contact the U.S. Department of Health and Human Services at www.healthreform.gov.
- You may get your health coverage through another type of organization. An example of this is when your employer offers a group health plan. That plan may be subject to the federal Employee Retirement Income Security Act (ERISA). Ask your employer if your health coverage is part of an ERISA plan.
 - If you are in an ERISA plan, contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
 - If you are not in an ERISA plan, contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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
Friday 8:00 am - 5:00 pm

IMPORTANT PHONE NUMBERS:

Emergency Care

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

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

Liability Recovery

Call the Liability and Recovery Department at 1-888-880-8699, x. 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 *PCP*, benefit questions, and information regarding eligibility for enrollment and billing.

Mental Health Services

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

Services for Hearing Impaired Members

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

Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call 1-800-868-5850. 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.tufts-healthplan.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 Member Services Department.

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

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ តែគំរោងថែរក្សាសុខភាពរបស់ Tufts ។

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

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

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

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການທຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts, ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

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

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

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

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

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

1-800-462-0224

TDD Telecommunications Device for the Deaf
1-800-868-5850

MassRelay 1-800-720-3480

Plan Information

Plan Name	Minuteman Nashoba Health Group EPO Rate Saver Plan
Employer	Minuteman Nashoba Health Group
Employer Address	c/o Group Benefits Strategies, Inc. 15 Midstate Drive, Suite 110 Auburn MA 01501
Employer's ID Number (EIN)	04-6001121
Plan Number	16116-000
Tufts HP Effective Date	This <i>Plan</i> became effective as of June 1, 2009.
Description of Benefits Effective Date	This <i>Description of Benefits</i> is effective June 1, 2011. It may be amended in accordance with Chapter 7.
Plan Year	June 1 st – May 31 st
Benefit Year	Calendar Year
Plan Administrator and Agent for Service of Legal Process	Minuteman Nashoba Health Group c/o Group Benefit Strategies 15 Midstate Drive, Suite 110 Auburn, MA 01501
Type of Plan	Medical and Prescription Benefits.
Plan Administration	The <i>Plan</i> is administered by the <i>Plan Administrator</i> . The cost of medical benefits is the responsibility of the <i>Sponsor</i> under a self-funded arrangement.
Collective Bargaining Agreement	<p>The health benefits option under the <i>Plan</i> described in this Description of Benefits is maintained pursuant to a collective bargaining agreement and among the participating governmental units of the Minuteman Nashoba Health Group.</p> <p>A copy of such agreement may be obtained upon written request from the participating governmental units.</p>
Plan Fiscal Year	The fiscal records of the <i>Plan</i> are kept on a plan year basis ending on each December 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 <i>Member</i> shall be required to terminate, modify, amend or change the <i>Plan</i> .
Employee Contribution to Benefits	<p>Benefits for <i>Employee</i> only:</p> <ul style="list-style-type: none">• The <i>Employee</i> is required to contribute to the cost of benefits. <p>Benefits for <i>Employee</i> and <i>Dependents</i>:</p> <ul style="list-style-type: none">• The <i>Employee</i> is required to contribute to the cost of benefits.

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Benefit Overview

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

COPAYMENTS	
<ul style="list-style-type: none"> <u>Emergency Care:</u> <ul style="list-style-type: none"> Emergency room \$100 In <i>Provider's</i> office \$20 <i>Copayment</i> for care received from your <i>PCP</i>. \$40 <i>Copayment</i> for care received from any other <i>Tufts Health Plan Provider</i>. 	
<p><u>Note:</u></p> <ul style="list-style-type: none"> An <i>Emergency Room Copayment</i> may apply if you register in an emergency room but leave that facility without receiving care. A <i>Day Surgery Copayment</i> may apply if <i>Day Surgery</i> services are received. 	
<ul style="list-style-type: none"> <u>Other Covered Services:</u> <ul style="list-style-type: none"> Office Visits: <ul style="list-style-type: none"> Lower Office Visit <i>Copayment</i>..... \$20. <u>Note:</u> This <i>Copayment</i> applies to certain covered <i>Outpatient</i> care provided by your <i>PCP</i>, a mental health/substance abuse <i>Provider</i>, or an obstetrician/ gynecologist (“Ob/Gyn”), as well as for routine eye care. Higher Office Visit <i>Copayment</i>..... \$40. <u>Note:</u> This <i>Copayment</i> applies to all covered <i>Outpatient</i> care subject to an Office Visit <i>Copayment</i>, <u>except</u> for care obtained from the <i>Providers</i> or for the services listed above under Lower Office Visit <i>Copayment</i>. <i>Inpatient Services</i> \$250. <i>Day Surgery</i> \$250. 	
<p><u>Note:</u> For certain <i>Outpatient</i> services listed as “covered in full” in the table below, you may be charged an Office Visit <i>Copayment</i> when these services are provided in conjunction with an office visit.</p>	

INPATIENT COPAYMENT MAXIMUM
<p>Most of the <i>Inpatient Covered Services</i> listed in the table below are subject to an <i>Inpatient Copayment</i>. You are responsible to pay <i>Inpatient Copayments</i> up to the \$1,000 <i>Inpatient Copayment Maximum</i> per calendar year.</p> <p>The \$1,000 <i>Inpatient Copayment Maximum</i> is the most money you will have to pay for <i>Inpatient Covered Services</i> in a calendar year.</p>

DAY SURGERY COPAYMENT MAXIMUM
<p>You are responsible to pay <i>Day Surgery Copayments</i> up to the \$1,000 <i>Day Surgery Copayment Maximum</i> per calendar year.</p> <p>The \$1,000 <i>Day Surgery Copayment Maximum</i> is the most money you will have to pay for <i>Day Surgery</i> in a calendar year. The \$1,000 <i>Day Surgery Copayment Maximum</i> consists of <i>Day Surgery Copayments</i> only. It does not include <i>Copayments</i> for <i>Outpatient</i> services (such as office visits), <i>Inpatient</i> services, or <i>Emergency room Copayments</i>. It also does not include payments you make for non-<i>Covered Services</i>. When the <i>Copayment Maximum</i> is reached, no more <i>Day Surgery Copayments</i> will be taken in that calendar year.</p>

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	PAGE
Emergency Care		
Treatment in an Emergency room	\$100 <i>Copayment</i> per visit. (waived if admitted as an <i>Inpatient</i>) Note: Observation services will take an <i>Emergency room Copayment</i> .	3-1
Treatment in a <i>Provider’s office</i>	\$20 <i>Copayment</i> for care received from your <i>PCP</i> . \$40 <i>Copayment</i> for care received from any other <i>Tufts Health Plan Provider</i> .	3-1
A Member should call <i>Tufts Health Plan</i> within 48 hours after <i>Emergency care</i> is received. If you are admitted as an <i>Inpatient</i>, you or someone acting for you must call your <i>PCP</i> or <i>Tufts HP</i> within 48 hours. <u>Note:</u> A <i>Day Surgery Copayment</i> may apply if <i>Day Surgery</i> services are received.		

