

MEMBER HANDBOOK EFFECTIVE JULY 1, 2018



Introduction

Welcome to Navigator by *Tufts Health Plan*™ (“Navigator”). We are pleased you have chosen this Point of Service (POS) health plan. We look forward to working with you to help you meet your health care needs. This *Member Handbook* describes the **Navigator** health care plan. **Please note that italicized words in this document have special meanings. These meanings are given in the “Definitions” section (see Part 8, pages 88-96).**

Navigator is a self-funded plan, which means that the *Group Insurance Commission* (the “GIC” or “Commission”) is responsible for the cost of the *Covered Services* you receive. The GIC has contracted with *Tufts Health Plan* to offer you access to a network of health care professionals known as *Tufts Health Plan* (“Tufts HP”) *Providers*. *Tufts Health Plan* also performs certain services, such as claims processing, but it does not insure plan benefits or determine your eligibility for benefits under the Navigator Plan.

This *Member Handbook* will help you find answers to your questions about your benefits. Navigator *Members* have benefits for *Covered Services* according to the terms of this *Member Handbook*.

Tufts HP administers your medical and behavioral health/substance use disorder benefits.

Medical and Behavioral Health Plan - *Tufts Health Plan* administers Navigator, which provides the medical and behavioral health/substance use disorder benefits described in this *Member Handbook*. Details on your coverage and costs for medical services are described in “Benefit Overview” (page 14) and “Plan and Benefit Information” (pages 29-33).

Navigator *Members* are encouraged to receive medical and behavioral health/substance use disorder services from the *Tufts Health Plan* network of health care *Providers*. Using these *Tufts HP Providers* will minimize your out-of-pocket expenses for *Covered Services*. To find out which *Providers* are in the network, you can:

- Visit the online *Provider* Directory at **tuftshealthplan.com/gic**
- Call the Member Services Department at 800-870-9488

Prescription Drug Plan -- Your Prescription Drug benefits are included in this plan but administered by Express Scripts. Your prescription drug benefits are described on pages 103-115. For further information about your prescription drug benefits, visit **express-scripts.com** or call Express Scripts at 855-283-7679.

Note: Italicized words are defined in Part 8.

Introduction, Continued

Medical and Behavioral Health Plan (continued) –

This is a POS plan. You must select a *Primary Care Provider (PCP)* under this plan. Each time you need to receive health care services, you may choose to obtain your health care either:

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

Your choice will determine the level of benefits you receive for *Covered Services*.

For **Outpatient medical care**, *Covered Services* from or authorized by your *Tufts HP PCP* are covered at the *Authorized Level of Benefits*. Your *PCP* will authorize you to receive care from other *Tufts HP Providers* unless the care you need is not available within *Tufts HP's* network of *Tufts HP Providers*. In that case, your *PCP* (after obtaining approval from an *Authorized Reviewer*) will refer you to a *Provider* not affiliated with *Tufts HP*.

At the *Authorized Level of Benefits*, your *Office Visit Copayment* will vary depending on the type of physician who provides your care. Under this plan, the *Provider* groups to which *PCPs*, specialists, and hospitals belong are placed into one of three tiers based on participation in the *GIC's* Centered Care Program, the providers' practice and referral patterns, and efficiency of performance. *Providers'* tiers are based on their group's tiering; *Providers* are not individually tiered. The lowest cost-sharing is applied to *Providers* that have the most efficient performance.

- *Providers* that participate in the Centered Care Program and are the most efficient are placed in Tier 1.
- *Providers* that participate in the Centered Care Program and are less efficient are placed in Tier 2.
- *Providers* that do not participate in the Centered Care Program are placed in Tier 3. However, hospitals that do not participate in the Centered Care Program, but to whom Centered Care Providers refer, are placed in the tier of the *Provider* who made the referral.

The following *Copayments* apply to the following *Providers*:

- **Primary care provider (PCP)**
PCPs may include general practitioners, family practitioners, internal medicine specialists, pediatric primary care providers, physician assistants, nurse practitioners, primary care physicians who are also specialists, and obstetrician/gynecologists. *PCPs* in Massachusetts are tiered based upon their participation in the Centered Care Program and their *Provider* group's efficiency.
 - *Copayment Tier 1 PCP* (Lowest Cost Share): Participates in Centered Care Program and provides the most efficient care -- \$10 *Copayment*
 - *Copayment Tier 2 PCP* (Mid-level Cost Share): Participates in Centered Care Program and provides less efficient care-- \$20 *Copayment*
 - *Copayment Tier 3 PCP* (Highest Cost Share): Does not participate in the Centered Care Program -- \$40 *Copayment*.
- **All *PCPs* outside of Massachusetts** -- \$20 *Copayment*
- **Massachusetts Specialists**
 - *Copayment Tier 1 Specialist* (Lowest Cost Share): Participates in the Centered Care Program and provides the most efficient care -- \$30 *Copayment*
 - *Copayment Tier 2 Specialist* (Mid-level Cost Share): Participates in the Centered Care Program and provides less efficient care -- \$60 *Copayment*
 - *Copayment Tier 3 Specialist* (Highest Cost Share): Does not participate in the Centered Care Program -- \$75 *Copayment*
- **All specialists outside of Massachusetts** -- \$60 *Copayment*

Introduction, Continued

Medical and Behavioral Health Plan (continued) –

- **Limited Service Medical Clinic or free-standing Urgent Care Center that participates in Tufts Health Plan** -- \$20 Copayment

Note: Copayments for Urgent Care Services at all other locations vary depending on the type of Provider (PCP vs. Specialist) you see and the location (for example, Provider's office, Limited Service Medical Clinic, Urgent Care Center, or Emergency room) where you receive services.

For a list of Tufts HP Providers (including tiers, if applicable), please refer to the online Provider Directory at tuftshealthplan.com/gic.

At the Authorized Level of Benefits, **Inpatient hospital stays** at Tufts HP Hospitals are grouped into Inpatient Hospital Copayment Levels based on their participation in the Centered Care program and their efficiency of performance (see Part 9, pages 97-102, for more information about the standards used for grouping the hospitals). All hospital admissions are subject to the Inpatient Care Copayment Limit.

- Tier 1 (Lowest Cost Share): Participates in the Centered Care program and provides the most efficient care -- **\$275 Inpatient Copayment**
- Tier 2 (Mid-level Cost Share): Participates in the Centered Care program and provides less efficient care -- **\$500 Inpatient Copayment**
- Tier 3 (Highest Cost Share): Does not participate in the Centered Care program -- **\$1500 Inpatient Copayment**

Note: Hospitals that do not participate in the Centered Care Program, but that Centered Care Providers refer to, are tiered at the same level as the Provider who made the referral.

Please see "Benefit Overview" (page 14) and "Plan and Benefit Information" (pages 29-33) for further details on your coverage and costs for medical services under this Plan. Covered Services that are not provided or authorized by your Tufts HP PCP are covered at the Unauthorized Level of Benefits (see page 37).

Behavioral Health Services (page 66) –You and your covered family Members are automatically eligible for a full range of confidential mental health and substance use disorder services through Tufts Health Plan.

Tufts Health Plan can help you access a conveniently located Tufts HP Provider for mental health or substance use disorder services, or in an emergency. In the event that you require Inpatient behavioral health or Inpatient substance use disorder services, you may go to any Tufts HP Hospital and receive coverage at the Authorized Level of Benefits, as described above.

Introduction, Continued

Prescription drug benefits are administered by Express Scripts. Coverage for prescription drugs and the requirements that each *Member* must follow in order to obtain these benefits is described on pages 103-115. Please see the "Prescription Drug Benefit" on pages 103-115 or call Express Scripts at 855-283-7679 for information about your prescription drug coverage.

Employee Assistance Program (EAP) benefits are provided through Optum. You may call Optum at 844-263-1982 or visit their website at www.liveandworkwell.com (Website Access Code: Mass4You) to find information about your EAP benefits and to check on the status or ask a question about an EAP claim.

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

Note: Services received in the U.S. territories are considered to be outside of the United States.

The Member Services Department is committed to excellent service. Your satisfaction with Navigator is important to us. If at any time you have questions, please call the Member Services Department which will be happy to help you. Calls to the Member Services Department may be monitored by supervisors to assure quality service.

Member Identification Card

Members must present their member identification card (member ID card) to *Providers* when they receive *Covered Services* in order for benefits to be administered properly. Each member ID card contains the following information:

- The amounts you must pay for certain *Covered Services* (for example, your *Copayments* for *Emergency* room visits or for office visits with your *Tufts HP PCP*)
- The toll-free *Tufts Health Plan* telephone number to call if you have questions about your medical and behavioral health/substance use disorder services coverage under the Navigator Plan
- The toll-free Express Scripts telephone number to call if you have questions related to your prescription drug coverage under this plan

Tufts Health Plan Address and Telephone Directory

TUFTS HEALTH PLAN

705 Mount Auburn Street

Watertown, Massachusetts 02472-1508

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

Friday 8:00 a.m. to 6:00 p.m. E.T.

IMPORTANT PHONE NUMBERS:

Emergency Care

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

If you have an urgent medical need and cannot reach your physician, you should seek care at the nearest emergency room or *Urgent Care* facility.

Member Services Department and Tufts HP Website

For more information about *Tufts Health Plan* and the self-service options available to you, please visit **tuftshealthplan.com/gic**. For general questions, benefit questions, and information about eligibility for enrollment and billing, call the Member Services Department at 800-870-9488 or visit the *Tufts HP* website.

Behavioral Health/Substance Use Disorder Services

If you need assistance obtaining a *Provider* or in receiving information regarding behavioral health/substance use disorder benefits, please contact the *Tufts Health Plan* Behavioral Health Department at 1-800-870-9488.

Services for Hearing Impaired Members

If you are hearing impaired, *Tufts HP* provides the following services:

- **Massachusetts Relay (MassRelay): 711**
- **Telecommunications Device for the Deaf (TDD): 711**

Coordination of Benefits (COB) and Workers' Compensation

For questions about coordination of benefits (how *Tufts HP* coordinates its coverage with other health care coverage you may have) and workers' compensation, call the Liability and Recovery Department at 888-880-8699, ext. 21098. The Liability and Recovery Department is available from 8:30 a.m. – 5:00 p.m. Monday through Friday.

Subrogation

Subrogation may occur if your illness or injury (such as injuries from an auto accident) was caused by someone else. For questions about subrogation, call the Member Services Department at 800-870-9488.

Fraud, Waste and Abuse

You may have concerns about being billed for services you never received, or that your insurance information has been stolen or used by someone else. To report potential health care fraud or abuse, or if you have questions, please call us at 800-870-9488 or email **fraudandabuse@tufts-health.com**. You can also call our confidential hotline any time at 877-824-7123 or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud and Abuse
705 Mount Auburn Street
Watertown, MA 02472

***Tufts Health Plan* Address and Telephone Directory**, continued

Appeals and Grievances Department

If you need to call *Tufts HP* about a concern or appeal, contact the Member Services Department at 800-870-9488. To submit your appeal or grievance in writing, send your letter to:

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

Treatment Cost Estimator

In compliance with Massachusetts law, *Tufts Health Plan* offers a cost transparency estimator tool to help *Members* estimate the cost of *Covered Services*. In order to access this tool, you must register at

www.tuftshealthplan.com/members. Once you have registered, enter the member portal to access the tool.

Examples of information you can find by using the treatment cost estimator include:

- the estimated or maximum allowed cost for a proposed admission, procedure or services; and
- the estimated amount you will be responsible for paying for admissions, procedures, or services that are *Covered Services* (including facility fees and *Cost Sharing Amounts*), based on information available to *Tufts Health Plan* at the time the request is made.

The actual amount you may be responsible for paying may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

Note: ***Italicized words are defined in Part 8.***

Translating Services

Translating services for over 200 languages

Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For no cost translation in English, call the number on your ID card.

Arabic الهوية بطاقة على المدون الرقم على الاتصال يرجى العربيه، بال لغة المجانية الى ترجمة خدمة على ل الحصول .
بالك الخاصة

Chinese 若需免費的中文版本，請撥打ID卡上的電話號碼。

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

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

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

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

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

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

Khmer (Cambodian)

សម្រាប់សេវាកម្រិតដោយឥតគិតថ្លៃជាភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើកាតសម្គាល់សមាជិករបស់អ្នក។

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

Laotian ສໍາລັບການແປພາສາເປັນພາສາລາວທີ່ບໍ່ໄດ້ເລືອກໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີທີ່ຢູ່ເທິງບັດປະຈຳຕົວຂອງທ່ານ.

Navajo Doo bą́ąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'é bee nées ho'díłzingo nantiniigíi bikáá'.

Persian. برای ترجمه رایگان فارسی به هر شماره تل فون مندرج در کارت شناسایی تان زندگی به زندید.

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

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

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

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

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

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

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NAVIGATOR

by TUFTS  Health Plan

Medical and Behavioral
Health/Substance Use Disorder Benefits

Part 1 - Benefit Overview

Do not rely on this chart alone. It merely summarizes certain important benefits available to Navigator *Members*. **Be sure to read the benefit explanations in Part 5 (see pages 50-76).** They describe *Covered Services* in more detail and contain some important restrictions. Remember, in order to receive *Covered Services* at the *Authorized Level of Benefits*, you must receive care from or authorized by your *Tufts HP PCP*.

Deductibles and Limits		
	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Day Surgery Copayment Limit (Authorized Level of Benefits only)  Page 29	Limit four \$250 <i>Day Surgery Copayments</i> per individual <i>Member</i> per <i>Contract Year</i> . Once the <i>Day Surgery Copayment Limit</i> is reached in a <i>Contract Year</i> , the <i>Member</i> is not responsible for any additional <i>Day Surgery Copayments</i> for the remainder of that <i>Contract Year</i> .	Not applicable
Inpatient Care Copayment Limit (Authorized Level of Benefits only)  Page 30	Limit one <i>Inpatient Copayment</i> per individual <i>Member</i> per quarter Waived for readmissions within 30 days of discharge, within the same <i>Contract Year</i>	Not applicable.
Deductible  Pages 30 and 32	\$500 per <i>Member</i> or \$1,000 per family (two or more <i>Members</i>) per <i>Contract Year</i> . (No family <i>Member</i> will pay more than his or her individual <i>Deductible</i> .) The <i>Authorized Deductible</i> accumulates separately from the <i>Unauthorized Deductible</i> . Please note that this <i>Authorized Deductible</i> applies only to <i>Authorized</i> medical benefits; it does not apply to your pharmacy benefit or your <i>Authorized</i> behavioral health/substance use disorder benefits.	\$500 per <i>Member</i> or \$1,000 per family (two or more <i>Members</i>) each <i>Contract Year</i> . (No family <i>Member</i> will pay more than his or her individual <i>Deductible</i> .) The <i>Unauthorized Deductible</i> accumulates separately from the <i>Authorized Deductible</i> . Please note that this <i>Unauthorized Deductible</i> applies to your <i>Unauthorized</i> medical and behavioral health/substance use disorder benefits.
Out-of-Pocket Maximum:  Pages 31 and 33	\$5,000 per <i>Member</i> or \$10,000 per family (two or more <i>Members</i>) per <i>Contract Year</i> . (No family member will pay more than his or her individual <i>Out-of-Pocket Maximum</i> .) The <i>Authorized Out-of-Pocket Maximum</i> accumulates separately from the <i>Unauthorized Out-of-Pocket Maximum</i> . The <i>Authorized Out-of-Pocket Maximum</i> includes your <i>Copayments</i> for <i>Authorized</i> medical services, prescription drugs and behavioral health and substance use disorder services. It also includes the <i>Authorized Deductible</i> and <i>Coinsurance</i> for services obtained at the <i>Authorized Level of Benefits</i> .	\$5,000 per <i>Member</i> or \$10,000 per family (two or more <i>Members</i>) per <i>Contract Year</i> . (No family member will pay more than his or her individual <i>Out-of-Pocket Maximum</i> .) The <i>Unauthorized Out-of-Pocket Maximum</i> accumulates separately from the <i>Authorized Out-of-Pocket Maximum</i> . The <i>Unauthorized Out-of-Pocket Maximum</i> includes your <i>Copayments</i> for <i>Unauthorized</i> medical services and behavioral health and substance use disorder services. It also includes the <i>Unauthorized Deductible</i> and <i>Coinsurance</i> for services obtained at the <i>Unauthorized Level of Benefits</i> .
Prescription Drug Deductible  Page 30	\$100 per <i>Member</i> or \$200 per family per <i>Contract Year</i> . No more than \$100 per <i>Member</i> will be applied to the family <i>Deductible</i> . Multiple family members can satisfy the family <i>Deductible</i> . Prescription drug <i>Copayments</i> apply only after the Prescription Drug <i>Deductible</i> is met.	