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

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

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided By Your PCP (or Ob/GYN, if applicable)	Care Provided by Any other Tufts HP Provider	
Outpatient Care			
Cardiac rehabilitation	\$20 Copayment per visit.	\$40 Copayment per visit.	3-2
Chiropractic care See “Spinal manipulation”			
Diabetes self-management training and educational services	\$20 Copayment per visit.	\$40 Copayment per visit.	3-3
Early intervention services for a <i>Dependent Child (BL)</i>	Covered in full.	Covered in full.	3-3
Family planning (procedures, services, and contraceptives)	Office Visit: \$20 Copayment per visit. Day Surgery: \$250 Copayment applies per admission*.	Office Visit: \$40 Copayment per visit. Day Surgery: \$250 Copayment applies per admission.	3-3
Hemodialysis	Covered in full.	Covered in full.	3-4

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

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

*This *Copayment* also applies for covered *Day Surgery* services at a free-standing surgical center.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided By Your PCP (or Ob/GYN, if applicable)	Care Provided by Any other Tufts HP Provider	
Outpatient Care - continued			
Infertility services (AR)	\$20 <i>Copayment</i> applies per visit. <u>Note:</u> Approved Assisted Reproductive Technology services are covered in full.	\$20 <i>Copayment</i> applies per visit. <u>Note:</u> Approved Assisted Reproductive Technology services are covered in full.	3-4
Maternity care <u>Note:</u> <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> .	\$20 <i>Copayment</i> applies per visit. <u>Note:</u> This Office Visit <i>Copayment</i> will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.	\$20 <i>Copayment</i> applies per visit. <u>Note:</u> This Office Visit <i>Copayment</i> will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.	3-5
Oral Health Services (AR)	Office Visit: \$20 <i>Copayment</i> applies per visit. Emergency Room: \$100 <i>Copayment</i> applies per visit. Inpatient Services: \$250 <i>Copayment</i> applies per admission. Day Surgery: \$250 <i>Copayment</i> applies per admission*	Office Visit: \$40 <i>Copayment</i> applies per visit. Emergency Room: \$100 <i>Copayment</i> applies per visit. Inpatient Services: \$250 <i>Copayment</i> applies per admission. Day Surgery: \$250 <i>Copayment</i> applies per admission*	3-5

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

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

*This *Copayment* also applies for covered *Day Surgery* services at a free-standing surgical center.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided By Your PCP (or Ob/GYN, if applicable)	Care Provided by Any other Tufts HP Provider	
Outpatient Care - continued			
<i>Outpatient</i> medical care			
Allergy testing and treatment	\$20 <i>Copayment</i> per visit.	\$40 <i>Copayment</i> per visit.	3-6
Allergy injections	Covered in full.	Covered in full.	3-6
Chemotherapy	Covered in full.	Covered in full.	3-6
Cytology examinations (Pap smears) (BL)	<u>Routine annual cytology screenings:</u> Covered in full. <u>Diagnostic cytology examinations:</u> Covered in full.	<u>Routine annual cytology screenings:</u> Covered in full. <u>Diagnostic cytology examinations:</u> Covered in full.	3-6

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

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

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided By Your PCP (or Ob/GYN, if applicable)	Care Provided by Any other Tufts HP Provider	
<i>Outpatient Care - continued</i>			
<i>Outpatient medical care, continued</i>			
Diagnostic Imaging <ul style="list-style-type: none"> • General imaging (such as x-rays and ultrasounds) and • MRI / MRA, CT/CTA, PET and nuclear cardiology (AR) 	<u>General Imaging:</u> Covered in full. <u>MRI/MRA:</u> Covered in full. <u>CT/CTA:</u> Covered in full. <u>PET:</u> Covered in full. <u>Nuclear cardiology:</u> Covered in full.	<u>General Imaging:</u> Covered in full. <u>MRI/MRA:</u> Covered in full. <u>CT/CTA:</u> Covered in full. <u>PET:</u> Covered in full. <u>Nuclear cardiology:</u> Covered in full.	3-6

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

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

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided By Your PCP (or Ob/GYN, if applicable)	Care Provided by Any other Tufts HP Provider	
<i>Outpatient Care - continued</i>			
<i>Outpatient medical care, continued</i>			
Diagnostic screening procedures (for example, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies) (AR)	<p><u>Diagnostic screening procedure only:</u> Covered in full.</p> <p><u>Diagnostic screening procedure accompanied by treatment/surgery (for example, polyp removal): <i>Day Surgery</i>:</u> \$250 <i>Copayment</i> applies per admission*</p>	<p><u>Diagnostic screening procedure only:</u> Covered in full.</p> <p><u>Diagnostic screening procedure accompanied by treatment/surgery (for example, polyp removal): <i>Day Surgery</i>:</u> \$250 <i>Copayment</i> applies per admission*</p>	3-6
Human leukocyte antigen (HLA) testing	Covered in full.	Covered in full.	3-6
Immunizations	<u>Routine preventive immunizations:</u> Covered in full.	<u>Routine preventive immunizations:</u> Covered in full.	3-7
Laboratory tests (AR)	Covered in full.	Covered in full.	3-7
Lead screenings	Covered in full.	Covered in full.	3-7

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

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

*This *Copayment* also applies for covered *Day Surgery* services at a free-standing surgical center.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided By Your PCP (or Ob/GYN, if applicable)	Care Provided by Any other Tufts HP Provider	
Outpatient Care - continued			
<i>Outpatient</i> medical care, continued			
Mammograms (BL)	<u>Routine mammograms:</u> Covered in full. <u>Diagnostic mammograms:</u> Covered in full.	<u>Routine mammograms:</u> Covered in full. <u>Diagnostic mammograms:</u> Covered in full.	3-7
Radiation therapy	Covered in full.	Covered in full.	3-7
Respiratory therapy and pulmonary rehabilitation services	Covered in full.	Covered in full.	3-7
Therapy for speech, hearing, and language disorders (AR)	\$20 <i>Copayment</i> applies per visit.	\$40 <i>Copayment</i> applies per visit.	3-7
Nutritional counseling	\$20 <i>Copayment</i> applies per visit.	\$40 <i>Copayment</i> applies per visit.	3-7
Office visits to diagnose and treat illness and injury	\$20 <i>Copayment</i> applies per visit.	\$40 <i>Copayment</i> applies per visit.	3-7
<i>Outpatient</i> surgery in a <i>Provider's</i> office	\$20 <i>Copayment</i> applies per visit.	\$40 <i>Copayment</i> applies per visit.	3-7
Patient care services provided as part of a qualified clinical trial (for treatment of cancer)	\$20 <i>Copayment</i> applies per visit.	\$40 <i>Copayment</i> applies per visit.	3-7
Pediatric dental care for <i>Members</i> under age 12	Covered in full.	Covered in full.	3-7
Preventive health care for <i>Members</i> under age 6	Covered in full.	\$40 <i>Copayment</i> applies per visit.	3-7
Preventive health care for <i>Members</i> age 6 and older	Covered in full.	\$40 <i>Copayment</i> applies per visit.	3-7

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

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

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided By Your PCP (or Ob/GYN, if applicable)	Care Provided by Any other Tufts HP Provider	
Outpatient Care - continued			
Routine annual gynecological exam	Covered in full.	Covered in full.	3-7
Short term physical and occupational therapy services (AR) (BL)	Physical Therapy: \$20 <i>Copayment</i> applies per visit. Occupational Therapy: \$20 <i>Copayment</i> applies per visit.	Physical Therapy: \$20 <i>Copayment</i> applies per visit. Occupational Therapy: \$20 <i>Copayment</i> applies per visit.	3-8
Vision care services			
Routine eye exam (BL)	\$20 <i>Copayment</i> applies per visit.	\$20 <i>Copayment</i> applies per visit.	3-8
Other vision care services	\$20 <i>Copayment</i> applies per visit.	\$40 <i>Copayment</i> applies per visit.	3-8

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	Care Provided at Community Hospital	Care Provided at Tertiary Hospital	
Day Surgery			
<i>Day Surgery (AR)</i>	\$250 <i>Copayment</i> applies per admission.	\$250 <i>Copayment</i> applies per admission.	3-8

*Note: This *Copayment* also applies for Covered *Day Surgery* services at a free-standing surgical center.