Note: Italicized words are defined in Part 8.

Part 1 - Benefit Overview, Continued

Important Note about your coverage under the Affordable Care Act (“ACA”): Under the ACA, preventive care services -- including women’s preventive health services, certain prescription medications, and certain over-the-counter medications when prescribed by a licensed *Provider* and dispensed at a pharmacy pursuant to a prescription – received at the *Authorized Level of Benefits* are covered in full. These services are noted in general in this Benefit Overview. For more information on what services are now covered in full, please visit <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>. You can find information about women’s preventive health services at [\[https://www.hrsa.gov/womensguidelines2016/index.html\]](https://www.hrsa.gov/womensguidelines2016/index.html).

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits*
	Member’s Cost	Member’s Cost
Emergency Care		
Treatment in an Emergency room  Page 51	\$100 <i>Copayment</i> (waived if admitted as an <i>Inpatient</i>), then <i>Authorized Deductible</i>. <i>Emergency care</i> is covered up to the <i>Reasonable Charge</i> regardless of whether care is provided by a <i>Tufts Health Plan Provider</i>. Observation services received in an <i>Emergency Room</i> will be subject to the <i>Emergency Room Copayment</i>, then the <i>Authorized Deductible</i>. Notes: • If you are admitted as an <i>Inpatient</i> after <i>Emergency care</i>, you must call <i>Tufts Health Plan</i> at 800-970-9488 within 48 hours to be covered. • If you are admitted as an <i>Inpatient</i> after receiving <i>Emergency care</i>, please call <i>Tufts Health Plan</i> in order to have your <i>Emergency room Copayment</i> waived (whether you are admitted to the same or a different hospital from which you received <i>Emergency care</i>).	\$100 <i>Copayment</i> (waived if admitted as an <i>Inpatient</i>), then <i>Authorized Deductible</i> (plus any balance).

Care provided by a specialist will be covered at the *Authorized Level of Benefits* only if the *Member’s Tufts HP PCP* authorizes that care.

Outpatient Care – Office Visit Copayments

If you receive *Outpatient* care at an office visit, your Office Visit *Copayment* will vary depending on the type of *Tufts HP Provider* you see. Massachusetts *Tufts HP PCPs* and Specialists have been rated based on their participation in the Centered Care Program and their *Provider* group's efficiency of performance, and then placed into three tiers.

- **Massachusetts Primary care providers (PCPs) -**
PCPs may include general practitioners, family practitioners, internal medicine specialists, pediatric primary care providers, physician assistants, nurse practitioners, primary care physicians who are also specialists, and obstetrician/gynecologists.
 - Tier 1 (Lowest Cost Share): Participates in the Centered Care Program and provides the most efficient care -- \$10 *Copayment*
 - Tier 2 (Mid-level Cost Share): Participates in the Centered Care Program and provides less efficient care -- \$20 *Copayment*
 - Tier 3 (Highest Cost Share): Does not participate in the Centered Care Program -- \$40 *Copayment*
 - **All PCPs outside of Massachusetts -- \$20 Copayment**
- **Massachusetts Specialists**
 - Tier 1 (Lowest Cost Share): Participates in the Centered Care Program and provides the most efficient care -- \$30 *Copayment*
 - Tier 2 (Mid-level Cost Share): Participates in the Centered Care Program and provides less efficient care -- \$60 *Copayment*
 - Tier 3 (Highest Cost Share): Does not participate in the Centered Care Program -- \$75 *Copayment*
- **All Specialists outside of Massachusetts -- \$60 Copayment**
- **Limited Service Medical Clinic or free-standing Urgent Care Center that participates in Tufts Health Plan -- \$20 Copayment**

Note: Copayments for *Urgent Care Services* at all other locations vary depending on the type of *Provider* (*PCP* vs. *Specialist*) you see and the location (for example, *Provider's* office, *Limited Service Medical Clinic*, *Urgent Care Center*, or *Emergency room*) in which you receive services.

For a list of *Tufts HP Providers* (including their tiers, if applicable), please visit the online *Provider Directory* at tuftshealthplan.com/gic.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Outpatient Care		
Autism spectrum disorders – diagnosis and treatment (AR)  Page 52	Habilitative or rehabilitative care (including applied behavioral analysis), and psychiatric and psychological care: For services provided by a licensed physical, occupational or speech therapist, see “Treatment of speech, hearing and language disorders” (page 57) and “Rehabilitative and Habilitative physical and occupational therapy services” (page 59). For services provided by a <i>Paraprofessional</i> or <i>Board-Certified Behavior Analyst (BCBA)</i>, a \$20 <i>Copayment</i> applies. For psychiatric and psychological care, see the “Behavioral Health/Substance Use Disorder Services” benefit (page 66). Prescription medications: These services are administered by Express Scripts. Please see “Prescription Drug Benefit” on pages 103-115. Note: Benefit limits for physical and occupational therapy services do not apply to the treatment of autism spectrum disorders.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Cardiac rehabilitation  Page 52	\$20 <i>Copayment</i>	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Chiropractic services (spinal manipulation)  Page 52	\$20 <i>Copayment</i> Limited to a total of one spinal manipulation evaluation and 20 visits per Contract Year (Authorized and Unauthorized Levels combined).	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Clinical trials for studying potential treatment(s) for cancer or other life-threatening diseases or conditions  Page 53	\$10/\$20/\$40 <i>PCP Copayment</i> , \$30/\$60/\$75 <i>Specialist Copayment</i>	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Coronary Artery Disease Program  Page 53	10% of the <i>Reasonable Charge</i>	Full cost. This is not covered at the <i>Unauthorized Level of Benefits</i> .
Diabetes self-management training and educational services  Page 53	\$10/\$20/\$40 <i>PCP Copayment</i> , \$30/\$60/\$75 <i>Specialist Copayment</i>	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Dialysis  Page 53	<i>Authorized Deductible</i> then covered in full	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Outpatient Care, continued:		
Early intervention services for a <i>Dependent Child</i>  Page 53	Covered in full (not subject to the <i>Authorized Deductible</i>)	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Family planning procedures, services, and contraceptives  Page 53	Office Visit: Covered in full (not subject to the <i>Authorized Deductible</i>) Day Surgery: \$250 <i>Copayment</i> per person per <i>Day Surgery</i> admission (applies to all covered <i>Day Surgery</i> services, including those performed at free-standing surgical centers), up to the <i>Day Surgery Copayment Limit</i>; then <i>Authorized Deductible</i>. Note: Women's preventive health services, including contraceptives and female sterilization procedures, are covered in full at the <i>Authorized Level of Benefits</i> and are not subject to the <i>Authorized Deductible</i>. For more information about which services are considered preventive, see https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ or https://www.hrsa.gov/womensguidelines2016/index.html.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Infertility services (including up to five attempted ART procedures) (AR)  Page 54	Office Visit: \$10/\$20/\$40 <i>PCP Copayment</i>, \$30/\$60/\$75 <i>Specialist Copayment</i> All other services: <i>Authorized Deductible</i>, then covered in full	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Maternity care office visits (includes prenatal & postpartum care)  Page 55	Maternity care office visits: - Routine maternity care: Covered in full - Non-routine maternity care: \$10/\$20/\$40 <i>PCP Copayment</i>, \$30/\$60/\$75 <i>Specialist Copayment</i> Routine maternity-related laboratory tests: Covered in full (not subject to the <i>Authorized Deductible</i>) Maternity-related diagnostic tests (i.e., ultrasounds and non-routine lab tests): <i>Authorized Deductible</i>, then covered in full	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Outpatient Care, continued:		
Outpatient medical care		
Allergy injections ☞ Page 55	Covered in full (not subject to the <i>Authorized Deductible</i>)	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Allergy testing ☞ Page 55	\$10/\$20/\$40 <i>PCP Copayment</i> , \$30/\$60/\$75 <i>Specialist Copayment</i>	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Chemotherapy ☞ Page 55	<i>Authorized Deductible</i> , then covered in full	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Diagnostic or preventive screening procedures (AR) ☞ Page 55	<u>Colon or colorectal cancer screening:</u> Covered in full (not subject to the <i>Authorized Deductible</i>) <u>Diagnostic procedure only (i.e., colonoscopies associated with symptoms):</u> <i>Authorized Deductible</i>, then covered in full <u>Diagnostic procedures with treatment/surgery (i.e. polyp removal):</u> Covered as <i>Day Surgery</i> admissions - \$250 <i>Copayment</i> (applies to all covered <i>Day Surgery</i> services, including those performed at free-standing surgical centers), up to the <i>Day Surgery Copayment Limit</i>; then <i>Authorized Deductible</i>.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Diagnostic imaging ☞ Page 55	<u>General imaging:</u> <i>Authorized Deductible</i>, then covered in full <u>MRI/MRA, CT/CTA, PET and nuclear cardiology (AR):</u> \$100 <i>Copayment</i> per day, then subject to <i>Authorized Deductible</i> Limit of one <i>Copayment</i> per day, even if you visit more than one <i>Provider</i>. Please call Member Services if you are charged more than one <i>Copayment</i> per day so we can adjust your claim.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Diagnostic testing (AR) ☞ Page 55	<i>Authorized Deductible</i> , then covered in full	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP *Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Outpatient Care, continued:		
Outpatient medical care, continued		
EKG testing ☞ Page 55	Covered in full (not subject to the <i>Authorized Deductible</i>)	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Human leukocyte antigen testing (AR) ☞ Page 55	<i>Authorized Deductible</i> , then covered in full	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Laboratory tests (AR) ☞ Page 55	<i>Authorized Deductible</i> , then covered in full. Note: Laboratory tests performed as part of preventive care are covered in full at the <i>Authorized Level of Benefits</i> and are not subject to the <i>Authorized Deductible</i> . For more information about which services are considered preventive, see https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Mammograms ☞ Page 56	Covered in full (not subject to the <i>Authorized Deductible</i>)	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Nutritional counseling ☞ Page 56	\$10/\$20/\$40 <i>PCP Copayment</i> , \$30/\$60/\$75 <i>Specialist Copayment</i> Note: Nutritional counseling is covered in full and not subject to the <i>Deductible</i> at the <i>Authorized Level of Benefits</i> when it is provided as preventive care services, as defined by the U.S. Preventive Services Task Force. Please see "Nutritional counseling" in Part 5 for more information. Limit of one initial evaluation and 3 treatment visits per Contract Year (Authorized and Unauthorized Levels combined)	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Office visits to diagnose and treat illness or injury, including consultations ☞ Page 56	\$10/\$20/\$40 <i>PCP Copayment</i> , \$30/\$60/\$75 <i>Specialist Copayment</i> Note: A telemedicine services visit with a <i>Tufts Health Plan Provider</i> will apply the same <i>Cost Sharing Amount</i> that applies to an in-person visit with that <i>Provider</i> .	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Outpatient Care, continued:		
Outpatient medical care, continued		
Outpatient surgery in a physician's office (AR) ☞ Page 56	\$10/\$20/\$40 PCP Copayment, \$30/\$60/\$75 Specialist Copayment	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Pap smears (cytology examinations) ☞ Page 56	Routine annual Pap smears (cytology examinations): Covered in full (not subject to the Authorized Deductible) Diagnostic Pap smears: Authorized Deductible, then covered in full	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Radiation therapy and x-ray therapy (AR) ☞ Page 56	Authorized Deductible, then covered in full	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Smoking cessation counseling services ☞ Page 56	Covered in full	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Telehealth services ☞ Page 57	For behavioral health/substance use disorder services: \$10 Copayment. For all other Covered Services: \$15 Copayment Note: These Copayments apply to telehealth services obtained through the Tufts Health Plan designated telehealth vendor, Teladoc. For more information, go to https://www.tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth , or contact Member Services.	Not covered. Telehealth services must be obtained from a Teladoc provider.
Telemedicine services ☞ Page 57	For behavioral health/substance use disorder services: \$10 Copayment. For all other Covered Services: \$10/\$20/\$40 PCP Copayment, \$30/\$60/\$75 Specialist Copayment Note: These Copayments apply to telemedicine visits with Tufts Health Plan Providers.	Unauthorized Deductible and 20% of the Reasonable Charge (plus any balance) for telemedicine services obtained from a Non-Tufts Health Plan Provider.
Treatment of speech, hearing and language disorders (AR) ☞ Page 57	\$20 Copayment Note: Copayments for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Voluntary second or third surgical opinions ☞ Page 57	\$10/\$20/\$40 PCP Copayment, \$30/\$60/\$75 Specialist Copayment	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Outpatient Care, continued:		
Preventive health care - Adults (age 18 and over) ☞ Page 58	Covered in full (not subject to the <i>Authorized Deductible</i>) Note: Preventive care services for adults are covered in full at the <i>Authorized Level of Benefits</i> and are not subject to the <i>Authorized Deductible</i> . For more information about which services are considered preventive, see https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ . Member cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Preventive health care - Children (under age 18) ☞ Page 58	Covered in full (not subject to the <i>Authorized Deductible</i>) Note: Preventive care services for children are covered in full at the <i>Authorized Level of Benefits</i> and are not subject to the <i>Authorized Deductible</i> . For more information about which services are considered preventive, see https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ . Member cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Routine annual gynecological exam ☞ Page 59	Covered in full (not subject to the <i>Authorized Deductible</i>) Note: Preventive gynecological services are covered in full and are not subject to the <i>Authorized Deductible</i> . For more information about which services are considered preventive, see https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ . Member cost-sharing does apply to diagnostic tests or diagnostic laboratory tests ordered as part of a preventive services visit.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
Rehabilitative and <i>Habilitative</i> physical therapy (PT) & occupational therapy (OT) services (AR) ☞ Page 59	\$20 <i>Copayment</i> Limit of 30 visits per Contract Year for each type of therapy. Note: Limit does not apply to the treatment of autism spectrum disorders or for physical or occupational therapy provided as part of home health care, as described in the "Home Health Care" benefit later in this document.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance)
<i>Urgent Care</i> in a free-standing <i>Urgent Care Center</i> ☞ Page 59	\$20 <i>Copayment</i> for care in a free-standing <i>Urgent Care Center</i> Note: <i>Copayments</i> for <i>Urgent Care</i> services in all other locations vary depending upon type of <i>Provider</i> (PCP vs. <i>Specialist</i>) and the location (i.e., <i>Provider's</i> office, <i>Limited Service Medical Clinic</i> , <i>Urgent Care Center</i> , or <i>Emergency room</i>) in which you receive services.	<i>Unauthorized Deductible & 20% of the Reasonable Charge</i> (plus any balance).

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP *Provider*, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Outpatient Care, continued:		
Vision care services, including: - Routine eye exam  Page 59 - Eye examinations and necessary treatment of a medical condition (AR)  Page 59	Routine eye exam: \$20 Copayment. Limit of one routine eye exam in each 24-month period. Note: Services must be received from an EyeMed network provider. Eye examinations and necessary treatment of a medical condition: \$10/\$20/\$40 PCP Copayment, \$30/\$60/\$75 Specialist Copayment	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Oral health services		
Emergency dental care  Page 60	Treatment in an Emergency room: \$100 Copayment (waived if admitted as an Inpatient), then Authorized Deductible applies. Note: If you are admitted as an Inpatient after receiving Emergency care, please call Tufts Health Plan to have your Emergency room Copayment waived (whether you are admitted to the same or a different hospital from which you received Emergency care).	Treatment in an Emergency room: \$100 Copayment (waived if admitted as an Inpatient), then Authorized Deductible applies (plus any balance)
Oral surgery for dental treatment (AR)  Page 60	Day Surgery: \$250 Copayment (applies to all covered Day Surgery services, including those performed at free-standing surgical centers) per person per Day Surgery admission up to the Day Surgery Copayment Limit; then Authorized Deductible applies. Inpatient care: \$275/\$500/\$1,500 Inpatient Copayment (see "Inpatient Care" below), then Authorized Deductible applies.	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Oral surgery for non-dental medical treatment (AR)  Page 60	Office visit: \$10/\$20/\$40 PCP Copayment, \$30/\$60/\$75 Specialist Copayment Day Surgery: \$250 Copayment (applies to all covered Day Surgery services, including those performed at free-standing surgical centers) per person per Day Surgery admission, up to the Day Surgery Copayment Limit; then Authorized Deductible applies. Inpatient care: \$275/\$500/\$1,500 Inpatient Copayment (see "Inpatient Care" below), then Authorized Deductible applies.	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Day Surgery		
Day Surgery (including physician and surgeon services) (AR)  Page 60	\$250 Copayment (applies to all covered Day Surgery services, including those performed at free-standing surgical centers) per person per Day Surgery admission up to the Day Surgery Copayment Limit; then Authorized Deductible applies.	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)

Members are required to notify Tufts Health Plan of any admissions to non-Tufts HP Hospitals, or that are not authorized by their Tufts HP PCP. Failure to do so may result in a \$500 Notification Penalty.

(AR) – These services may require approval by an Authorized Reviewer prior to treatment for coverage at both the Authorized and Unauthorized Levels of Benefits. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an Authorized Reviewer. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 – Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits*
	Member's Cost	Member's Cost
Inpatient Care:		
Acute hospital services (including room and board, physician and surgeon services, surgery, and related services) (AR) ☞ Page 61	\$275/\$500/\$1,500, (up to the <i>Inpatient Care Copayment Limit</i>), then <i>Authorized Deductible</i> applies Note: See Part 9 (pages 97-102) for a list of the Navigator <i>Inpatient Hospital Tiers</i> and their <i>Copayments</i>.	<i>Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)</i>
Bone marrow transplants for breast cancer, hematopoietic stem cell transplants, and human solid organ transplants (AR) ☞ Page 61		
Cleft lip or cleft palate treatment and services for <i>Children</i> ☞ See "Other Health Services" on page 67		
Gender reassignment surgery (AR) ☞ Page 62 Note: Other <i>Covered Services</i> related to this benefit, such as <i>Day Surgery</i> , <i>Outpatient</i> medical care, prescription medications, and behavioral health care, are covered under the applicable benefits as listed here in the Benefit Overview.		
Maternity care ☞ Page 62		
Patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions ☞ Page 64		
Reconstructive surgery and procedures (AR) ☞ Page 64	<i>Authorized Deductible</i>, then covered in full.	<i>Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)</i>
<i>Inpatient</i> services for enrolled newborn <i>Children</i> who stay in the hospital beyond the mother's discharge ☞ Page 97		

Members are required to notify Tufts Health Plan of any admissions to non-Tufts HP Hospitals, or that are not authorized by their Tufts HP PCP. Failure to do so may result in a \$500 Notification Penalty.

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 – Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits*
	Member's Cost	Member's Cost
Behavioral Health and Substance Use Disorder Services		
To contact the Tufts Health Plan Behavioral Health Department, call 1-800-870-9488.		
Outpatient services (AR) ☞ Page 66	Individual session: \$10 Copayment. Group session: \$10 Copayment.	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Medication assisted treatment, including methadone maintenance (AR) ☞ Page 66	Covered in full when provided by a medication assisted treatment clinic.	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Inpatient services, including Medically Necessary treatment in a behavioral health residential treatment facility (AR) ☞ Page 66	\$200 Inpatient care Copayment per calendar quarter.	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Intermediate care (AR) ☞ Page 66	Authorized Deductible, then covered in full.	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Telehealth services ☞ Page 57	\$10 Copayment. Note: This Copayment applies to telehealth services obtained through the Tufts Health Plan designated telehealth vendor, Teladoc. For more information, go to https://www.tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth or contact Member Services.	Not covered. Telehealth services must be received from a Teladoc Provider.
Telemedicine services ☞ Page 57	\$10 Copayment. Note: This Copayment applies to telemedicine services received from a Tufts Health Plan Provider.	Unauthorized Deductible and 20% of the Reasonable Charge (plus any balance).

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Other Health Services:		
Ambulance services (AR) ☞ Page 67	Authorized Deductible, then covered in full.	Authorized Deductible and then covered in full up to the Reasonable Charge.
Cleft lip or cleft palate treatment and services for Children ☞ Page 67	Medical or facial surgery: <i>Inpatient services:</i> \$275/\$500/\$1,500 <i>Inpatient Copayment</i> (up to the <i>Inpatient Care Copayment</i> Limit (page 30), then <i>Authorized Deductible</i> applies <i>Day Surgery:</i> \$250 <i>Copayment</i> (applies to all covered <i>Day Surgery</i> services, including those performed at free-standing surgical centers) per person per <i>Day Surgery</i> admission, up to the <i>Day Surgery Copayment</i> Limit; then <i>Authorized Deductible</i> Note: See Part 9 on pages 97-102 for the Navigator <i>Inpatient Hospital Copayment Tiers</i> and for information on <i>Inpatient Copayments</i> for newborn <i>Children</i>. Oral surgery: Covered to the same extent as other covered surgical procedures. Dental surgery or orthodontic treatment and management: Covered in full (not subject to the <i>Authorized Deductible</i>). Preventive and restorative dentistry: Covered in full (not subject to the <i>Authorized Deductible</i>). Speech therapy and audiology services: \$20 <i>Copayment</i> Nutrition services: \$10/\$20/\$40 <i>PCP Copayment</i>, \$30/\$60/\$75 <i>Specialist Copayment</i>	Dental surgery, orthodontic treatment and management, or preventive and restorative dentistry: Covered in full. All other services: <i>Unauthorized Deductible</i> and 20% of the <i>Reasonable Charge</i> (plus any balance).

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits	Unauthorized Level of Benefits
	Member's Cost	Member's Cost
Other Health Services, continued:		
Extended care facility services (AR) in: ▪ Skilled nursing facility ▪ Rehabilitation hospital ▪ Chronic hospital  Page 67	Skilled nursing facility*: Authorized Deductible, then 20% of the Reasonable Charge Rehabilitation hospital or chronic hospital: Authorized Deductible, then covered in full Limit of 45 days per Member per Contract Year in a skilled nursing facility (Authorized and Unauthorized Levels combined). Note: Members are required to notify Tufts Health Plan prior to any admission to non-Tufts HP facilities, or the Member must pay a \$500 Notification Penalty (see page 33).	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance) Note: The cost of services provided in a skilled nursing facility at the <i>Unauthorized Level of Benefits</i> cannot be used to satisfy the <i>Unauthorized Out-of-Pocket Maximum</i>.
Home health care (AR)  Page 68	Authorized Deductible, then covered in full	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Hospice care (AR)  Page 68	Authorized Deductible, then covered in full	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Injectable, infused or inhaled medications (AR)  Page 69	Authorized Deductible, then covered in full	Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)
Medical appliances and Equipment, including: <i>Durable Medical Equipment (including Prosthetic Devices) (AR)</i>  Page 70 Eyeglasses/contact Lenses (only the first pair after cataract surgery)  Page 71 Hearing aids  Page 71	Durable Medical Equipment (including Prosthetic Devices) (AR): Authorized Deductible, then covered in full Eyeglasses/contact lenses: Authorized Deductible, then covered in full. Limited to the first pair of lenses after cataract surgery. Hearing aids: • Members 21 and under: One hearing aid per ear per prescription change covered in full (not subject to the <i>Authorized Deductible</i>). Limit of \$2,000 per ear per Member every 24 months (Authorized and Unauthorized Levels combined). • Members 22 and over: First \$500 covered in full (not subject to the <i>Authorized Deductible</i>), then 20% of the next \$1,500 (plus any balance). Limit of \$1,700 per Member every 24 months (Authorized and Unauthorized combined).	Durable Medical Equipment (including Prosthetic Devices) (AR): Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance) Eyeglasses/contact lenses: 20% of the Reasonable Charge (not subject to the <i>Unauthorized Deductible</i>). Limited to the first pair of lenses after cataract surgery.

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining his prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Part 1 - Benefit Overview, Continued

Covered Services	Authorized Level of Benefits		Unauthorized Level of Benefits	
	Member's Cost		Member's Cost	
Other Health Services, continued:				
Personal Emergency Response System (hospital-based) 👉 Page 72	20% of charges Limit of \$50 for installation and \$40 per month for rental charges for hospital-based systems			
Private duty nursing care (Inpatient and Outpatient) (AR) 👉 Page 72	Authorized Deductible, then covered in full Limit of \$8,000 per Member per Contract Year (Authorized and Unauthorized Levels combined)		Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance)	
Scalp hair prostheses or wigs for cancer or leukemia patients 👉 Page 72	Covered in full (not subject to the Authorized Deductible)			
Special medical formulas, including: Low protein foods 👉 Page 72 Nonprescription enteral formulas (AR) 👉 Page 72 Special medical formulas (AR) 👉 Page 72	Authorized Deductible, then covered in full		Low protein foods: Unauthorized Deductible & 20% of the Reasonable Charge (plus any balance) Nonprescription enteral formulas (AR) and special medical formulas (AR): Unauthorized Deductible, then covered in full	

(AR) – These services may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *Authorized* and *Unauthorized Levels of Benefits*. When you receive care from a non-Tufts HP Provider, you are responsible for obtaining this prior approval from an *Authorized Reviewer*. If prior approval is not received, the Navigator Plan will not cover those services and supplies. For more information, call Member Services.

Prescription Drug Benefit (see pages 103-115)

Benefits administered by Express Scripts. For information, see the "Prescription Drug Benefit", visit express-scripts.com, or call 855-283-7679.

Employee Assistance Program (EAP) Benefits

Employee Assistance Program (EAP) benefits are provided through Optum. You may call Optum at 844-263-1982 or visit their website at www.liveandworkwell.com (Website Access Code: Mass4You) to find information about your EAP benefits and to check on the status or ask a question about an EAP claim.

Part 2 – *Plan* and Benefit Information

Your Cost for Medical Services

You are responsible for paying the costs described below for *Covered Services* you receive at the *Authorized* and *Unauthorized Levels of Benefits*. For more information about the *Covered Services* subject to these costs, please see Part 5.

Authorized Level of Benefits

Covered Services are covered at the *Authorized Level of Benefits* only when the *Covered Services* are provided or authorized by your *Tufts HP PCP*.

If *Tufts HP* determines that a *Covered Service* is not available from a *Tufts HP Provider*, you may receive *Covered Services* at the *Authorized Level of Benefits* from a non-*Tufts HP Provider* (with the approval of an *Authorized Reviewer*), up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge*.

Copayments

- *Emergency Care*: *Emergency room* (waived if admitted) \$100 per visit

Notes:

- If you register in an *Emergency room*, but leave without receiving care, an *Emergency Room Copayment* (and then the *Authorized Deductible*) may apply.
- A *Day Surgery Copayment* may apply if *Day Surgery* services are received.
- If you are admitted to an *Inpatient* mental health facility after being seen at the *Emergency Room*, please call the *Tufts Health Plan* Member Services Department to request that your *Emergency Room Copayment* be waived, or to request an adjustment of the claim.
- If you are admitted as an *Inpatient* after receiving *Emergency care*, please call *Tufts Health Plan* in order to have your *Emergency room Copayment* waived (whether you are admitted to the same or a different hospital from which you received *Emergency care*).
- *Authorized Level of Benefits:*
 - Office Visit.....\$10/20/\$40 *PCP Copayment*, \$30/\$60/\$75 *Specialist Copayment*; see page 16
 - Behavioral health/substance use disorder office visits \$10 *Copayment*; see page 25

Note: You may be charged an *Office Visit Copayment* for certain *Outpatient* services listed as “covered in full” in the Benefit Overview table (see pages 14-28) if these services are provided in conjunction with an office visit.

- *Inpatient Services*Varies by hospital tier; see Part 9
- *Day Surgery* \$250 per admission

Day Surgery Copayment Limit (Authorized Level of Benefits only)

Each individual *Member* is responsible for paying a limit of four *Day Surgery Copayments* per *Contract Year*. (The *Contract Year* runs from July 1 to the following June 30.) When you have paid four *Day Surgery Copayments*, no more *Day Surgery Copayments* will be charged in that *Contract Year*.

The *Day Surgery Copayment Limit* consists of *Authorized Day Surgery Copayments* only. It does not include *Deductibles*, *Coinsurance*, other *Copayments*, or payments you make for non-*Covered Services* or care received at the *Unauthorized Level of Benefits*.

Note: Italicized words are defined in Part 8.

Your Cost for Medical Services, continued

(Authorized Level of Benefits, continued)

Inpatient Care Copayment Limit (Authorized Level of Benefits only)

Each individual *Member* is responsible for paying a limit of one *Inpatient Copayment* per *Contract Year* quarter. (The *Contract Year* quarters are: July/August/September, October/November/December, January/February/March, and April/May/June.) The *Inpatient Care Copayment* is waived if you are readmitted within 30 days of discharge, if both admissions are in the same *Contract Year*. Contact the *Tufts Health Plan Member Services* Department if you are billed so that we can adjust your claim.

The quarterly *Inpatient Care Copayment* includes only *Inpatient care Copayments* at the *Authorized Level of Benefits*. It does not include *Deductibles*, *Coinsurance*, other *Copayments*, or payments you make for non-Covered *Services*.

Authorized Deductible

A \$500 individual *Authorized Deductible* and a \$1,000 family *Authorized Deductible* apply each *Contract Year*. Your family *Authorized Deductible* is met once any combination of family *Members* reaches \$1,000; no family *Member* will pay more than his or her individual *Authorized Deductible* per *Contract Year*.

The *Authorized Deductible* is the amount that you must first pay for for *Covered Services* before the *Navigator Plan* will pay for certain *Covered Services* at the *Authorized Level of Benefits*. It accumulates separately from the *Unauthorized Deductible* under this Medical and Behavioral Health/Substance Use Disorder Plan. It also **does not** apply to prescription drugs or care from in-network behavioral health *Providers*.

Note: The *Authorized Deductible* applies to: *Day Surgery*, *Emergency room*, *Inpatient hospital*, and many *Outpatient services*, when they are received at the *Authorized Level of Benefits*. It also applies to all services and supplies categorized as “Other Health Services”, except for hearing aids, Personal Emergency Response Systems, scalp hair prostheses or wigs for cancer and leukemia patients, and chiropractic services (spinal manipulation). See the “Benefit Overview” in Part 1 for more information.