Inpatient Care			
Acute hospital services (AR)	\$250 <i>Copayment</i> applies per admission.	\$250 <i>Copayment</i> applies per admission.	3-9
Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants (AR)	Covered in full.	Covered in full.	3-9
Extended care (AR) (BL)	Covered in full.	Covered in full.	3-9
	Covered up to 100 days per calendar year.		

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

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

Benefit Overview, continued

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

<i>COVERED SERVICE</i>	YOUR COST		PAGE
	<i>Care Provided at Community Hospital</i>	<i>Care Provided at Tertiary Hospital</i>	
<i>Inpatient Care</i>			
Maternity care	\$250 <i>Copayment</i> applies per admission.	\$250 <i>Copayment</i> applies per admission.	3-10
Patient care services provided as part of a qualified clinical trial (for treatment of cancer)	Covered in full.	Covered in full.	3-10
Reconstructive surgery and procedures (AR)	\$250 <i>Copayment</i> applies per admission.	\$250 <i>Copayment</i> applies per admission.	3-10

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

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

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	PAGE
Mental Health and Substance Abuse Services		
Mental Health and Substance Services To contact the <i>Tufts HP</i> Mental Health Department, call 1-800-208-9565. (See “Benefit Limits” and Chapter 3 for visit, day, and dollar limits)		
<i>Outpatient services (AR)</i>	\$20 <i>Copayment</i> applies per visit.	3-11
<i>Inpatient services (AR)</i>	\$250 <i>Copayment</i> applies per admission.	3-12
Intermediate care (AR)	Covered in full.	3-12

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

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

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	PAGE
Other Health Services		
Ambulance services (AR)	Covered in full.	3-14
<i>Durable Medical Equipment</i> (AR) (BL)	Covered in full up to a maximum of \$1500 per calendar year. Note: This benefit limit includes the contributions of both <i>Tufts HP</i> and the <i>Member</i> .	3-15
Home health care (AR)	Covered in full.	3-16
Hospice care (AR)	Covered in full.	3-16
Injectable, infused, or inhaled medications (AR)	Covered in full.	3-17
Low protein food (BL)	Covered in full.	3-17
Medical supplies	Covered in full.	3-17
Nonprescription enteral formulas (AR)	Covered in full.	3-17
Scalp hair prostheses or wigs for cancer or leukemia patients (BL)	Covered in full.	3-17
Special medical formulas (AR)	Covered in full.	3-17
Prescription Drug Benefit		
For information about your <i>Copayments</i> for covered prescription drugs, see the “Prescription Drug Benefit” section in Chapter 3.		3-18

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

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

Benefit Limits

Extended Care Services

Covered up to 100 days per calendar year.

Scalp Hair Protheses or Wigs for Cancer or Leukemia Patients

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

Short-term Physical and Occupational Therapy Services

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

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

Chapter 1

How Your Exclusive Provider Option Plan Works

Overview

Introduction

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

How the *Plan* works

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

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

IMPORTANT NOTE:

- *For Outpatient care:* When you receive certain services from your *PCP*, a mental health/substance abuse *Provider*, or an obstetrician/gynecologist ("*Ob/Gyn*"), as well as for infertility services, *Outpatient* maternity care, and routine eye care, your *Copayment* may be lower than for services from other *Providers*.

About the *Tufts HP* Network

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

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

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

Eligibility for Benefits

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

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

Calls to Member Services

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

How the Plan Works

Primary Care Providers

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

Note: If you require non-*Emergency* health care services, always call your *PCP*. Without authorization from your *PCP*, services will not be covered.

Medically Necessary services and supplies

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

Service Area (see Appendix A)

In most cases, you must receive your care in the *Tufts HP Service Area*. Please note that the *Service Area*, which is defined in Appendix A, includes both the Standard and Extended *Service Area*. The exceptions are for an *Emergency*, or *Urgent Care* while traveling outside of the *Service Area*. See the *Tufts HP Directory of Health Care Providers* for *Tufts HP's Service Area*.

In the rare event that a service cannot be provided by a *Tufts Health Plan Provider*, in either the Standard or Extended *Service Area*, please call a Member Specialist for assistance or visit our Web site at www.tuftshealthplan.com.

Provider network

Tufts HP offers *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*.

Changes to Tufts HP's Provider Network

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

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

Coverage

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

IF you...	AND you are...	THEN...
receive routine health care services, visit a specialist, or receive covered elective procedures	in the Standard or Extended <i>Service Area</i>	you are covered, if you receive care through your <i>PCP</i> or with <i>PCP</i> referral
	outside the Standard or Extended <i>Service Area</i>	you are <u>not</u> covered.
require <i>Urgent Care</i>	in the Standard or Extended <i>Service Area</i>	you are covered. Contact your <i>PCP</i> first.
	outside the Standard or Extended <i>Service Area</i>	you are covered for <i>Urgent Care</i> .
have an <i>Emergency</i>	in the Standard or Extended <i>Service Area</i>	you are covered.
	outside the Standard or Extended <i>Service Area</i>	you are covered

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

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

Emergency Care and Urgent Care

Emergency Care

Definition of *Emergency*: See Appendix A.

Follow these guidelines for receiving *Emergency care*

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.
- You do not need approval from your *PCP* before receiving *Emergency care*.
- If you receive *Outpatient Emergency care* at an emergency facility, you or someone acting for you should call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. You are encouraged to contact your *Primary Care Provider* so your *PCP* can provide or arrange for any follow-up care that you may need.
- If you receive *Emergency Covered Services* from a non-*Tufts Health Plan Provider*, we will pay up to the *Reasonable Charge*. You pay the applicable *Copayment* and any difference between what we paid and what the non-*Tufts Health Plan Provider* charged for the service.

Urgent Care

Definition of *Urgent Care*: See Appendix A.

Follow these guidelines for receiving *Urgent Care*

If you are in the Standard or Extended Service Area

- Contact your *PCP* first. You may seek *Urgent Care* in your *PCP's* office, in an Emergency room, or at an Urgent Care Center affiliated with *Tufts Health Plan*.

If you are outside the Standard or Extended Service Area

- You may seek *Urgent Care* in a *Provider's* office, an Urgent Care Center, or the Emergency room.
- You do not need the approval of your *PCP* before receiving *Urgent Care*.

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

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

Inpatient Hospital Services

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

Mental Health/Substance Abuse Services

Inpatient and intermediate mental health/substance abuse services

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

The *Designated Facilities*

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

Outpatient mental health/ substance abuse services

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

Continuity of Care

If you are an existing *Member*

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

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

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

To choose a new *PCP*, call a Member Specialist. 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*.

Continuity of Care, continued

If you are enrolling as a new *Member*

When you enroll as a *Member*, if none of the health plans offered by the *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* for up to 30 days from your *Effective Date*.
- the *Provider* is your *PCP*. In this instance, you may continue to see your *PCP* for up to 30 days from your *Effective Date*;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* through your first postpartum visit;
- you are terminally ill. In this instance, you may continue to see your *Provider* as long as necessary.

Conditions for coverage of continued treatment

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

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

About Your *Primary Care Provider*

Importance of choosing a *PCP*

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

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

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

What a *PCP* does

A *PCP*:

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

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

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

About your *Primary Care Provider*, continued

Choosing a *PCP*

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

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

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 *PCP*. A Member Specialist can give you more information. Please see "Continuity of Care" on page 1-6.
- For additional information about a *PCP* or specialist, the Massachusetts Board of Registration in Medicine provides information about physicians licensed to practice in Massachusetts. You may reach the Board of Registration at (617) 654-9800 or www.massmedboard.org.

Contacting your new *PCP*

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

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

If you can't reach your *PCP*

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

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

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

Changing your *PCP*

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

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

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

Canceling appointments

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

About your *Primary Care Provider*, continued

Referrals for specialty services

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

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

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

Notes:

- A referral to a specialist must be obtained from your *PCP* **before** you receive any *Covered Services* from that specialist. If you do not obtain a referral **prior** to receiving services, you will be responsible for the cost of those services.
- *Covered Services* provided by non-*Tufts HP Providers* are not paid for unless authorized in advance by your *PCP* and approved by an *Authorized Reviewer*.
- For mental health and substance abuse services, you do not need a referral from your *PCP*; however, you may need authorization from a *Tufts HP* Mental Health *Authorized Reviewer*. See “*Inpatient and intermediate mental health/substance abuse services*” and “*Outpatient mental health/substance abuse services*” later in this chapter for more information.
- *Copayments* for certain *Covered Services* provided by your *PCP*, a mental health/substance abuse *Provider*, an obstetrician/gynecologist (“*Ob/Gyn*”), as well as for *Outpatient* physical, occupational, or speech therapy services, infertility services, *Outpatient* maternity care, and routine eye exams may be lower than for services provided by other *Providers*. Please see Chapter 3 for more information.

Referral forms for specialty services

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

Authorized Reviewer approval

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

About your *Primary Care Provider*, continued

When referrals are not required

The following *Covered Services* do not require a referral or prior authorization from your *Primary Care Provider*. Except as detailed earlier in this chapter, or for *Urgent Care* outside of the *Tufts HP Service Area*, or for *Emergency care*, you must obtain these services from a *Tufts HP Provider*.

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

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

Methods of payment to *Tufts HP Providers*

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

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

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

Member Identification Card

Introduction

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

Reporting errors

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

Member Identification Card, continued

Identifying yourself as a *Tufts HP Member*

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

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

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

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

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

Membership requirement

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

Membership identification number

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

Utilization Management

Introduction

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

Utilization management

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

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

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

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

Tufts 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.

Utilization Management, continued

Specialty case management

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

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

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

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

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

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

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

Individual case management (ICM)

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

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

Chapter 2

Eligibility, Enrollment and Continuing Eligibility

Eligibility

Waiting Period

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

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

Eligibility rule

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

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

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

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

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

Minimum Hours

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

If you live outside Tufts HP's Service Area

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

- you are a *Child* attending school full-time outside of the *Service Area*;
- you are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced *Spouse* for whom coverage is required.

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

Proof of eligibility

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

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

Enrollment

When to enroll

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

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

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

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

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

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

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

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

Effective Date of coverage

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 *Group* has an IRS qualified cafeteria plan, any other qualifying event under that plan.

Adding *Dependents*, continued

How to add *Dependents*

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

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

Effective Date of *Dependents*' coverage

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

Effective Dates will be no later than:

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

Availability of benefits after enrollment

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

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

Newborn *Children* and *Adoptive Children*

Introduction

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

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

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

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

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

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

Step	Action
1	Choose a <i>PCP</i> from the list of <i>PCPs</i> in the <i>Tufts HP Directory of Health Care Providers</i> or call a Member 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*, continued

Coverage after termination

When a Child loses coverage under this Description of Benefits, he or she may be eligible for federal continuation of coverage or to enroll in a Non-Group Coverage. See Chapter 5 for more information.

How to continue coverage for *Disabled Dependents*

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

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

When coverage ends

Disabled Dependent coverage ends when:

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

Coverage after termination

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

Continuing Eligibility for *Dependents*, continued

Keeping the *Plan's* records current

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

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

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

Chapter 3

Covered Services

Overview

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

Covered Services

When health care services are Covered Services

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

- listed as *Covered Services* in this chapter;
- *Medically Necessary*;
- consistent with applicable law;
- 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;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your *PCP*, except in an *Emergency* or for *Urgent Care* (see “When You Need *Emergency* or *Urgent Care*” earlier in this *Description of Benefits* for more information);
- approved by an *Authorized Reviewer*, in some cases; and
- in the case of *Inpatient* or intermediate mental health/substance abuse services, provided by a *Designated Facility*.

Notes:

- For information about your costs for the *Covered Services* listed below (for example, *Copayments*), see the “Benefit Overview” section at the beginning of this document.
- Information about the day, dollar, and visit limits under this plan are listed in certain *Covered Services* in this chapter.
- For *Outpatient* care: When you receive services from your *PCP*, a mental health/substance abuse *Provider*, or an obstetrician/gynecologist (“Ob/Gyn”), your *Copayment* may be lower than for services from other *Providers*.
- *Authorized Reviewer* approval: Certain *Covered Services* described in this chapter must be authorized in advance by an *Authorized Reviewer*. If such authorization is not received, the *Plan* will not cover those services and supplies.

Emergency care

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

Notes:

- The *Emergency Room Copayment* is waived if the *Emergency* room visit results in immediate hospitalization.
- If you receive *Emergency Covered Services* from a non-*Tufts HP Provider*, the *Plan* will pay up to the *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.
- A *Day Surgery Copayment* may apply if *Day Surgery* services are received.

Covered Services, continued

Outpatient care

Cardiac rehabilitation services

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

The *Plan* covers only the following services:

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

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

Diabetes self-management training and educational services

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

Important Notes:

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

Early intervention services for a *Dependent Child*

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

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

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

Family planning

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

- Procedures
 - sterilization; and
 - pregnancy terminations (no *PCP* referral required).
- Services
 - medical examinations;
 - consultations;
 - birth control counseling; and
 - genetic counseling.
- Contraceptives
 - cervical caps;
 - Intrauterine devices (IUDs);
 - 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 *Tufts HP* covers certain contraceptives, such as oral contraceptives and diaphragms, under a Prescription Drug Benefit. If those contraceptives are covered under that benefit, they are not covered here.

Covered Services, continued

Outpatient care (continued)

Hemodialysis

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

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

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

- artificial insemination (intrauterine or intracervical) when done with donor sperm and/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; and
- with respect to the procurement and processing of donor sperm, eggs or inseminated eggs or banking of donor sperm or inseminated eggs, to the extent such costs are not covered by the donor's health care coverage, if any.

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

Covered Services, continued
Outpatient care, (continued)

Maternity care

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

Notes:

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

Oral health services

- *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 above criteria 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.
Surgical removal of unerupted teeth when embedded in bone	Hospital, <i>Provider</i> , and surgical charges.
Extraction of seven or more permanent teeth during one visit	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 medical care

- Allergy testing (including antigens) and treatment, and allergy injections.
- chemotherapy;
- cytology examinations (Pap Smears) - one annual screening for women age 18 and older, or as otherwise *Medically Necessary*;
- diagnostic imaging, including general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA, and PET tests and nuclear cardiology (may require the prior approval of an *Authorized Reviewer*);
- diagnostic screening procedures, including, but not limited to, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies (requires the prior approval of an *Authorized Reviewer*);
- human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a Member's bone marrow transplant donor suitability. Includes costs of testing for A, B or DR antigens, or any combination consistent with the rules and criteria established by the Department of Public Health;
- immunizations;
- 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*;
- lead screenings;
- mammograms (no *PCP* referral required) at the following intervals:
 - one baseline at 35-39 years of age,
 - one every year at age 40 and older,
 - or as otherwise *Medically Necessary*;
- *Medically Necessary* diagnosis and treatment of speech, hearing and language disorders (services may require the approval of an *Authorized Reviewer*);
- Nutritional counseling;
- Office visits to diagnose and treat illness or injury.
Note: This includes *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions (no *PCP* referral required).
- *Outpatient* surgery in a *Provider's* office;
- radiation therapy;
- respiratory therapy and pulmonary rehabilitation services.