Prescription Drug Deductible

A \$100 individual *Prescription Drug Deductible* and a \$200 family *Prescription Drug Deductible* apply each *Contract Year*. Your family *Prescription Drug Deductible* is met once any combination of family *members* reaches \$200; no family *Member* will pay more than his or her individual *Prescription Drug Deductible* per *Contract Year*.

The *Prescription Drug Deductible* is the amount you must first pay for covered prescription drugs before the *Navigator Plan* will pay for any covered prescription drugs.

Note: This *Prescription Drug Deductible* does not apply to preventive drugs, orally-administered anti-cancer drugs, or generic buprenorphine-naloxone, naloxone, and naltrexone products. See the “Prescription Drug Benefit” on pages 103-115 for more information.

Coinsurance

There is no *Coinsurance* for most *Covered Services* provided by a *Tufts HP Provider*. Except as shown in Part 1 (see “Benefit Overview” on pages 14-28), the *Member* pays the applicable *Deductible* and/or *Copayment* for all *Covered Services* provided by a *Tufts HP Provider*. The *Plan* will cover the remaining charges for *Covered Services*.

Your Cost for Medical Services, continued

(Authorized Level of Benefits, continued)

Authorized Out-of-Pocket Maximum

A \$5,000 individual *Authorized Out-of-Pocket Maximum* and a \$10,000 family (two or more *Members*) *Authorized Out-of-Pocket Maximum* apply each *Contract Year* for *Covered Services* received at the *Authorized Level of Benefits*. The *Family Out-of-Pocket Maximum* includes all amounts any enrolled family *Members* pay toward their individual *Authorized Out-of-Pocket Maximums*, including the *Authorized Deductible*, *Coinsurance*, and *Copayments*.

Once the family *Authorized Out-of-Pocket Maximum* has been met, all enrolled family *Members* will thereafter have satisfied their individual *Authorized Out-of-Pocket Maximums* for the remainder of that *Contract Year*. Once you satisfy the *Authorized Out-of-Pocket Maximum*, all *Covered Services* you receive at the *Authorized Level of Benefits* are covered in full up to the *Reasonable Charge* for the rest of that *Contract Year*.

The *Authorized Out-of-Pocket Maximum* accumulates separately from the *Unauthorized Out-of-Pocket Maximum*. Your *Copayments* for prescription drugs and for in-network mental health and substance use disorder services also count towards this *Out-of-Pocket Maximum*.

Note: You cannot use the following services and supplies to satisfy this *Out-of-Pocket Maximum*:

- Any service or supply that does not qualify as a *Covered Service*. This includes any services that require the approval of an *Authorized Reviewer* prior to treatment for which you do not obtain such approval.
- Any amount you pay for *Covered Services* received at the *Unauthorized Level of Benefits*.

Your Cost for Medical Services, continued

Unauthorized Level of Benefits

Covered Services are covered at the *Unauthorized Level of Benefits* when you receive them from a *Tufts HP Provider* without your *PCP's* authorization, or from a non-*Tufts HP Provider*. These *Covered Services* are subject to a *Deductible* and *Coinsurance*, and are covered at a lower level than *Covered Services* provided at the *Authorized Level of Benefits*.

Notes: Each time you receive care at the *Unauthorized Level of Benefits* from a non-*Tufts HP Provider*, you must submit a claim form to *Tufts Health Plan*. (You are not required to submit claim forms for care you receive from *Tufts HP Providers*.) You may be required to notify *Tufts Health Plan* and/or obtain prior authorization for certain *Covered Services*. If you do not notify *Tufts Health Plan* and/or obtain prior authorization for these certain *Covered Services*, you will incur additional costs. Please see “*Inpatient Notification*” on pages 43-45 and the “*Important Notes*” on page 50 for more information.

For more information, contact the Member Services Department at 800-870-9488.

Coinsurance

Except as shown in Part 1 (see “*Benefit Overview*” on pages 14-28), the *Member* pays 20% *Coinsurance* for all *Covered Services* provided by a *Tufts HP Provider* without the authorization of his or her *Tufts HP PCP*, or for all *Covered Services* provided by a Non-*Tufts HP Provider*. The *Plan* will cover the remaining charges for *Covered Services*, up to the *Reasonable Charge*. (The *Member* is responsible for any charges in excess of the *Reasonable Charge*.)

Unauthorized Deductible

A \$500 individual *Unauthorized Deductible* and a \$1,000 family *Unauthorized Deductible* apply each *Contract Year*. Your family *Unauthorized Deductible* is met once any combination of family *Members* reaches \$1,000; no family *Member* will pay more than his or her individual *Unauthorized Deductible* per *Contract Year*.

The *Unauthorized Deductible* is the amount you must first pay for *Covered Services* before the *Navigator Plan* will pay for any *Covered Services* at the *Unauthorized Level of Benefits*. It applies to all *Covered Services* received at the *Unauthorized Level of Benefits*. Costs in excess of the *Reasonable Charge* do not count towards the *Individual Deductible*.

The *Unauthorized Deductible* accumulates separately from the *Authorized Deductible* under this Medical and Behavioral Health Plan.

Note: The *Deductible* does not apply to *Outpatient Emergency* care and *Urgent Care* you receive in a hospital *Emergency* room or physician's office; Personal Emergency Response Systems (PERS); hearing aids, scalp hair prostheses or wigs for cancer or leukemia patients; and the first pair of eyeglass lenses and/or contact lenses needed after cataract surgery. See the “*Benefit Overview*” in Part 1 for more information.

Your Cost for Medical Services, continued

(Unauthorized Level of Benefits, continued)

Unauthorized Out-of-Pocket Maximum

A \$5,000 individual *Unauthorized Out-of-Pocket Maximum* and a \$10,000 family (two or more *Members*) *Unauthorized Out-of-Pocket Maximum* apply each *Contract Year* for *Covered Services* received at the *Unauthorized Level of Benefits*. The *Unauthorized Out-of-Pocket Maximum* accumulates separately from the *Authorized Out-of-Pocket Maximum*. The Family *Unauthorized Out-of-Pocket Maximum* includes all amounts any enrolled family *Members* pay towards their individual *Unauthorized Out-of-Pocket Maximum*, including the *Unauthorized Deductible* and *Coinsurance*.

Once the family *Unauthorized Out-of-Pocket Maximum* has been met, all enrolled family *Members* will thereafter have satisfied their individual *Unauthorized Out-of-Pocket Maximums* for the remainder of that *Contract Year*. Once you satisfy the *Unauthorized Out-of-Pocket Maximum*, all *Covered Services* received at the *Unauthorized Level of Benefits* are covered in full up to the *Reasonable Charge* for the rest of that *Contract Year*. (You continue to pay for any costs in excess of the *Reasonable Charge*.)

The *Unauthorized Out-of-Pocket Maximum* accumulates separately from the *Authorized Out-of-Pocket Maximum*.

Note: You cannot use the following services and supplies to satisfy the *Unauthorized Out-of-Pocket Maximum*:

- Any service or supply that does not qualify as a *Covered Service*, including any services that require approval from an *Authorized Reviewer* prior to treatment and for which approval was not received.
- Charges that exceed the *Reasonable Charge* for services received at the *Unauthorized Level of Benefits*
- Any amount paid for prescription drugs
- Any amount paid as a *Notification Penalty* or any other reduction or denial of benefits due to failure to notify *Tufts Health Plan* as required under the Navigator Plan (see pages 43-45 for more information)
- Any *Copayment* or other amount paid for *Covered Services* received at the *Authorized Level of Benefits*.

Notification Penalty

You must pay the *Notification Penalty* listed below for failure to notify *Tufts Health Plan* of a hospitalization or hospital transfer in accordance with Part 3.

- **Authorized Level of Benefits:**
There is no *Notification Penalty* for a hospitalization at a *Tufts HP Hospital* or a hospital transfer to a *Tufts HP Hospital*. Your *Tufts HP Provider* will notify *Tufts Health Plan* of the procedure for you.
- **Unauthorized Level of Benefits:**
You must pay a \$500 *Notification Penalty* for failure to notify *Tufts Health Plan* of a hospitalization or hospital transfer when (1) the hospitalization or transfer is not authorized by your *Tufts HP PCP*, or (2) the hospitalization is at or the transfer is to a hospital that is not a *Tufts HP Hospital*, in accordance with Part 3. For more information, please see “*Inpatient Notification*” in Part 3 (pages 43-45).

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

Part 3 – How Your Health *Plan* Works

How the *Plan* Works

Eligibility for Benefits

When you need health care services, you may choose to obtain these services either from or authorized by your *Tufts HP PCP (Authorized Level of Benefits)* or from any health care *Provider* without your *PCP's* authorization (*Unauthorized Level of Benefits*). Your choice will determine the level of benefits you receive for your health care services.

The *Plan* covers only the services and supplies described as *Covered Services* in Part 5. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

Behavioral health and substance use disorder services have different authorization requirements. Please see “*Inpatient Behavioral Health and Substance Use Disorder Services*” in Part 3, and the “*Behavioral Health and Substance Use Disorder Services*” benefits in Part 5 for more information.

In accordance with federal law (45 CFR § 148.180), *Tufts Health Plan* does not:

- Adjust premiums based on genetic information;
- Request or require genetic testing; or
- Collect genetic information from individuals prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

Medically Necessary services and supplies

The *Plan* will pay for *Covered Services* and supplies when they are *Medically Necessary*, as determined by *Tufts Health Plan*. *Covered Services* must be provided or authorized by your *Tufts HP PCP* to be covered at the *Authorized Level of Benefits*. *Covered Services* obtained from any other health care *Provider* without your *PCP's* authorization will be covered at the *Unauthorized Level of Benefits*. For behavioral health services, you must obtain approval from a *Tufts Health Plan Behavioral Health Authorized Reviewer*.

Important: The Navigator Plan will not pay for services or supplies which are not *Covered Services*, even if they are provided by your *Tufts HP PCP*, a *Tufts HP Provider* or any other *Provider*.

Authorized Level of Benefits

Outpatient Care

Each *Member* must choose a *Primary Care Provider (PCP)* in order to receive care at the *Authorized Level of Benefits*. The *PCP* is responsible for providing or authorizing all of your health care services at the *Authorized Level of Benefits*. Except for *Emergency* care, if you do not choose a *PCP*, or if you receive care from any *Provider* without the authorization of your *PCP*, this care will be covered at the *Unauthorized Level of Benefits*.

If your care is provided or authorized by your *Tufts HP PCP*, or if you seek care at a *Limited Service Medical Clinic* or *Urgent Care Center* that participates with *Tufts Health Plan*, you are entitled to coverage for *Covered Services* at the *Authorized Level of Benefits*. For behavioral health services, you must obtain approval from a *Tufts Health Plan Behavioral Health Authorized Reviewer*.

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

You will be required to pay a *Copayment* for certain *Covered Services* you receive at the *Authorized Level of Benefits*. For more information about your *Copayments*, please see “Benefit Overview” and “Plan and Benefit Information” earlier in this *Member Handbook*. In order to obtain coverage at the *Authorized Level of Benefits*, you must live in or near the *Service Area* so that you can access *Tufts HP Providers*. Otherwise, your coverage will be at the *Unauthorized Level of Benefits*.

Note: Italicized words are defined in Part 8.

Authorized Level of Benefits, continued

Outpatient care, continued

If your *PCP* cannot provide the services you need, he or she will refer you to another *Tufts HP Provider*. If the services you need are not available from any *Tufts HP Providers*, your *PCP*, after obtaining approval from an *Authorized Reviewer*, will refer you to a *Provider* not affiliated with *Tufts HP*. You will be covered at the *Authorized Level of Benefits* for these services. The *Plan* will pay up to the *Reasonable Charge* for these services. You will be responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable *Cost Sharing Amount*). You may receive a bill for these services. If you do receive a bill, please call Member Services or see “Bills from *Providers*” in Part 6 for more information on what to do if you receive a bill.

Your *PCP* is responsible for completing a referral form and sending it to the specialist prior to your visit for specialty care. In order to expedite matters, sometimes your *PCP* will give you the referral form to deliver to the specialist. Your *PCP* must authorize, in advance, any referral that a specialist may make to another *Provider*. A *PCP* may authorize a standing referral for specialty health care provided by a *Tufts HP Provider*.

Note: A referral to a specialist must be obtained from your *PCP* **before** you receive any *Covered Services* from that specialist. If you do not obtain a referral **prior** to receiving services, the services will be covered at the *Unauthorized Level of Benefits*.

Selecting a PCP

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

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

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

You do not need to select a *PCP* in order to receive coverage at the *Authorized Level of Benefits* for *Inpatient* mental health and *Inpatient* substance use disorder services. You will receive coverage for these services as long as the services are provided by a *Tufts HP Hospital*. See “*Inpatient* Behavioral Health and Substance Use Disorder Services” below in this Chapter 1.

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 that *Provider*. A Member Specialist can give you more information. Please see “Continuity of Care” later in this chapter for more information.
- For additional information about a *PCP* or specialist, contact the Massachusetts Board of Registration in Medicine at 800-377-0550 or mass.gov/massmedboard. The Board of Registration provides information about physicians licensed to practice in Massachusetts.

Changing Your PCP

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

Canceling Appointments

The *Plan* will not pay for missed appointments which you did not cancel in advance (usually at least 24 hours). If the *Tufts HP Provider's* office policy is to charge for missed appointments that were not canceled in advance, you will have to pay the charges.

Authorized Level of Benefits, continued

Changes to Tufts HP Provider network

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

This can happen for many reasons, including a *Provider's* retirement, the *Provider's* moving out of the *Service Area*, or his or her failure to continue to meet *Tufts HP's* credentialing standards. This can also happen if *Tufts HP* and the *Provider* are unable to reach agreement on a contract.

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

When Referrals are Not Required at the Authorized Level of Benefits

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

- *Emergency* care. (**Note:** If you are admitted as an *Inpatient*, you or someone acting for you must call your *PCP* or *Tufts HP* within 48 hours after receiving care. Notification from the attending physician satisfies this requirement.)
- Mammograms at the following intervals:
 - One baseline at 35-39 years of age
 - One every year at age 40 and older
 - As otherwise *Medically Necessary*
- Care in a *Limited Service Medical Clinic*, if available
- Care in an *Urgent Care Center*, if available
- Pregnancy terminations
- Routine eye exams
- Medical treatment provided by an optometrist
- Dental surgery, orthodontic treatment and management, or preventive and restorative dentistry, when provided for the treatment of cleft lip or cleft palate for *Children* under age 18
- Oral surgery
- Chiropractic services (spinal manipulation)
- The following specialty care provided by a *Tufts HP Provider* who is an obstetrician, gynecologist, certified nurse midwife or family practitioner:
 - Maternity care
 - *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions
 - Routine annual gynecological exam, including any *Medically Necessary* follow-up obstetric or gynecological care as a result of that exam

Inpatient Care

At the *Authorized Level of Benefits*, the Navigator Plan has three different *Copayment* Levels for *Inpatient* hospital stays at *Tufts HP Hospitals*. *Copayments* vary based on which hospital you choose. If you are admitted as an *Inpatient*, you or someone acting on your behalf must notify your *PCP* or *Tufts HP* of the admission within 48 hours in order for the services to be covered at the *Authorized Level of Benefits*.

Part 9 provides a list of the *Tufts HP Hospitals* and their *Copayment* tiers.