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

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

Covered Services, continued

Outpatient care (continued)

Pediatric dental care for *Members* under age 12

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

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

Preventive health care for *Members* under age 6

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

Covered Services, continued

Outpatient care (continued)

Preventive health care for *Members age 6 and older*

- routine physical examinations, including appropriate immunizations and lab tests as recommended by a *Tufts HP Provider*;
- hearing examinations and screenings.

Routine annual gynecological exam

Including any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam (no *PCP* referral required) and hormone replacement therapy services;

Short term physical and occupational therapy services

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

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

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.

Vision care services

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

Covered Services, continued

Day Surgery

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

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

Inpatient care

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

(must be approved by an *Authorized Reviewer*)

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

Notes:

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

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

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

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

Hospital services (Acute care)*

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

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

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

Covered Services, continued

Inpatient care, (continued)

Maternity care (no *PCP* referral required)

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

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

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

Notes:

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

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

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

Reconstructive surgery and procedures

Coverage is provided for the cost of:

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

*Prosthetic devices are covered as described under "*Durable Medical Equipment*" later in this chapter. However, those prosthetic devices are not subject to the "*Durable Medical Equipment*" maximum of \$1,500 per calendar year.

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

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

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

Notes:

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

Covered Services, Continued

Mental Health 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 any other means. Prior approval 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

Other Health Services, (continued)

Durable Medical Equipment

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

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

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

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

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

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

Important Note: You may be responsible for paying towards the 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*.

The following examples of covered and non-covered items are for illustration only. Please call a Member Specialist 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 \$1500 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 purchase or rent the equipment for you. This equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with *Tufts HP* to provide such equipment.

(continued on next page)

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;
- foot orthotics and arch supports;
- fixtures to real property, such as ceiling lifts, elevators, ramps, stair lifts or stair climbers;
- 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 physician. Commercially available standard mattresses not used primarily to treat an illness or injury (e.g., Tempur-Pedic® or Posturepedic® mattresses), even if used in conjunction with a hospital bed, are not covered.

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

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

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

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

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

Covered Services, continued

Other Health Services, (continued)

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

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

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

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

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

Injectable, infused, or inhaled medications

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

Notes:

- Prior authorization and dispensing limitations may apply.
- There are designated home infusion *Providers* for a select number of specialized pharmacy products and drug administration services. These *Providers* offer clinical management of drug therapies, nursing support, and care coordination to *Members* with acute and chronic conditions. Medications offered by these *Providers* include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency and enzyme replacement therapy. Please contact Member Services or see our 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 the “Injectable medications” benefit. For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

Low protein foods

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

Covered in full up to \$2500 per calendar year.

Medical supplies

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

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

Notes:

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

Covered Services, continued

Other Health Services, (continued)

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

Coverage is provided:

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

Scalp hair prostheses or wigs for cancer or leukemia patients

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

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

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

For the treatment of:

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

Covered Services, continued

Prescription Drug Benefit

Introduction

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

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

How Prescription Drugs Are Covered

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

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

For a current list of covered drugs, please go to our Web site at www.tuftshealthplan.com, or call a Member 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		
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a <i>Tufts HP</i> designated retail pharmacy.		
<u>Tier-1 drugs:</u>	<u>Tier-2 drugs:</u>	<u>Tier-3 drugs:</u>
\$10 for up to a 30-day supply	\$25 for up to a 30-day supply	\$45 for up to a 30-day supply
\$20 for a 31-60 day supply	\$50 for a 31-60 day supply	\$90 for a 31-60 day supply
\$30 for a 61-90 day supply	\$75 for a 61-90 day supply	\$135 for a 61-90 day supply
Note: If you fill your prescription in a state that allows you to request a brand-name drug even though your <i>Provider</i> authorizes the generic equivalent, you will pay the applicable <i>Tier Cost Sharing Amount</i> plus the difference in cost between the brand-name drug and the generic drug.		
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a <i>Tufts HP</i> designated mail services pharmacy.		
<u>Tier-1 drugs:</u>	<u>Tier-2 drugs:</u>	<u>Tier-3 drugs:</u>
\$10 for up to a 90-day supply	\$25 for up to a 90-day supply	\$45 for up to a 90-day supply

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 on 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.

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 “Family planning” benefit earlier in this chapter),
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under “Preventive health care” earlier in this chapter.
- Prescriptions written by *Providers* who do not participate in *Tufts HP*, except in cases of authorized referral or *Emergency care*.
- Prescriptions filled at pharmacies other than *Tufts HP* designated pharmacies, except for *Emergency care*.
- Smoking cessation agents.
- Drugs for asymptomatic onchomycosis, except for Members with diabetes, vascular compromise, or immune deficiency status.
- 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 ≤ 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 a Member Specialist.
- 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 our Web site at www.tuftshealthplan.com, or call a Member Specialist.

Covered Services, continued

Prescription Drug Benefit, continued

Filling Your Prescription

Where to Fill Prescriptions:

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

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

How to Fill Prescriptions:

- Make sure the prescription is written by a *Tufts HP* participating *Provider*, except in cases of authorized referral or in *Emergencies*.
- When you fill a prescription, provide your Member ID to any *Tufts HP* designated pharmacy and pay your *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 is honored only at *Tufts HP* designated pharmacies. In cases of *Emergency*, please call the *Tufts HP* Member Services Department for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:

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

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

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

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

NOTE: Your *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, and medications:

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

This exclusion does not apply to:

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

which meet the requirements of applicable law.

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

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

Exclusions from Benefits, continued

- Preventive dental care, except as provided under “Pediatric dental care for *Members* under age 12” earlier in this chapter; except as described earlier under Pediatric dental services; 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 earlier in this chapter), 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 when performed in any setting other than a hospital, *Day Surgery*, or a *Provider’s* office.
- Infertility services for *Members* who do not meet the definition of infertility as described in the “Outpatient Care” section earlier in this chapter; experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days) sperm or embryo cryopreservation unless the *Member* is in active infertility treatment; costs associated with donor recruitment and compensation; infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; and donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.

*the costs of surrogacy means: (1) all costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*. These costs include, but are not limited to: costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a *Member*.

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

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

Note: *Tufts HP* may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a *Member’s* future fertility. Prior approval by an *Authorized Reviewer* is required. Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an *Authorized Reviewer*, is provided at a *Tufts HP* ART center, and the *Member* is the sole recipient of the donor’s eggs.

- 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”; and
 - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs, or banking of donor sperm or inseminated eggs, under “Infertility services” (to the extent such costs are not covered by the donor’s health coverage, if any).
- Acupuncture; biofeedback, except for treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; spinal manipulation services, *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

- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies or procedures, and all services, procedures, labs and supplements associated with this type of medicine.
- Any service, supply or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts, therapeutic programs, camps and clinics).
- 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. Except as described earlier in this chapter, the *Plan* will not cover contact lenses or contact lens fittings.
- Hearing aids, except for one hearing aid per ear per prescription change for *Children* under age 19, as described under "*Durable Medical Equipment*" earlier in this chapter.
- Private duty nursing (block or non-intermittent nursing).
- Methadone treatment or methadone maintenance related to substance abuse disorders.
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.
 - Note: This exclusion also does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:
 - are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
 - are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in "Ambulance services" earlier in this chapter.
- Lodging related to receiving any medical service.

Chapter 4

When Coverage Ends

Overview

Reasons coverage ends

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

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

Benefits after termination

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

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

Continuation and conversion

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

When a *Member* is No Longer Eligible

Loss of eligibility

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

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

Dependent Coverage

- An enrolled *Dependent's* coverage ends when the *Subscriber's* coverage ends. Coverage of any *Child* of an enrolled *Dependent Child* ends when the enrolled *Dependent Child's* coverage ends.

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

If you are a *Subscriber* or *Spouse* and you move out of the *Tufts HP Service Area*, coverage ends as of the date you move. Please note that *Children* are not required to maintain primary residence in the *Service Area*. However, care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only.

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

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

When a *Member* is No Longer Eligible, continued

You choose to drop coverage

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

Membership Termination for Acts of Physical or Verbal Abuse

Acts of physical or verbal abuse

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

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

Membership Termination for Misrepresentation or Fraud

Policy

Your coverage may be terminated for misrepresentation or fraud. 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; or
- 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 *Group's* contract with *Tufts HP* terminates;
- your *Group* fails to pay its obligation;
- *Tufts HP* stops operating; or
- your *Group* stops operating.

Obtaining a Certificate of Creditable Coverage

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

Chapter 5

Continuation of Coverage

Federal Continuation Coverage (COBRA)

Introduction

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

Rules for federal COBRA continuation

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

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

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

Qualifying events

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

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

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

When federal COBRA coverage is effective

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

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

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

Cost of Coverage

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

Duration of Coverage

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

Federal Continuation Coverage (COBRA), continued

FEDERAL COBRA - DURATION OF COVERAGE CHART		
Qualifying Event(s)	Qualified Beneficiaries	Maximum Period of Coverage
<ul style="list-style-type: none"> Termination of <i>Subscriber's</i> employment for any reason other than gross misconduct. Reduction in the <i>Subscriber's</i> work hours. 	<i>Subscriber, Spouse, and Dependent Children</i>	18 months*
<i>Subscriber's</i> divorce, legal separation, entitlement to Medicare, or death.	<i>Spouse and Dependent Children</i>	36 months
<i>Subscriber's</i> or <i>Spouse's</i> enrolled <i>Dependent</i> ceases to be a <i>Dependent Child</i> .	<i>Dependent Child</i>	36 months
<p>*Important Note: If a qualified beneficiary is determined under the federal Social Security Act to have been disabled within the first 60 days of federal COBRA continuation coverage for these qualifying events, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA coverage for up to an additional 11 months.</p>		

When coverage ends

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

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

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Under USERRA:

- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed services, and (1) you ensure that your employer receives advance written or verbal notice of your service; (2) you have five years or less of cumulative service in the uniformed service while with that particular employer; (3) you return to work or apply for reemployment in a timely manner after conclusion of service; and (4) you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service, or, in some cases, a comparable job.
- If you are a past or present member of the uniformed services, have applied for membership in the uniformed services, or are obligated to service 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

Member Satisfaction

Overview

Introduction

This chapter contains information about:

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

Address and telephone number

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

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

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

Member Satisfaction Process

Process Summary

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

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

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

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

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

Internal Inquiry

Call a *Tufts HP* Member 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 Satisfaction Process, continued

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.

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 grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

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

Member Satisfaction Process, continued

Internal Member Appeals

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

You can submit a verbal appeal of a benefit coverage decision to a *Tufts HP* Member 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.

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 which are in the possession and control of *Tufts HP*. The time limits of this process will be waived or extended by a mutual written agreement between you or your authorized representative and *Tufts HP*.

The Appeals 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

Medical Expenses

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

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

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

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

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

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

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

Pharmacy Expenses

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

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

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

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

Med Pay

You may be covered for medical expenses under optional automobile medical payments insurance ("Med Pay"). To the extent permitted under applicable state law, our coverage is secondary to Med Pay benefits. If we pay benefits before Med Pay benefits have been exhausted, we may recover the cost of those benefits as described above.

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 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 up to the cost of health care services and supplies, and expenses that the *Plan* paid or will pay for your illness or injury.

Subrogation, continued

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 Agent

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

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.

Coordination of Benefits, continued

How COB works

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

(1) No COB Rule

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

(2) COB Rule

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

• Employee/Dependent Rule

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

• Birthday Rule

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

• Children of Separated/Divorced Parents Rule

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

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

• Court Decree Rule

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

• Active/Inactive Rule

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

• Longer/Shorter Rule

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

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

Coordination of Benefits, continued

Right to receive and release necessary information

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

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

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

Right to recover overpayment

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

For more information

For more information about COB, contact the *Tufts HP* 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

Medicare eligibility

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

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

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

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

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

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

Use and Disclosure of Medical Information

For information about how *Tufts HP* uses and discloses your medical information, please contact a Member 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*, change this *Description of Benefits*, or assume or create any obligation for the *Plan* or *Tufts HP*.

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

Circumstances Beyond *Tufts Health Plan's* Reasonable Control

Circumstances beyond *Tufts HP's* reasonable control

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

Group Contract

Acceptance of the terms of the *Plan*

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

Payments

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

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

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

Notice

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

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

Enforcement of terms

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

Appendix A

Glossary of Terms

Terms and Definitions

Adoptive Child

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

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

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

Annual Coverage Limitations

Annual dollar or time limitations on *Covered Services*.

Authorized Reviewer

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

Benefit Year

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

Child

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

Coinsurance

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

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

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

Copayment

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

Cost Sharing Amount

The cost you pay for certain *Covered Services*.

Terms and Definitions, continued

Covered Services

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

- described in Chapter 3;
- *Medically Necessary*; and
- provided or authorized by your *PCP* and in some cases, approved by an *Authorized Reviewer*.

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

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

Covering Provider

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

Custodial Care

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

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

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

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

Day Surgery

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

Dependent

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

Description of Benefits

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

Designated Facility

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

Terms and Definitions, continued

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 PCPs* and their affiliated *Tufts HP Hospitals* and certain other *Tufts HP Providers*.

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

Disabled Dependent

The Subscriber's unmarried *Child* who:

- became permanently physically or mentally disabled before age 26.
- 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 26 (or before losing eligibility as a *Dependent*) or has been covered by other group health coverage since the disability began.

Durable Medical Equipment

Devices or instruments of a durable nature that:

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

Effective Date

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

Terms and Definitions, continued

Emergency

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

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

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

Employee

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

Employer

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

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is 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; or
- the treatment, or the "informed consent" form used with the treatment, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval; or
- reliable evidence shows that the treatment: is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or
- 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 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 *Member* and his or her *Dependents*.

Terms and Definitions, continued

Group

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

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

Group Contract

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

Individual Coverage

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

Inpatient

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

Medically Necessary

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

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

In determining coverage for *Medically Necessary* services, *Tufts HP* uses 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 provided, of the American Psychiatric Association's Diagnostic and Statistical Manual: Mental Disorders.

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.

Provider Organization

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

Plan

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

Plan Sponsor

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

Primary Care Provider (PCP)

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

Provider

A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, limited service medical clinics (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; or
- amount that *Tufts Health Plan* determines to be reasonable, based upon nationally accepted means and amounts of claims payment. Nationally accepted means and amounts of claims payment include, but are not limited to, Medicare fee schedules and allowed amounts, CMS medical coding policies, AMA CPT coding guidelines, nationally recognized academy and society and clinical guidelines.

Routine Nursery Care

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

Terms and Definitions, continued

Service Area

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

The Standard *Service Area* is comprised of:

- all of Massachusetts, and all of Rhode Island except Block Island; and
- the cities and towns in New Hampshire:
 - n which *Tufts HP PCPs* are located; and
 - which are a reasonable distance from *Tufts Health Plan* specialists who provide the most-often used services, such as behavioral health practitioners and *Providers* who are surgeons and or OB/GYNs.