Note: *Inpatient* hospital *Copayments* are based on their participation in the Centered Care program and their efficiency of performance

Authorized Level of Benefits, continued

Non-Tiered Services

Covered transplant services for *Members* at the *Authorized Level of Benefits* at *Tufts Health Plan's* designated transplant network are not grouped in a *Copayment Level*. **These services are subject to a \$275 Copayment per admission.** Any additional *Inpatient* admission to a *Tufts HP Hospital* for *Covered Services* related to the transplant procedure(s) is subject to the applicable *Inpatient Hospital Copayment* in the "Navigator *Inpatient Hospital Copayment List*." Please see pages 97-102 of this *Navigator Member Handbook* for those *Copayment* amounts in effect as of July 1, 2018.

In addition, there are other services that are not included under these *Copayment Levels*. These include *Day Surgery*; *Inpatient* and intermediate behavioral health and substance use disorder services; certain care for newborn *Children*; and rehabilitation, extended care, and skilled nursing services at a skilled nursing facility, rehabilitation hospital, or chronic care facility. For information about your costs and limits for these services, please see "Benefit Overview" and Part 9 in this *Member Handbook*.

Inpatient Notification for services authorized by your PCP

As long as your *Inpatient* admission or procedure is authorized by your *Tufts HP PCP*, you are not responsible for notifying *Tufts Health Plan* about the admission or procedure. Your *Tufts HP Provider* will notify *Tufts Health Plan* about the admission or procedure for you. See "Inpatient Notification" on pages 43-45 for more information.

Covered Services Not Available from a Tufts HP Provider

If *Tufts Health Plan* determines that a *Covered Service* is not available from a *Tufts HP Provider*, with *Tufts Health Plan's* prior approval, you may go to a non-*Tufts HP Provider* and receive *Covered Services* at the *Authorized Level of Benefits* up to the *Reasonable Charge*. You are responsible for any charges in excess of the *Reasonable Charge*.

Unauthorized Level of Benefits

Unauthorized Level of Benefits

If your care is not provided or authorized by your *Tufts HP PCP*, *Covered Services* will be covered at the *Unauthorized Level of Benefits*. If you choose to obtain care at the *Unauthorized Level of Benefits*, (or if you have not chosen a *PCP*), you pay a *Deductible* and *Coinurance* for certain *Covered Services*. The *Member* is responsible for any charges in excess of the *Reasonable Charge*. For more information about your *Member* costs for medical services, see "Plan and Benefit Information" at the front of this *Member Handbook*.

Please note that you must submit a claim form for each service that is not authorized or provided by your *Tufts HP PCP*. For information on filing claim forms, see pages 77 and 82.

Inpatient Notification by You

If you receive *Inpatient* services that were not authorized by your *Tufts HP PCP*, you must notify *Tufts Health Plan* of these services within 48 hours of seeking or receiving care. If you do not notify *Tufts Health Plan*, you will be subject to a *Notification Penalty*. See "Inpatient Notification" on pages 43-45 for more information.

Covered Services outside of the 50 United States

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

Note: Services provided in U.S. territories are considered to be provided outside of the United States.

Continuity of Care

If you are an existing *Member*

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

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

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

To choose a new *PCP*, call Member Services at 800-870-9488 or visit tuftshealthplan.com/gic. 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* website at tuftshealthplan.com to choose a *PCP*.

If you are enrolling as a new *Member*

If your *Provider* is not included in one of the *Group Insurance Commission's* health plans at the time of your enrollment as a new *Member*, you may continue to see him or her if:

- **Undergoing Treatment.** If you are undergoing a course of treatment, you may continue to see your *Provider* for *Covered Services* for up to 30 days from your *Effective Date* and receive the *Covered Services* at the *Authorized Level of Benefits*.
- **Pregnancy.** If you are in your second or third trimester of pregnancy, you may continue to see your *Provider* to obtain *Covered Services* at the *Authorized Level of Benefits* through your first postpartum visit.
- **Terminal Illness.** If you are terminally ill, you may continue to see your *Provider* to obtain *Covered Services* at the *Authorized Level of Benefits* as long as necessary.

Conditions for coverage of continued treatment

As a condition for continued coverage of *Covered Services* at the *Authorized Level of Benefits*, *Tufts Health Plan* may require your *Provider* to agree to:

- Accept reimbursement from *Tufts Health Plan* at the rates applicable prior to notice of disenrollment as payment in full, and not to impose *Member* cost sharing in an amount exceeding the cost sharing that could have been imposed prior to the *Provider's* disenrollment
- Adhere to the quality assurance standards of *Tufts Health Plan* and to provide *Tufts HP* with any necessary medical information
- Adhere to *Tufts Health Plan's* policies and procedures, including those regarding referrals, prior authorization, and providing services pursuant to a treatment plan approved by *Tufts HP*.

Inpatient Behavioral Health and Substance Use Disorder Services

Authorized Level of Benefits: If you require *Inpatient* or intermediate behavioral health or substance use disorder services and wish to receive coverage for these services at the *Authorized Level of Benefits*, you may go to any *Tufts HP Hospital*. There is no need to contact your *PCP* first. Simply call or go directly to any *Tufts HP Hospital*. Identify yourself as a *Tufts Health Plan Member*. You are not responsible for notifying *Tufts Health Plan* of your admission at a *Tufts HP Hospital*.

Unauthorized Level of Benefits: If you wish to receive *Inpatient* or intermediate behavioral health or substance use disorder services at a facility that is not a *Tufts HP Hospital*, your coverage will be at the *Unauthorized Level of Benefits*. This is the case even if your *PCP* authorizes your care at a *Non-Tufts HP Hospital*. *Inpatient* or intermediate behavioral health or substance use disorder services not provided by a *Tufts HP Hospital* will only be covered at the *Unauthorized Level of Benefits*. Coverage at the *Unauthorized Level of Benefits* means that you pay a *Deductible* and *Coinsurance* (as well as any charges in excess of the *Reasonable Charge*) and are responsible for notifying *Tufts Health Plan* of your admission. In order to receive care for *Inpatient* or intermediate behavioral health or substance use disorder services at the *Unauthorized Level of Benefits*, you must receive authorization from an *Authorized Reviewer*. Please call the *Tufts Health Plan* Behavioral Health Department at 1-800-870-9488 for more information on how to receive this authorization.

Emergency Admission to a non-Tufts HP Hospital

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

Emergency Care

To Receive Emergency Care

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

Outpatient Emergency Care

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

If you receive *Emergency Covered Services* from a non-*Tufts HP Provider*, the *Plan* will pay up to the *Reasonable Charge*. You pay the applicable *Copayment*, then the *Authorized Deductible*, as well as any charges in excess of the *Reasonable Charge*. You may receive a bill for these services. If you receive a bill, call Member Services or see “Bills from *Providers*” for more information on what to do if you receive a bill.

Note: You or someone acting for you must call your *PCP* or *Tufts HP* within 48 hours of receiving care. You are encouraged to contact your *PCP* so he or she can provide or arrange for any follow-up care that you may need.

Emergency Care, continued

Inpatient Emergency Care

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

Also, if you are admitted as an *Inpatient* to a hospital that is not a *Tufts HP Hospital* after receiving *Emergency* care, that admission will be subject to *Inpatient Copayment Tier 1* (a \$275 *Copayment* per admission). In addition, you or someone acting for you must notify your *PCP* of the admission within 48 hours after you are admitted for *Inpatient Emergency* care or you will be charged a \$500 *Notification Penalty*. *Inpatient* notification guidelines are described on pages 43-45.

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

Financial Arrangements between Tufts Health Plan and Tufts HP Providers

Methods of payment to Tufts HP Providers

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

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

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

Member Identification Card

The *Plan* gives each *Member* a Member Identification card (*Member ID card*). Your *Member ID card* identifies your health care plan and your individual Member Identification Number.

When you receive your *Member ID card*, check it carefully. If any information is incorrect, call Member Services at 800-870-9488.

Please remember to carry your card with you at all times and bring it to your medical appointments. When you receive services, you must tell the office staff that you are a *Navigator Member*.

Note: If you do not identify yourself as a *Member*, and, as a result, your *PCP* and/or the *Plan* does not manage your care, then the *Plan* may not pay for the services provided. If this occurs, the *Covered Services* you receive from that *Tufts HP Provider* may be covered at the *Unauthorized Level of Benefits*.

Utilization Management

The purpose of the *Tufts HP* utilization management program is to evaluate whether health care services provided to *Members* are *Medically Necessary* and provided in the most appropriate and efficient manner. Under this program, *Tufts Health Plan* sometimes uses prospective, concurrent, and retrospective review of health care services.

Type of Review	Timeframe for Determinations*
Prospective (Pre-service) <i>Tufts Health Plan</i> determines whether the proposed treatment is <i>Medically Necessary</i>	Within two (2) working days of receiving all necessary information, but no later than 15 days from receipt of the request
Concurrent <i>Tufts Health Plan</i> monitors the course of treatment as it occurs and determines when it is no longer <i>Medically Necessary</i>	Determination is made prior to treatment being reduced or terminated. This allows you to appeal an adverse determination.
Retrospective (Post-Service) <i>Tufts Health Plan</i> evaluates care after it has been provided, and to more accurately determine the appropriateness of health care services provided to <i>Members</i>	30 days
Urgent care review	72 hours

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

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

Notes: *Members* can call *Tufts Health Plan* at 1-800-870-9488 to determine the status or outcome of utilization review decisions.

Care Management

Some *Members* with severe illnesses or injuries may warrant care management intervention under *Tufts Health Plan's* case management program.

Severe illness and injuries may include, but are not limited to, the following:

- High-risk pregnancy and newborn *Children*
- Serious heart or lung disease
- Cancer
- Certain neurological diseases
- AIDS or other immune system diseases
- Severe traumatic injury

Under this program, *Tufts Health Plan*

- Encourages the use of the most appropriate and cost-effective treatment
- Supports the *Member's* treatment and progress

If a *Member* is identified by *Tufts Health Plan* as an appropriate candidate for care management or is referred to the program, *Tufts HP* may contact *Members* and their *Providers* to:

- Discuss a treatment plan
- Established prioritized goals
- Explore potential alternative services or supplies.

Members and their *Tufts HP Providers* will be contacted if *Tufts Health Plan* identifies alternatives to the *Member's* current treatment plan that qualify as *Covered Services*, are cost effective, and are appropriate for the *Member*.

Individual case management (ICM)

In certain circumstances, *Tufts Health Plan* may authorize an individual case management ("ICM") plan for a *Member* with severe illnesses or injuries. The goal of the ICM plan is to identify and arrange for the most appropriate type, level, and setting of health care services and supplies for the *Member*.

Under the ICM plan, *Tufts Health Plan* may authorize coverage for alternative services and supplies that do not otherwise constitute *Covered Services* for that *Member*. This will occur only if *Tufts Health Plan*, at its sole discretion, determines that all of the following conditions are satisfied:

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

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

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

Authorized Reviewer Approval

Certain *Covered Services* require prior approval from an *Authorized Reviewer*. These services are identified by **(AR)** in the “Benefit Overview”.

If you receive these services from or authorized by your *Tufts HP PCP*, your *PCP* is responsible for obtaining approval from an *Authorized Reviewer*.

If your services are not provided or authorized by your *Tufts HP PCP*, you are responsible for obtaining prior approval from an *Authorized Reviewer*. If you fail to obtain prior approval, the Navigator Plan will not cover those services and supplies. In addition, if you receive services that *Tufts HP* determines are not *Covered Services*, you will be responsible for the cost of those services.

For more information about how to obtain this prior approval, please call Member Services at 800-870-9488.

If a request for coverage is denied, you have a right to appeal. Please see Part 6, “How to File a Claim and Member Satisfaction Process”, for information on how to file an appeal.

Services that you receive in an *Emergency* do not require prior approval from an *Authorized Reviewer*.

Inpatient Notification (formerly known as pre-registration)

Inpatient Notification

Inpatient notification is a process that makes *Tufts Health Plan* aware of all *Inpatient* hospital admissions and transfers to another hospital. We will evaluate the anticipated hospital stay, and, in certain cases, will also:

- Evaluate your proposed medical care
- Verify whether that care is *Medically Necessary*
- Assess the need for a care management program after discharge
- Recommend an alternative treatment setting.

Important note about *Inpatient* notification

The *Inpatient* notification to *Tufts Health Plan* by your *Provider* does not guarantee that the *Plan* will cover the health care services you receive. Even if *Tufts Health Plan* is notified of an *Inpatient* admission or hospital transfer, the *Plan* is not obligated to cover any services or supplies for any person who:

- Fails to meet eligibility rules
- Receives services or supplies that are not *Covered Services*
- Receives care that is not *Medically Necessary*, as determined by *Tufts Health Plan*

When *Covered Services* are Authorized by your *Tufts HP PCP*

When your *Tufts HP PCP* (or in the case of *Inpatient* behavioral health or *Inpatient* substance use disorders, a *Tufts HP Hospital*) is directing your care, he or she is responsible for notifying *Tufts Health Plan* of your *Inpatient* admission or transfer. In this case, you do not need to notify us of the admission or transfer.

Inpatient Notification, continued

When Covered Services are not Authorized by your Tufts HP PCP

When your care is not authorized by your *Tufts HP PCP* (or, when you receive care for *Inpatient* behavioral health or *Inpatient* substance use disorders at a non-*Tufts HP Hospital*), you, the *Member*, are responsible to notify *Tufts Health Plan* of any *Inpatient* admission or transfer.

Important: If you do not notify *Tufts Health Plan*, you will be required to pay a \$500 *Notification Penalty* for the care you receive in addition to the *Deductible* and *Coinsurance*. Please carefully read the following description of the *Inpatient* notification process that you must complete when your *Tufts HP PCP* is not directing your care. For more information about coverage for *Inpatient* behavioral health and substance use disorder services, see “*Inpatient Behavioral Health and Substance Use Disorder Services*” earlier in this chapter.

How to Notify Tufts Health Plan of a Hospital Admission or Transfer

You must call the Member Services Department at 800-870-9488 to report your hospital admission or transfer.

You, or someone acting on your behalf, will need to provide the following information:

- The patient name, address, and phone numbers (work and home)
- The *Member's* identification number (from your member ID)
- The admitting physician's name, address, and phone number
- The admitting hospital's name, address, and phone number
- The *Member's* diagnosis and proposed procedure;
- The proposed admission and discharge dates

When to notify Tufts Health Plan

You must notify *Tufts Health Plan* of the following services within the following time limits:

- For elective hospital admissions or transfers -You must notify *Tufts Health Plan* at least seven (7) days prior to hospitalization or transfer. After you notify us, we will consult with your physician and then:
 - Notify you or your physician of the determination of the admission, including the anticipated hospital stay; or
 - Recommend alternative treatment settings.
- For urgent or emergent admissions – For an urgent admission, you must notify *Tufts Health Plan* as soon as possible, but no later than one business day after the admission. An urgent admission is one which requires prompt medical intervention but one in which there is a reasonable opportunity to notify *Tufts Health Plan* prior to, or at the time of, admission. Notification for an *Emergency* admission should be completed within one business day following the admission. For a definition of *Emergency*, see Appendix A.
- For delivery of a newborn Child - Notification to *Tufts Health Plan* for delivery of your newborn *Child* should occur within 30 days of your due-date.
- For Inpatient hospital care for a newborn Child - You must immediately notify *Tufts Health Plan* of the hospital stay of your newborn *Child*, if the newborn *Child* remains a hospital *Inpatient* for more than 48 hours after birth (following a vaginal delivery) or 96 hours after birth (following a cesarean delivery), and his or her care is not provided or authorized by his or her *Tufts HP PCP*.

Note: If your newborn *Child* is a hospital *Inpatient* for less than 48 hours after birth, you do not need to pre-register *Inpatient* hospital care for that *Child*.

Inpatient Notification, continued

When Covered Services are not Authorized by your Tufts HP PCP, continued

Notification Penalty

You must notify *Tufts Health Plan* of your *Inpatient* hospital admission or a transfer for care that is not authorized by your *Tufts HP PCP*, as described above. If you fail to meet any of the *Inpatient* notification requirements described in this Part 3, you must pay a \$500 *Notification Penalty*. This *Notification Penalty* is in addition to any *Deductible* and *Coinsurance* that you are required to pay for that care.

After you notify Tufts Health Plan of a hospital admission

After you call with the required information, your physician or the hospital will be notified of the decision made by *Tufts Health Plan*.

Changes to hospital admission information

Notification of your hospital admission is valid only for the diagnosis, procedure, admission date, and medical facility specified at the time of the notification. You must notify *Tufts Health Plan* about any delays, changes, or cancellations of your proposed hospital admission.

A separate notification to *Tufts Health Plan* must be obtained for:

- A new date for your hospital admission
- Readmission or a new admission as a hospital *Inpatient*
- Transfer to another facility

Important Note: You must notify *Tufts Health Plan* about these changes before your hospital admission begins. If you fail to do this, you will be required to pay a \$500 *Notification Penalty* for that admission.

Extending Inpatient Hospital Care

You or someone acting for you (for example, your physician) may contact *Tufts Health Plan* to request an extension of your *Inpatient* hospital care beyond the originally determined stay. This is true whether or not your *Tufts HP PCP* authorized this care.

Tufts Health Plan will review your request to extend your *Inpatient* hospital care. As a part of this review, your physician or hospital may be asked to provide additional information about your medical condition. If *Tufts Health Plan* determines that an extension of your *Inpatient* hospital care is *Medically Necessary*, additional hospital days may be authorized for you.

Important Note: *Tufts Health Plan* may determine that your *Inpatient* hospital care is no longer *Medically Necessary*. In this case, *Tufts Health Plan* will notify you that the *Plan* will not pay for any additional hospital days. You will be responsible for paying all hospital and physician charges, if you choose to remain as a hospital *Inpatient* beyond the length of stay initially authorized by *Tufts Health Plan*.

Part 4 - Enrollment and Termination Provisions

Enrollment

When to enroll

As a *Subscriber*, you may enroll yourself and your eligible *Dependents*, if any, for this coverage. You must apply to the *GIC* for enrollment in the *Plan*. To obtain the appropriate forms, active employees should contact their *GIC* Coordinator, and retirees should contact the *GIC*.

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

- Within 10 days of your hire date as an eligible new employee
- During the *Annual Enrollment Period*
- Within 60 days of the date your *Dependent* is first eligible for this coverage.

You must complete an enrollment form to enroll or add *Dependents* in a *Family Plan*. Additional documentation may be required, as follows:

- Newborns and *Dependent Children* (including stepchildren) under age 26: copy of hospital announcement letter (for a newborn) or the *Child's* certified birth certificate
- Adopted *Children*: photocopy of proof of placement letter or adoption, court decree of adoption, or amended birth certificate
- Foster *Children* ages 19-26: photocopy of proof of placement letter or court order
- *Spouses*: copy of certified marriage certificate

Enrollment is subject to the provisions of Massachusetts General Laws, Chapter 32A, the *GIC* Rules and Regulations, and applicable federal law.

Special Enrollment Condition

If you declined to enroll your spouse or *Dependents* when first eligible, you and your eligible *Dependents* may be enrolled within 60 days of a qualifying status change event ("qualifying events") or during the *GIC's Annual Enrollment Period*. Qualifying events include the following:

- Your coverage under other health coverage ends involuntarily
- Your marriage or divorce
- The birth, adoption, or placement for adoption of your *Dependent Child*
- The employee or *Dependent* is eligible under a state Medicaid plan or state children's health insurance program (CHIP), and the Medicaid or CHIP coverage is terminated
- The employee or *Dependent* becomes eligible for a premium assistance subsidy under a state Medicaid plan or CHIP.

To obtain *GIC* enrollment and change forms, active employees should contact the *GIC* Coordinator at their workplace, and retirees should contact the *GIC*. Enrollment and change forms are also available on the *GIC's* website at mass.gov/gic.

Additional Information about Newborn *Children*

The *Plan* will cover your newborn *Child* from birth under a *Family Plan*, provided the *Subscriber* enrolls the newborn *Child* within 60 days after birth.

If the *Subscriber* does not enroll the newborn *Child* within 31 days after birth, the Navigator *Plan* will only cover that newborn *Child* at birth for an initial 31-day period. During this period, the Navigator *Plan* will only cover *Routine Nursery Care* for up to 48 hours (in the case of a vaginal delivery) or up to 96 hours (in the case of a caesarean delivery).

To continue coverage for the newborn *Child* after this 31-day period, **the *Subscriber* must apply to enroll the *Child* within 60 days after birth.**

Note: Italicized words are defined in Part 8.

Enrollment, continued

Handicapped Child

Coverage may be available under a *Family Plan* for a *Handicapped Child* over the age of 25, provided that the *Child* was either mentally or physically handicapped so as not to be capable of earning his or her own living before age 19. Contact the *GIC* at 617-727-2310 for an application to continue coverage for a *Handicapped Child*.

Coverage may also be available under age 26 for *Children* who become handicapped at age 19 or older. Contact the *GIC* for information.

Effective Date

New employees

Coverage begins on the first day of the month following 60 days or two (2) calendar months of employment, whichever comes first.

Persons applying during an Annual Enrollment Period

Coverage begins each year on July 1.

Spouses and Dependents

Coverage begins on the later of:

- The date your own coverage begins, or
- The date that the *GIC* has determined your *Spouse* or *Dependent* is eligible.

Surviving Spouses

Upon application, you will be notified by the *GIC* of the date your coverage begins.

Residence in Service Area Requirement

Every individual covered by a *Family Plan* must reside in the *Service Area* for at least 9 months of the year. Adult *Children* age 19-26 may reside outside of the *Service Area* but will be subject to the plan's coverage rules.

Termination

Subscribers

Your coverage ends on the earliest of:

- The end of the month in which you cease to be eligible for coverage
- The date of death
- The date the surviving *Spouse* (or covered former *Spouse*) remarries
- The end of the month covered by your last contribution toward the cost of coverage
- The date the *Plan* terminates
- The date a *Subscriber* becomes eligible for Medicare and retires (or is already retired). Contact the *GIC* for more information about the options to continue health care coverage in one of the *GIC's* Medicare health plans.
- The date the *Subscriber* moves out of the *Service Area*. In order to remain enrolled in the Navigator *Plan*, the *Subscriber* must remain in the *Service Area* for 9 months in each calendar year.

Dependents

A *Dependent's* coverage ends on the earliest of:

- The date the *Subscriber's* coverage under the *Plan* ends
- The end of the month covered by your last contribution toward the cost of coverage
- The date you become ineligible to have a *Spouse* or *Dependent* covered
- The end of the month in which the *Dependent* ceases to qualify as a *Dependent*
- The date the *Handicapped Child* marries
- The date the covered divorced *Spouse* remarries (or the date the *Subscriber* marries)
- The date of the *Spouse* or *Dependent's* death
- The date the *Plan* terminates
- The date the *Spouse* of a retired *Subscriber* becomes eligible for Medicare. Contact the *GIC* for more information about the options to continue health care coverage in one of the *GIC's* Medicare health plans.

Continuation of Coverage

Option to Continue Coverage for *Dependents* Age 26 and Over

Dependent Children age 26 and over are no longer eligible for coverage under this *Plan*. *Dependents* age 26 and over who are full-time students at accredited educational institutions may continue to be covered. However, you must pay 100% of the individual premium. The student must also submit an application to the *GIC* no later than 30 days after his or her 26th birthday. If this application is submitted late, your *Dependent Child* may apply during the *GIC*'s annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their *GIC* coverage.

Continuing Coverage for Surviving *Spouses* and *Dependent Children*

In the event of the death of the *Subscriber*, the surviving *Spouse* and/or eligible *Dependent Children* may be able to continue coverage. For more information on eligibility for survivors and orphans, contact the *GIC*.

To continue coverage, you must submit an enrollment form to the *GIC* within 30 days of the covered employee or retiree's death. You must also make the required contribution toward the cost of the coverage. Coverage will end on the earliest of:

- The end of the month in which the survivor dies
- The end of the month covered by your last contribution payment for coverage
- The date the coverage ends
- The date the *Plan* terminates
- For *Dependents*: the end of the month in which the *Dependent* would otherwise cease to qualify as a dependent
- The date the surviving *Spouse* remarries

Option to Continue Coverage after a Change in Marital Status

Your former *Spouse* will not cease to qualify as a *Dependent* under the *Plan* solely because a judgment of divorce or separate support is granted. Massachusetts law presumes that he or she continues to qualify as a *Dependent*, unless the divorce judgment states otherwise.

If you get divorced, you must notify the *GIC* within 60 days and send the *GIC* a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions. **If you or your former *Spouse* remarries, you must also notify the *GIC*.** If you fail to report a divorce or remarriage, *Tufts Health Plan* and the *GIC* have the right to seek recovery of health claims paid or premiums owed for your former *Spouse*.

Under M.G.L. Ch. 32A as amended and the *GIC*'s regulations, your former *Spouse* will no longer qualify as a dependent after the earliest of these dates:

- The end of the period in which the judgment states he or she must remain eligible for coverage
- The end of the month covered by the last contribution toward the cost of coverage
- The date he or she remarries
- The date you remarry. If your former *Spouse* is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the *GIC*) under a divorced *Spouse* rider. Alternatively, your former *Spouse* may enroll in COBRA coverage.

Family Members of *Subscribers* Enrolled in Medicare

When a retired *Subscriber* turns 65 years of age and becomes eligible to enroll in the Medicare Program (Parts A and B), the *Subscriber's* family *Members* who are under age 65 may stay on the *Plan* provided that the *Subscriber* enrolls in one of the *GIC*'s Medicare plans.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the *GIC*'s plan to similarly situated employees or dependents. The *GIC* administers COBRA coverage.

For more information about COBRA coverage, please see "Group Insurance Commission Notices" beginning on page 116.

Coverage under an *Individual Contract*

Under certain circumstances, a person whose *Group Insurance Commission* coverage is ending has the option to convert to an *Individual Contract*. Please note that conversion to non-group health coverage may offer less comprehensive benefits and higher member cost-sharing than either COBRA coverage or plans offered under the Health Insurance Marketplaces in many states.

If you live in Massachusetts

If your *Group Insurance Commission* coverage ends, you may be eligible to enroll in coverage under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Massachusetts Health Insurance Connector Authority (“the Connector”). For more information, call Member Services or contact the Connector by phone at 877-MA-ENROLL or on its website at mahealthconnector.org.

If you live outside Massachusetts

If your *Group Insurance Commission* coverage ends, you are not eligible to enroll in coverage under an *Individual Contract* offered either directly by *Tufts Health Plan* or through the Massachusetts Health Insurance Connector Authority. Please contact your state insurance department for information about coverage options that are available to you in your state.

For more information

Please call *Tufts Health Plan* Member Services at 800-870-9488.

Part 5 - Covered Services

Covered Services

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

- Listed as *Covered Services* in this Part 5
- *Medically Necessary*, as determined by *Tufts Health Plan*
- Consistent with applicable law
- Consistent with *Tufts Health Plan's Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available to you at **tuftshealthplan.com** or by calling Member Services at 800-870-9488.
- Obtained within the 50 United States (U.S. territories are excluded), except for *Emergency* or *Urgent Care* services while traveling
- Provided to treat an injury, illness or pregnancy, or are preventive care services
- With respect to care at the *Authorized Level of Benefits*: provided or authorized in advance by your *PCP*, except in an *Emergency* or for care at a *Limited Service Medical Clinic* or *Urgent Care Center* that participates with *Tufts Health Plan*
- Approved by an *Authorized Reviewer* (if applicable)

Important Notes:

- Certain *Covered Services* at both the *Authorized* and *Unauthorized Levels of Benefits* require prior approval from an *Authorized Reviewer*. (See “Benefit Overview” for the services that require prior approval.)
 - If these services are from or authorized by your *Tufts HP PCP*, your *PCP* is responsible for obtaining approval from an *Authorized Reviewer*.
 - If your services are not provided or authorized by your *Tufts HP PCP*, you are responsible for obtaining prior approval from an *Authorized Reviewer*. If you fail to obtain prior approval, the Navigator Plan will not cover those services and supplies. For more information about obtaining this prior approval, please call Member Services at 800-870-9488, or, for behavioral health and substance use disorder services, the *Tufts Health Plan* Behavioral Health Department at 1-800-870-9488.
- All claims are subject to retrospective review from an *Authorized Reviewer* to ensure that they are for the *Covered Services* described in Part 5. The *Plan* will only pay claims that are for *Covered Services*.
- *Inpatient* notification: You must notify *Tufts Health Plan* of any *Inpatient* services you receive at the *Unauthorized Level of Benefits*. Please see “*Inpatient* Notification” in Part 3 (pages 43-45) for more information.
- At the *Authorized Level of Benefits*: you may be charged an *Office Visit Copayment* for certain *Outpatient* services listed as “covered in full” in the “Benefit Overview”, if these services are provided in conjunction with an office visit.

YOUR COSTS FOR COVERED SERVICES: For information about your costs (i.e., *Copayments*, *Coinsurance*, and *Deductibles*) for the *Covered Services* listed below, see the “Benefit Overview” starting on page 14. Information about the day, dollar, and visit limits under this plan can be found in the “Benefit Overview” and in certain *Covered Services* listed below.

Note: Italicized words are defined in Part 8.

Covered Services, Continued

Emergency Care

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

No PCP referral is required for receiving *Emergency* care. However, you or someone acting for you should call your *PCP* or *Tufts HP* within 48 hours after receiving care so your *PCP* can provide or arrange for any follow-up care that you may need.

If you receive *Emergency* services but are not admitted as an *Inpatient*, the services will be covered up to the *Reasonable Charge*. You will be required to pay a *Copayment*, then the *Deductible* for each *Emergency* room visit. *Emergency Covered Services* from a non-*Plan Provider* are subject to the applicable *Copayment* and *Authorized Deductible* (up to the *Reasonable Charge*). If you receive a bill for these services from a non-*Plan Provider*, please contact Member Services at 800-870-9488.

Notes:

- The *Emergency Room Copayment* is waived if you are admitted as an *Inpatient*, or if the *Emergency* room visit results in an immediate *Day Surgery*. It may apply if you register in an *Emergency* room but leave without receiving care. The *Emergency Room Copayment* applies to *Observation* services. Call Member Services at 800-870-9488 for more information, or to have your *Emergency* room *Copayment* waived if you are admitted as an *Inpatient* (whether you are admitted to the same or a different hospital from which you received *Emergency* care).
- If you are admitted as an *Inpatient* after receiving *Emergency* care, you or someone acting for you must notify *Tufts Health Plan* within 48 hours of seeking care to be covered. (Notification from the attending physician satisfies this requirement.)
- If you are admitted to an *Inpatient* mental health facility after being seen at the *Emergency* Room, the *Emergency Room Copayment* will be waived. *Members* must call the *Tufts Health Plan* Member Services Department to request this waiver or to have the claim adjusted.
- If you receive *Emergency Covered Services* from a non-*Tufts HP Provider*, the *Plan* will pay the *Provider* up to the *Reasonable Charge*. You will be responsible for any charges in excess of the *Reasonable Charge* (as well as any applicable *Cost Sharing Amount*). You may receive a bill for these services. If you receive a bill, please call Member Services or see “Bills from *Providers*” for more information on what to do if you receive a bill.