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

- surround the Standard Service Area; and
- are within a reasonable distance from *Tufts Health Plan PCPs* and specialists who provide the most-often used services such as behavioral health practitioners and *Providers* who are surgeons and OB/GYNs.

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

Spouse

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

Skilled

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

Subscriber

The person who is 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 preferred providers and to provide certain services to the health benefit plans including, but not limited to, processing claims for benefits and enrollment. THP is not the *Plan Sponsor* and does not insure the *Plan*. Also referred to as “*Tufts HP*”.

Tufts HP Hospital

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

Tufts HP Provider

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

Urgent Care

Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, 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 when used in this *Description of Benefits*, regardless of whether or not it is capitalized: the *Member*.

Appendix B – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2011 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	clindamycin gel + benzoyl peroxide gel
Accupril	quinapril
Accuretic	quinapril/hydrochlorothiazide
AcipHex	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole
Actiq	fentanyl citrate
Acuvail	Acular, Acular LS, ketorolac
Aczone	benzoyl peroxide gel
Adalat CC	nifedipine extended-release
Adderall	amphetamine/dextroamphetamine mixed salts
Adderall XR	amphetamine/dextroamphetamine mixed salts extended release
Alcortin A Topical Gel	hydrocortisone/iodoquinal cream
Aldactone	spironolactone
Aldactazide	spironolactone/hydrochlorothiazide
Altace	ramipril capsules
Altoprev	lovastatin tablets
Ambien	zolpidem tartrate
Ambien CR	zolpidem tartrate
Amrix	cyclobenzaprine
Anafranil	clomipramine HCl
Analpram E Rectal Kit	hydrocortisone/pramoxine rectal cream
Anaprox DS	naproxen sodium
Ansaid	flurbiprofen
Antara	fenofibrate
Arava	leflunomide
Atacand	losartan, Benicar, or Diovan
Atacand HCT	losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT
Ativan	lorazepam
Auralgan	A/B Otic, Benzotic, Aurodex
Avalide	losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT
Avapro	losartan, Benicar, or Diovan
Avar LS Cleanser	Avar
Avar-E LS Cream	Avar E
Axid capsules	cimetidine, famotidine, nizatidine, ranitidine
Beconase AQ	fluticasone nasal spray, flunisolide nasal spray, Nasonex
BenzEfoam	benzoyl peroxide
Benziq	<i>benzoyl peroxide</i>
Benziq LS	benzoyl peroxide
Bepreve	azelastine eye drops, Patanol
Besivance	ciprofloxacin eye drops, Vigamox, Zymar
Buspar	bupirone
Bystolic	atenolol, carvedilol, metoprolol
Calan	verapamil
Calan SR	verapamil extended-release
Cambia	diclofenac potassium tablets
Caphosol	saliva substitute (OTC, not covered)
Cardizem	diltiazem
Cardizem CD/LA	diltiazem extended-release

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

Brand Name	Suggested Alternatives
Cardura	doxazosin
Cataflam	diclofenac potassium
Catapres	clonidine
Catapres TTS	clonidine transdermal
Chenodal	ursodiol
Celexa	citalopram
Cleanse and Treat	benzoyl peroxide wash + salicylic acid pads (OTC, not covered)
Clinoril	sulindac
Clobex spray	clobetasol lotion
Colestid	colestipol
Coreg	carvedilol
Coreg CR	carvedilol
Cozaar	losartan
Darvocet-N 1--	propoxyphene napsylate/acetaminophen
Darvon	propoxyphene
Daypro	oxaprozin
Demadex	torsemide
Demerol	meperidine
Deprizine suspension	ranitidine
Desonate	desonide cream/lotion
Dexedrine	dextroamphetamine
Dexedrine Spansule	dextroamphetamine extended-release
Dexilant	Prilosec OTC, omeprazole, lansoprazole, pantoprazole
Dicopanor suspension	diphenhydramine liquid
Dilacor XR	diltiazem extended-release
Dilaudid	hydromorphone
Duragesic	fentanyl patch
Durasal	salicylic acid liquid/patch
Durezol	diclofenac eye drops, prednisolone acetate
Dyazide	triamterene/hydrochlorothiazide capsules
Dynacin	minocycline capsules
EC Naprosyn	enteric-coated naproxen
Edluar	zolpidem tartrate tablets
Effexor XR	venlafaxine extended-release capsules
Epiduo	adapalene 0.1% gel, benzoyl peroxide 2.5% gel
Exalgo	hydromorphone tablets
Extina	ketoconazole cream or shampoo
Factive	ciprofloxacin, ofloxacin, Avelox
Fanapt	irsperidone, Seroquel, Zyprexa
Fanatrex	Neurontin solution
Feldene	piroxicam
Fenoglide	fenofibrate
Fentora	fentanyl citrate lollipop
Fexmid	cyclobenzaprine
Fibricor	fenofibrate
Fioricet	butalbital/acetaminophen/caffeine
Fiorinal	butalbital/aspirin/caffeine
Flagyl 375 mg, Flagyl ER	metronidazole tablets
Flector	diclofenac tablets
Flexeril	cyclobenzaprine
Flonase	flunisolide nasal spray, fluticasone nasal spray, Nasonex
Focalin	dexmethylphenidate
Fortamet	metformin extended-release
Fosamax	alendronate
Fosamax Plus D	alendronate + Vitamin D (Vitamin D is OTC, not covered)
Genotropin	Norditropin, Norditropin Nordiflex, Norditropin Flexpro
Glumetza	metformin ER
Glycolax	Miralax (OTC, not covered)

Italicized words are defined in Appendix A.

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

Brand Name	Suggested Alternatives
Halcion	triazolam
Humatrope	Norditropin, Norditropin Nordiflex
Hydro 35/Hydro 40	urea lotion, urea cream
Hyzaar	losartan/hydrochlorothiazide
Inderal LA	propranolol extended-release
Indocin SR	indomethacin
Inova	benzoyl peroxide wash, Stridex (OTC, not covered)
Invega	risperidone, Seroquel, Zyprexa
Invega Sustenna	Risperdal Consta, risperidone
Keppra XR	Keppra, levetiracetam
Kerafoam	urea lotion/cream
Keralac Nailstik	urea nail gel, Keralac nail gel
Kerol	urea cream/lotion
Kerol AD	urea emulsion/lotion
Kerol ZX	urea liquid/lotion
Klonopin	clonazepam
Lasix	furosemide
Levaquin	ciprofloxacin, ofloxacin, Avelox
Lialda	Apriso, Asacol
Librax	chlordiazepoxide/clidinium
Lidamantle HC Medicated Pads	lidocaine-HC cream or lotion
Lipofen	fenofibrate
Livalo	simvastatin
Lofibra	fenofibrate
Lopid	gemfibrozil
Lopressor	metoprolol
Lopressor HCT	metoprolol/hydrochlorothiazide
Lotensin	benazepril
Lotensin HCT	benazepril/hydrochlorothiazide
Lotrel	amlodipine/benazepril
Lovaza	omega-3 fish oil (OTC, not covered)
Luvox CR	fluvoxamine tablets
Mavik	trandolapril
Maxzide	triamterene/hydrochlorothiazide tablets
Megace ES	megestrol acetate oral suspension 40 mg/mL
Metadate ER	methylphenidate extended-release 10 mg
Methylin Oral Solution	methylphenidate oral solution
Metozolv ODT	metoclopramide oral solution
Mevacor	lovastatin
Micardis	losartan, Benicar, Diovan
Micardis HCT	losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT
Minipress	prazosin
Minocin	minocycline capsules
Metozolv ODT	metoclopramide oral solution
Mevacor	lovastatin
Micardis	losartan, Benicar, Diovan
Micardis HCT	losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT
Minipress	prazosin
Minocin	minocycline capsules
Mobic	meloxicam
Monodox	doxycycline monohydrate