Covered Services, Continued

Outpatient care

Autism spectrum disorders – diagnosis and treatment (requires prior approval at both the *Authorized* and *Unauthorized Levels of Benefits*)

Autism spectrum disorders include any of the pervasive *Developmental* disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include autistic disorder, Asperger's disorder, and pervasive *Developmental* disorders not otherwise specified.

Coverage is provided, in accordance with Massachusetts law, for the diagnosis and treatment of autism spectrum disorders.

Covered Services include:

- *Habilitative* or rehabilitative care: professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavior analysis (ABA) supervised by a *Board-Certified Behavior Analyst*. For purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Services include those provided by a *Paraprofessional* or a *Board-Certified Behavior Analyst*. For more information about these programs, call the *Tufts Health Plan* Behavioral Health Department at 1-800-870-9488.
- Services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers (see "*Outpatient medical care*" and "*Rehabilitative and Habilitative physical and occupational therapy services*" on pages 57 and 59). Please note that benefit limits for physical and occupational therapy do not apply when these services are provided for the treatment of autism spectrum disorders.
- Prescription medications (coverage is administered by Express Scripts. Please see "*Prescription Drug Benefit*" on pages 103-115 for more information about this coverage)
- Psychiatric and psychological care (see "*Behavioral Health and Substance Use Disorder Services*" benefit on page 66)

Cardiac rehabilitation

The *Plan* covers services for the *Outpatient* treatment of documented cardiovascular disease that: (1) Meet the standards promulgated by the Massachusetts Commissioner of Public Health; and (2) Are initiated within 26 weeks after diagnosis of cardiovascular disease.

The *Plan* covers only the following services:

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

Notes:

- Once treatment has been initiated, the *Member* can receive covered cardiac rehabilitation services for up to 6 months from the date of the first visit.
- For *Members* with *angina pectoris*, only one course of cardiac rehabilitation services will qualify as *Covered Services*.
- The *Plan* does not cover the program phase that maintains rehabilitated cardiovascular health.

Chiropractic services

Spinal manipulation, when provided by a chiropractor.

Limited to one spinal manipulation evaluation and a total of 20 visits per *Member* in a *Contract Year* (*Authorized* and *Unauthorized Levels* combined).

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

Covered Services, Continued

Outpatient Care - continued

Clinical trials studying potential treatment(s) for cancer or other life-threatening diseases or conditions

As required by applicable law, patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions are covered to the same extent as those *Outpatient* services would be covered if the *Member* did not receive care in a qualified clinical trial.

Please see page 53 or call Member Services at 800-870-9488 for more information about the criteria for a qualified clinical trial.

Contraceptives – See “Family Planning Procedures, Services, and Contraceptives” below.

Coronary Artery Disease Program

A Coronary Artery Disease secondary prevention program assists *Members* with documented coronary artery disease in making necessary lifestyle changes to reduce your cardiac risk factors. This benefit is available, when *Medically Necessary*, at designated programs to *Members* who meet the clinical criteria established for this program.

For more information about this program, call Member Services at 800-870-9488.

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.

Notes:

- *Tufts Health Plan* will only cover these services at the *Authorized Level of Benefits* when they are 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 on page 56.

Dialysis

Outpatient dialysis treatment, including hemodialysis and peritoneal dialysis, is covered. Home peritoneal dialysis is a *Covered Service*. Home hemodialysis is covered only when provided under the direction of a general or chronic disease hospital or free-standing dialysis facility.

Early intervention services for a *Dependent Child*

Early intervention services include occupational, physical and speech therapy, nursing care and psychological counseling. These services must be provided by early intervention programs that meet the standards established by the Massachusetts Department of Public Health.

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

Family planning procedures, services, and contraceptives

Covered family planning procedures include tubal ligation, sterilization, and pregnancy termination. Family planning services include medical examinations, birth control counseling, and genetic counseling.

The following contraceptives are available, when provided by a physician and administered in that physician's office:

- Cervical caps
- Implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants)
- IUDs
- Depo-Provera or its generic equivalent.

Note: Certain contraceptives, such as oral contraceptives, over-the-counter female contraceptives, and diaphragms, are covered through Express Scripts. Information about your coverage with Express Scripts can be found under the “Prescription Drug Benefit”, which is described on pages 103-115.

Covered Services, Continued

Outpatient Care - continued

Infertility services (may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

Infertility occurs when a female *Member* has been unable to conceive or produce conception, during a period of: (1) one year if age 35 or younger, or (2) during a period of six months if over the age of 35. If a woman conceives but is unable to carry the pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one-year or six-month period, as applicable.

Covered infertility services, which may require prior approval from an *Authorized Reviewer* (as noted by **(AR)** below), include:

- Diagnostic procedures and tests
- Procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment
- Artificial insemination (intrauterine or intracervical) **(AR)**
- Cryopreservation of eggs (less than 90 days) **(AR)**
- Procurement and processing of eggs or inseminated eggs or banking of inseminated eggs when associated with active infertility treatment **(AR)**
- Assisted Reproductive Technology (“ART”) procedures, including:
 - I.V.F. (in-vitro fertilization and embryo transfer) **(AR)**
 - D.O. (donor oocyte) **(AR)**
 - F.E.T. (frozen embryo transfer) **(AR)**
 - Z.I.F.T. (zygote intra-fallopian transfer) **(AR)**
 - Assisted hatching **(AR)**
 - G.I.F.T. (gamete intra-fallopian transfer) **(AR)**
 - I.C.S.I. (intracytoplasmic sperm injection) **(AR)**

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

Oral and injectable drug therapies used in the treatment of infertility associated with the *Covered Services* below are covered only when the *Member* has been approved for associated infertility services. These services are provided through your prescription drug benefit, which is administered by Express Scripts. Please see “Prescription Drug Benefit” on pages 103-115 for more information.

Note: Artificial insemination and the ART procedures described above will only be considered *Covered Services* for *Members* with infertility who meet the eligibility criteria of both *Tufts HP* (based on the *Member’s* medical history) and the *Plan’s* contracted Infertility Services providers. Services at both the *Authorized* and *Unauthorized Levels of Benefits* must be approved in advance by an *Authorized Reviewer*. The procurement and processing of donor sperm or eggs will be covered to the extent such costs are not covered by the donor’s health care coverage, if any.

Covered Services, continued

Outpatient Care – continued

Maternity care

Covered Services include prenatal care, exams, and tests, and postpartum care provided in a physician's office.

Notes: You will be reimbursed for up to three visits with a lactation consultant per pregnancy. Please contact the *Tufts Health Plan* Member Services Department for information on how to be reimbursed for these services.

Maternity related tests (i.e., ultrasounds, diagnostic testing, and non-routine laboratory tests) are subject to the *Deductible*. However, in accordance with the ACA, routine laboratory tests associated with maternity care at the *Authorized Level of Benefits* are covered in full and not subject to the *Deductible*. Please call Member Services at 800-870-9488 for further information.

Outpatient medical care

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

Note: Allergy treatment provided to you at the *Authorized Level of Benefits* is subject to an Office Visit *Copayment* when received as part of an office visit. However, there may not be a *Copayment* if the sole purpose of your visit is to receive allergy treatment (for example, an allergy shot).

- Chemotherapy. Please see “Injectable, inhaled and infused medications” later in this Part 5 for more information about coverage for medications.
- Diagnostic or preventive screening procedures (including, for example, colonoscopies, sigmoidoscopies, and proctosigmoidoscopies) **(may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Level of Benefits*)**

Note: Please see page 19 of the “Benefit Overview” for information about your *Copayments* for these procedures.

- Diagnostic imaging, including:
 - General imaging (such as x-rays and ultrasounds)
 - MRI/MRA, CT/CTA, and PET tests and nuclear cardiology **(may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Level of Benefits*)**

Note: Please call Member Services at 800-870-9488 with questions about specific imaging services.

- Diagnostic testing, including, but **not limited to**, sleep studies and diagnostic audiological testing **(may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)**.

Note: Please call Member Services at 800-870-9488 with questions about specific tests.

- EKG testing
- 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 Massachusetts Department of Public Health. **These services require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.**
- Laboratory tests, including, but not limited to, blood tests, urinalysis, throat cultures, glycosolated hemoglobin (A1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles

Note: Laboratory tests must be ordered by a licensed *Provider* and be performed at a licensed laboratory. **Some lab tests (e.g., genetic testing) may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*.** In addition, please note that laboratory tests performed as part of preventive care are covered in full at the *Authorized Level of Benefits*.

Covered Services, Continued

Outpatient Care – continued

Outpatient medical care (continued)

- Mammograms at the following intervals:
 - One baseline at 35-39 years of age
 - One every year at age 40 and older
 - As otherwise *Medically Necessary*
- Nutritional counseling, including nutritional counseling for an eating disorder, when given outside of an approved home health care plan, prescribed by a physician and performed by a registered dietician/nutritionist. Coverage is provided for one initial evaluation and a total of 3 treatment visits per *Contract Year*. Nutritional counseling visits are covered:
 - When *Medically Necessary*, for the purpose of treating an illness. Please see “Nutritional Counseling” in the “Benefit Overview” (Part 1) for the applicable *Cost Sharing Amount*; or
 - As preventive services, including preventive obesity screening and counseling services, healthy diet counseling, and behavior change counseling. In accordance with the Affordable Care Act, preventive services that are currently recommended by the U.S. Preventive Services Task Force (USPSTF) are covered in full at the *Authorized Level of Benefits*.

Notes: Weight loss programs and clinics are not covered. The visit limit does not apply to *Outpatient* nutritional counseling provided as part of:

- An approved home health care plan (see “Home health care” on page 68)
 - Treatment for an eating disorder
 - Diabetes self-management training and educational services (see page 53)
- Office visits to diagnose and treat illness or injury.

Note: This includes consultations, *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions, and visits to a *Limited Service Medical Clinic*.
 - *Outpatient* surgery in a physician’s office (**requires prior approval from an *Authorized Reviewer* at both the *Authorized and Unauthorized Levels of Benefits***).
 - Pap smears (cytology examinations) - one annual screening for women age 18 and older, or as otherwise *Medically Necessary*;
 - Radiation therapy and x-ray therapy (**requires prior approval from an *Authorized Reviewer* at both the *Authorized and Unauthorized Levels of Benefits***).
 - Smoking cessation counseling services. These services may be provided through the QuitWorks program, or by physicians, nurse practitioners, physician assistants, nurse midwives, or *Tobacco Cessation Counselors*. This benefit includes individual, group, and telephonic smoking cessation counseling services that (1) are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and (2) meet the requirements of the ACA.

Note: Coverage is also provided for prescription and over-the-counter smoking cessation agents. These services are administered through Express Scripts. For more information, see the “Prescription Drug Benefit” on pages 103-115.

Covered Services, Continued

Outpatient Care – continued

Outpatient medical care (continued)

- Telehealth and telemedicine services. For purposes of clarification, “telehealth services” are those rendered through our preferred vendor, Teladoc. “Telemedicine services” are services obtained from any *Tufts Health Plan* or *Non-Tufts Health Plan Provider*.

The *Plan* covers *Medically Necessary* telehealth and telemedicine services for the purpose of diagnosis, consultation, or treatment in the same manner as an in-person consultation between you and your *Provider*. Telehealth and telemedicine services are provided through real-time interactive audio, video, or other electronic media communications and substitute for in-person consultation with *Providers* when determined to be medically appropriate. Telehealth and telemedicine services are available for both medical and behavioral health/substance use disorder services.

Telehealth services may be obtained through *Tufts HP’s* designated telehealth vendor, Teladoc. For additional information on Teladoc and how to access services from Teladoc providers, please visit <https://www.tuftshealthplan.com/member/health-information-tools/digital-tools/telehealth> or contact Member Services. Telemedicine services are available from both *Tufts Health Plan* and *Non-Tufts Health Plan Providers* that offer these services. Please see the “Benefit Overview” for information on applicable *Cost Sharing Amounts*.

- Treatment of speech, hearing and language disorders **(may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*).**

Services include speech therapy; and short-term cognitive retraining or cognitive rehabilitation services, if provided to restore function lost or impaired as the result of an accidental injury or sickness. For these services to be covered, measurable improvement must be anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery. Please note that *Cost Sharing Amounts* for the diagnosis of speech, hearing and language disorders vary depending upon the service provided (e.g., x-rays, diagnostic testing, office visits).

- Voluntary second or third surgical opinions.

Covered Services, Continued

Outpatient Care – continued

Preventive health care – Adults (age 18 and over)

Preventive care services for *Members* age 18 and over include routine physical examinations, including appropriate immunizations and lab tests as recommended by the physician. They also include immunizations and lab tests, when not rendered as part of a routine physical exam

Please visit <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations> for more information about which services are considered preventive.

Note: Any *Medically Necessary* follow-up care resulting from a routine physical exam is subject to an *Office Visit Copayment* at the *Authorized Level of Benefits*, as described under “Office visits to diagnose and treat illness or injury” (page 56).

Preventive health care – Children (under age 18)

Preventive care services for *Children* from the date of birth until age 18, include:

- Physical examination, including limited developmental testing with interpretation and report
- History
- Measurements
- Sensory screening, including hearing exams and screenings
- Neuropsychiatric evaluation
- Developmental screening and assessment at the following intervals:
 - Birth until age 6 months: 6 visits
 - Age 6 months until age 18 months: 6 visits
 - Age 18 months until age 3: 6 visits
 - Age 3 until age 18: 1 visit per *Contract Year*
- Hereditary and metabolic screening at birth
- Appropriate immunizations and tuberculin tests
- Hematocrit, hemoglobin, or other appropriate blood tests
- Urinalysis as recommended by the physician
- Newborn auditory screening tests, as required by state law

Please visit <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations> for more information about which services are considered preventive.

Note: Any *Medically Necessary* follow-up care resulting from a routine physical exam is subject to an office visit *Copayment* at the *Authorized Level of Benefits*, as described under “Office visits to diagnose and treat illness or injury” (page 56). Diagnostic tests or diagnostic laboratory tests ordered as part of a routine physical exam are subject to the *Deductible*.

Covered Services, Continued

Outpatient Care – continued

Routine annual gynecological exams

Includes any follow-up obstetric or gynecological care determined to be *Medically Necessary* as a result of that exam.

Please visit <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations> for more information about which services are considered preventive.

Note: Any *Medically Necessary* follow-up care resulting from a routine annual gynecological exam is subject to an *Office Visit Copayment* at the *Authorized Level of Benefits*, as described under “Office visits to diagnose and treat illness or injury” on page 56. Diagnostic tests or diagnostic laboratory tests ordered as part of a routine physical exam are subject to the *Deductible*.

Rehabilitative and *Habilitative* physical and occupational therapy services (may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

Rehabilitative and *Habilitative* physical and occupational therapy services, including cognitive rehabilitation or cognitive retraining, are covered for up to 30 visits per *Contract Year* for each type of therapy.

Rehabilitative services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness. For rehabilitative therapy services to be covered, *Tufts Health Plan* must determine that the *Member's* condition is subject to significant improvement as a direct result of these therapies.

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

Notes: Benefit limits do not apply when these services are provided for the treatment of autism spectrum disorders or for physical or occupational therapy provided in conjunction with a *Provider's* approved home health care plan, as described in the “Home Health Care” benefit later in this document.

Massage therapy may be covered as a treatment modality only 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* and prior authorization guidelines (if applicable).

Urgent Care in an Urgent Care Center

Urgent Care refers to services provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. To find an *Urgent Care Center* (a medical facility, clinic, or medical practitioner's office) in the *Plan's* network, please visit tuftshealthplan.com and click on “Find a Doctor”.