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

Brand Name	Suggested Alternatives
Moxatag	amoxicillin 500 mg, amoxicillin 875 mg
MS Contin	morphine sulfate extended-release
Naprelan	naproxen sodium extended-release
Naprelan CR DosePak	naproxen sodium extended-release tablets
Naproxyn	naproxen
Nasacort AQ	flunisolide nasal spray, fluticasone nasal spray, Nasonex
Neobenz MicroKit	benzoyl peroxide
Neobenz Micro SD	benzoyl peroxide
Neutrasal	saliva substitute (OTC, not covered)
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
Norco	hydrocodone/acetaminophen
Norpramin	desipramine
Norvasc	amlodipine
Noxafil	fluconazole
Nutropin	Norditropin, Norditropin Nordiflex, Norditropin Flexpro
Nutropin AQ	Norditropin, Norditropin Nordiflex, Norditropin Flexpro
Norditropin AQ Nuspin	Norditropin, Norditropin Nordiflex, Norditropin Flexpro
Olux-E	Olux foam, clobetasole 0.05% foam
Olux-Olux E	Olux foam, clobetasole 0.05% foam
Omnisar	azelastine nasal spray, Astepro, Astelin
Omnitrope	Norditropin, Norditropin Nordiflex, Norditropin Flexpro
Opana	oxymorphone, hydromorphone tablets, oxycodone tablets
Opana ER	oxycodone ER
Oracea	doxycycline
Oravig	fluconazole
Orbivan	butalbital/acetaminophen/caffeine
Pacnex	benzoyl peroxide cleanser
Pacnex MX	benzoyl peroxide
Pamelor	nortriptyline
Parnate	tranylcypromine
Pataday	Zaditor (OTC, not covered), Patanol
Patanase	azelastine nasal spray, Astepro, Astelin, fluticasone nasal spray
Paxil	paroxetine
Paxil CR	paroxetine extended-release
Pepcid (except suspension)	cimetidine, famotidine, nizatidine, ranitidine
Peranex HC	lidocaine-hydrocortisone-aloe kit
Peranex HC medicated pads	lidocaine HC rectal kit
Percocet	oxycodone/acetaminophen
Percodan	Endodan
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) PLEASE NOTE: Prevacid Solutab is covered for <i>Members</i> 12 years of age or younger.
Prilosec	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole
Prinivil	lisinopril
Prinzide	lisinopril/hydrochlorothiazide
Procardia	nifedipine
Procardia XL	nifedipine extended-release
Proscar	Avodart, finasteride 5 mg

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

Brand Name	Suggested Alternatives
Protonix	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole PLEASE NOTE: Protonix suspension is covered for <i>Members</i> 12 years of age or younger.
Prozac	fluoxetine
Prozac Weekly	fluoxetine delayed-release
Questran	cholestyramine
Rapaflo	doxazosin, tamsulosin, Uroxatral
Remeron/Remeron Soltab	mirtazapine
Restoril	temazepam
Rhinocort Aqua	flunisolide nasal spray, fluticasone nasal spray, Nasonex
Ritalin	methylphenidate
Ritalin-SR	methylphenidate extended-release
Rosula cleanser	Prascion, Sulfatol
Roxicodone	oxycodone HCl
Rybix ODT	tramadol
Ryzolt	tramadol
Saizen	Norditropin, Norditropin Nordiflex, Norditropin Flexpro
Salkera Foam	salicylic acid cream or lotion
Salvax 6% Foam	salicylic acid cream or lotion
Salvax Duo Plus Combo Pack	salicylic acid lotion + urea lotion
Saphris	risperidone, Seroquel, Zyprexa
Sectral	acebutolol
Skelaxin	metaxalone
Solodyn	minocycline tablets
Soma 250 mg	carisoprodol tablets
Sonata	zaleplon
Sular	amlodipine, felodipine, nisoldipine
Sumaxin	sulfacetamide sodium 10%, sulfur 5% Med Pads
Taclonex	betamethasone dipropionate/calcipotriene ointment
Taclonex Scalp	betamethasone dipropionate + calcipotriene solution
Tarka	trandolapril/verapamil extended-release
Tekturna HCT	lisinopril/hydrochlorothiazide, enalapril/hydrochlorothiazide, losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT
Tenex	guanfacine
Tenormin	atenolol
Tenoretic	atenolol/hydrochlorothiazide
Tersi Foam	selenium sulfide shampoo
Teveten	losartan, Benicar, or Diovan
Teveten HCT	losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT
Tev-Tropin	Norditropin, Norditropin Nordiflex, Norditropin Flexpro
Tiazac	diltiazem extended-release
Tofranil	imipramine
Toprol XL	metoprolol succinate extended release
Toviaz	oxybutynin ER, trospium, Enablex, Vesicare
Trandate	labetalol
Tranxene T-Tab	clorazepate
Treximet	sumatriptan tablets + naproxen sodium tablets
Triaz Foaming Cloths	benzoyl peroxide cleanser or pads
Tricor	fenofibrate
Triglide	fenofibrate
Trilipix	fenofibrate
Trioxin	antipyrine/benzocaine otic, OtiRX
Twynsta	amlodipine + ARB, Azor, Exforge
Tylenol with Codeine NO. 3	acetaminophen with codeine NO. 3
Tylox	oxycodone/acetaminophen

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

Brand Name	Suggested Alternatives
Ultracet	tramadol/acetaminophen
Ultram	tramadol
Ultram ER	tramadol
Umeecta PD	urea lotion
Uniretic	moexipril/hydrochlorothiazide
Univasc	moexipril
Uramaxin	urea cream, gel, or lotion
Uramaxin 20% Foam	urea cream or lotion
Uramaxin 45% Cream	urea cream
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	imiquimod, podofilox, Condylox
Verelan/PM	verapamil extended-release
Vicodin	hydrocodone/acetaminophen
Vicodin ES	hydrocodone/acetaminophen es
Vicoprofen	hydrocodone/ibuprofen
Vimovo	naproxen + omeprazole
Vistaril	hydroxyzine pamoate
Voltaren	diclofenac sodium
Voltaren XR	diclofenac sodium delayed-release
Vusion	miconazole nitrate & zinc oxide (OTC, not covered)
Wellbutrin	bupropion
Wellbutrin SR/XL	bupropion sr, bupropion extended-release
Xanax	alprazolam
Xanax XR	alprazolam extended-release
Xolegel	ketoconazole cream
Zamicet	hydrocodone bitartrate/APAP, Hycet oral solution
Zaroxolyn	metolazone
Zebeta	bisoprolol
Zegerid	Prilosec OTC (OTC, not covered), omeprazole, pantoprazole
Zelapar	selegiline tablets
Zestoretic	lisinopril/hydrochlorothiazide
Zestril	lisinopril
Ziac	bisoprolol/hydrochlorothiazide
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
Zofran/Zofran ODT	ondansetron, ondansetron ODT
Zoloft	sertraline
Zuplenz	ondansetron, ondansetron ODT
Zyflo CR	Singulair, Accolate
Zymaxid	ciprofloxacin drops, ofloxacin
Zypram Rectal Kit	Analpram HC, hydrocortisone/pramoxine cream