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*.

Vision care services

Covered vision care services include:

- Routine eye exams (one each 24-month period). Exams must be received from a *Provider* in the EyeMed Vision Care network to be covered at the *Authorized Level of Benefits*. Please go to tuftshealthplan.com or contact Member Services at 800-870-9488 for more information.
- Eye examinations and necessary treatment of a medical condition

Covered Services, Continued

Oral health services (may require prior approval from an *Authorized Reviewer*)

Emergency Dental Care

Benefits are provided for treatment rendered by a dentist within 72 hours of an accidental external injury to the mouth and sound natural teeth. This treatment is limited to initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.

Note: Repair or restoration of teeth is not a *Covered Service*.

Oral Surgery for Dental Treatment in an *Inpatient* or *Day Surgery* setting

Benefits are provided only if the *Member* is (1) of young age or (2) has a serious medical condition (including, but not limited to, hemophilia and heart disease) that makes it essential that he or she be admitted to a general hospital as an *Inpatient* or to a *Day Surgery* unit or ambulatory surgical facility for the dental care to be performed safely.

Covered procedures in an *Inpatient* or *Day Surgery* setting include:

- Extraction of seven or more permanent, sound natural teeth
- Gingivectomies (including osseous surgery) of two or more gum quadrants
- Excision of radicular cysts involving the roots of three or more teeth
- Removal of one or more bone impacted teeth

Note: The above services are not covered when performed in an office setting.

Oral surgical procedures for non-dental medical treatment

Oral surgical procedures for non-dental medical treatment (i.e., the reduction of a dislocated or fractured jaw or facial bone, surgical treatment of cleft lip or cleft palate for *Children* under the age of 18, and removal or excision of benign or malignant tumors) are covered to the same extent as are other covered surgical procedures.

Day Surgery (may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

Covered *Day Surgery* services include *Outpatient* surgery done under anesthesia in an operating room of a facility licensed to perform surgery, and associated physician and surgeon services. You must be expected to be discharged the same day and be shown on the facility's census as an *Outpatient*.

Note: If you are admitted to a *Tufts HP Hospital* immediately following *Day Surgery*, the *Day Surgery Copayment* will be waived. You will instead be required to pay the applicable *Inpatient Copayment* for that hospital admission. Call Member Services at 800-870-9488 for more information.

Covered Services, Continued

Inpatient care

Important Note: At the *Authorized Level of Benefits*, *Members* will only be responsible for one *Inpatient Copayment* if readmitted within 30 days of discharge. Please call Member Services to arrange to have the second *Copayment* waived.

Acute hospital services

- Semi-private room (private room when *Medically Necessary*)
- Physician's and surgeon's services while hospitalized
- Surgery (**AR**)
- Anesthesia
- Nursing care
- Intensive care/coronary care
- Diagnostic tests, imaging, and lab services
- Radiation therapy
- Dialysis
- Physical, occupational, speech, and respiratory therapies
- *Durable Medical Equipment* and appliances
- Drugs

Bone Marrow Transplants for Breast Cancer, Hematopoietic Stem Cell Transplants, and Human Solid Organ Transplants (requires prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

Bone marrow transplants for *Members* diagnosed with metastatic breast cancer who meet the criteria established by the Massachusetts Department of Public Health.

Covered Services also include hematopoietic stem cell transplants and human solid organ transplants. The *Plan* pays for charges incurred by the donor in donating the organ to the *Member*, but only to the extent that charges are not covered by any other health insurer. This includes evaluation and preparation of the donor, surgery, and recovery services when those services relate directly to donating the organ to the *Member*.

Notes:

- The *Plan* covers a *Member's* human leukocyte antigen (HLA) testing. See page 55 in "*Outpatient care*" for more information.
- The *Plan* **does not cover** the following services related to bone marrow and human organ transplants:
 - Transportation costs for the donated stem cells or solid organ
 - Donor charges for *Members* who donate stem cells or solid organs to non-*Members*
 - Search costs for matching or for laboratory testing, either (1) to identify a donor for a recipient who is a *Member*, or (2) for a *Member* being considered as a potential stem cell or solid organ donor (whether or not the recipient is a *Member*)

Covered Services, continued

Inpatient care, continued

Gender reassignment surgery and related services

Coverage is provided for gender reassignment surgery and related pre- and post-operative services and prescription drugs. Prescription drugs for *Members* undergoing gender reassignment process are covered through Express Scripts. (See the “Prescription Drug Benefit” section (pages 103-115) for more information.)

Covered Services offered through *Tufts HP* include:

- *Inpatient* services, including female to male or male to female gender reassignment surgery and related surgical procedures
- *Day Surgery* for surgical procedures related to the female to male or male to female gender reassignment surgery. These services are covered as described under “*Day Surgery*” earlier in this Part 5.
- *Outpatient* medical care (pre- and post-operative) related to gender reassignment surgery. These services are covered as described under “Office visits to diagnose and treat illness or injury”, earlier in this Part 5.
- Behavioral health services for *Members* undergoing the gender reassignment process are described under “Behavioral Health and Substance Use Disorder Services”, later in this Part 5.
- Prescription medications required as part of the gender reassignment process. These medications are covered through Express Scripts and described under the “Prescription Drug Benefit” (pages 103-115).

Note: Services at both the *Authorized* and *Unauthorized Levels of Benefits* must be authorized in advance by an *Authorized Reviewer*. *Members* must meet specific *Medical Necessity* Guidelines in order for these services to be covered. Gender reassignment surgery and related services only qualify as *Covered Services* when they are obtained within the 50 United States. Please call Member Services at 800-970-9488 for more information.

Maternity care

The following *Covered Services* are available to a mother and her newborn *Child*, regardless of whether or not there is an early discharge (less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery):

- Hospital and delivery services
- Newborn hearing screening test
- Well newborn *Child* care in hospital
- *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
- One home visit by a registered nurse, physician, or certified nurse midwife, and additional home visits licensed health care *Provider*, when *Medically Necessary*
- Parent education, assistance, and training in breast and bottle feeding
- The performance of any necessary and appropriate clinical tests

Covered Services, continued

Inpatient care, continued

Benefits for Newborn *Children* at Time of Delivery

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

See Part 4 for information about enrolling a newborn *Child* in the *Plan*.

The *Plan* will pay for *Medically Necessary* care as follows:

IF the mother is...	AND the newborn <i>Child</i> is...	THEN the <i>Plan</i> covers...
A Member whose delivery was performed or authorized by her <i>Tufts HP PCP</i>	Enrolled	<i>Routine Nursery Care</i> at the <i>Authorized Level of Benefits</i> Other <i>Medically Necessary</i> care • At the <i>Authorized Level of Benefits</i> if from or authorized by <i>Child's Tufts HP PCP</i>; and • At the <i>Unauthorized Level of Benefits</i> if not provided or authorized by the <i>Child's Tufts HP PCP</i>.
	Not enrolled	<i>Routine Nursery Care</i> only
Not a Member under the <i>Plan</i> and has no other maternity coverage benefits	Enrolled (e.g., by the other parent, who is a <i>Subscriber</i>)	<i>Routine Nursery Care</i> : • At the <i>Authorized Level of Benefits</i> if from or authorized by the <i>Child's Tufts HP PCP</i>, and at a <i>Tufts HP Hospital</i>; and • At the <i>Unauthorized Level of Benefits</i> if not provided at a <i>Tufts HP Hospital</i> Other <i>Medically Necessary</i> care: • At the <i>Authorized Level of Benefits</i> if from or authorized by the <i>Child's Tufts HP PCP</i>; and • At the <i>Unauthorized Level of Benefits</i>, if not provided or authorized by the <i>Child's Tufts HP PCP</i>
	Not enrolled	Not covered

Covered Services, continued

Inpatient care, continued

Patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions

As required by applicable law, the *Plan* covers patient care services provided as part of a qualified clinical trial studying potential treatment(s) for cancer or other life-threatening diseases or conditions. Patient care services include items and services provided when you are enrolled in a qualified clinical trial consistent with your diagnosis and the study protocol.

Coverage is subject to all pertinent provisions of the *Plan*, including, but not limited to, use of *Tufts HP Providers*, utilization review, and provider payment methods.

The following services are covered under this benefit:

- (1) All medically necessary services for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the *Plan*
- (2) The allowed cost, as determined by the *Plan*, of investigational drugs or devices approved for use in the qualified clinical trial if they are not paid for by its manufacturer, distributor or provider. This is true regardless of whether the Food and Drug Administration has approved the drug or device for use in treating your particular condition.

“Patient care services” do not include any of the following:

- Investigational drugs or devices that do not meet the criteria in (2) above
- Non-health care services that a patient may be required to receive as a result of participation in the clinical trial.
- Costs associated with managing the research of the clinical trial.
- Costs that would not be covered for non-investigational treatments.
- Any items, services or costs that are reimbursed or provided by the sponsor of the clinical trial.
- Services that are inconsistent with widely accepted and established national or regional standards of care.
- Services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration under the clinical trial.
- Services or costs that are not covered under the *Plan*.

Covered Services, continued

Inpatient care, continued

Reconstructive surgery and procedures (may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

- Services required to repair or restore a bodily function that is impaired as a result of a congenital defect (including treatment of cleft lip or cleft palate for *Children* under the age of 18), birth abnormality, traumatic injury, or covered surgical procedure **(AR)**
- 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
 - Prostheses (covered as described under “Medical Appliances and Equipment” on page 70) and treatment of physical complications of all stages of mastectomy.
 - Removal of breast implants when there is documented rupture of a silicone implant, auto-immune disease or infection **(AR)**

Notes: *Cosmetic* surgery is not covered.

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

Covered Services, continued

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

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

Services to diagnose and treat *Behavioral Health Disorders* (including diagnosis, detoxification and treatment of substance use disorders), given by the following *Providers*:

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

Note: *Outpatient* treatment of substance use disorders includes methadone maintenance or methadone treatment related to chemical dependency disorders. Psychopharmacological services and neuropsychological assessment services are covered as “Office visits to diagnose and treat illness or injury”, as described earlier in this chapter.

Important Notes:

- Prior approval by a *Tufts Health Plan* Behavioral 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 Health Plan* Behavioral Health Department at 1-800-870-9488 for more information on how to obtain this authorization.
- You must notify *Tufts Health Plan* if you obtain *Outpatient* behavioral health and substance use services at the *Authorized Level of Benefits*. Please contact the *Tufts Health Plan* Behavioral Health Department at 1-800-870-9488 for more information.

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

- *Inpatient* behavioral health and substance use disorder services for *Behavioral Health Disorders* in a facility that is licensed as a general hospital, behavioral health hospital, or substance use disorder facility, or behavioral health residential treatment facility.
- Intermediate behavioral health and substance use disorder services: *Medically Necessary* behavioral health and substance use disorder services that are more intensive than traditional *Outpatient* behavioral health and substance use disorder services, but less intensive than 24-hour hospitalization. Some examples of *Covered* intermediate behavioral health and substance use disorder services are:
 - level III community-based detoxification;
 - intensive outpatient programs;
 - crisis stabilization;
 - partial hospital programs.

Important Note: *Inpatient* and intermediate behavioral health services must be obtained at a *Tufts Health Plan Hospital* in order to be covered at the *Authorized Level of Benefits*. See “*Inpatient Behavioral Health and Substance Use Disorder Services*” in Chapter 1 for more information. To receive care at the *Unauthorized Level of Benefits*, you must receive authorization from an *Authorized Reviewer*. Please contact the *Tufts Health Plan* Behavioral Health Department at 1-800-870-9488 for more information on how to receive this authorization.

Covered Services, continued

Other Health Services

Ambulance services (may require prior approval from an *Authorized Reviewer*)

The following ambulance services are *Covered Services*.

- Ground, sea, and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance services (e.g., Medflight) **(AR)**
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities **(AR)**
- Non-emergency ambulance transportation for *Medically Necessary* care when the *Member's* medical condition prevents safe transportation by any other means **(AR)**

Notes: Please note that the *Plan* does not cover transportation by chair car or wheelchair van. 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 may be responsible for the costs of this treatment.

Cleft lip or cleft palate treatment and services for *Children* under age 18

The following *Covered Services* must be prescribed by the treating physician or surgeon, who must certify that the services are *Medically Necessary* and are required because of the cleft lip or cleft palate:

- **Medical and facial surgery:** Covered as described under “*Day Surgery*”, “*Acute hospital services*”, and “*Reconstructive surgery and procedures*” earlier in this chapter. This includes surgical management and follow-up care by plastic surgeons.
- **Oral surgery:** Covered as described under “*Oral surgical procedures for non-dental medical treatment*” in the “*Oral Health Services*” benefit earlier in this chapter. This includes surgical management and follow-up care by oral surgeons.
- **Dental surgery or orthodontic treatment and management**
- **Preventive and restorative dentistry** to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy.
- **Speech therapy and audiology services:** Covered as described under “*Treatment of speech, hearing and language disorders*” earlier in this chapter.
- **Nutrition services:** Covered as described under “*Nutritional counseling*” earlier in this chapter.

Extended Care (requires prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

The *Plan* covers the following *Covered Services* in an extended care facility (skilled nursing facility, rehabilitation hospital, or chronic hospital) for:

- Skilled nursing services (limit of 45 days per *Member* in a *Contract Year*)
- Chronic disease services
- Rehabilitative services

Covered Services, continued

Other Health Services – continued

Home health care (requires prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

The *Plan* covers home health care services to homebound *Members*. To be considered homebound, you do not have to be bedridden. However, you must usually be unable to leave the home without a considerable and taxing effort. You may be considered homebound if your absences from the home are infrequent, for periods of relatively short duration, or to receive medical treatment. Please note that this homebound requirement does not apply to *Covered Services* for palliative care under this benefit.

The following services are *Covered Services* when provided by an accredited home health agency under a physician's written order:

- 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,
 - *Durable Medical Equipment* (see "Medical Appliances and Equipment" on page 70)
 - The services of a part-time home health aide.

Note: Home health services for physical and occupational therapies following an injury or illness are covered only if provided to restore lost or impaired function, as described under "Rehabilitative and *Habilitative* physical and occupational services" on page 59. However, those home health care services are not subject to the 30-visit limit.

Hospice and End-of-Life care services (requires prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)

Hospice provides multidisciplinary care designed to address the physical, social, emotional, and spiritual needs of persons likely to live 6 months or less. Hospice care has many benefits: better quality of life, better coping for you and your family, and longer survival time at home.

The *Plan* will cover the following hospice care services when a physician certifies (or re-certifies) that you have a medical prognosis of 6 months or less to live:

- Physician services
- Nursing care provided by or supervised by a registered professional nurse
- Social work services
- Volunteer services
- Counseling services (including bereavement counseling services for the *Member's* family or a primary care person for up to one year following the *Member's* death).
- Concurrent palliative chemotherapy and radiation therapy, if palliative, are permitted.

"Hospice care services" are a coordinated licensed program of services provided to *Members* with six months or less to live. Such services can be provided at home; on an *Outpatient* basis; and on a short-term *Inpatient* basis, to control pain and manage acute and severe clinical problems that cannot medically be managed at home.

If you have a medical prognosis of greater than six months to live, but you have symptoms like severe pain or difficulty breathing, the *Plan* covers palliative care services. Palliative care is focused on relieving pain or other symptoms of illness and improving the quality of life for patients and their families.

Covered Services, continued

Other Health Services – continued

Injectable, infused or inhaled medications (may require prior approval from an *Authorized Reviewer*)

The *Plan* covers 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) administered at home by a home infusion *Provider*.

Medications include, but are not limited to, total parenteral nutrition therapy, chemotherapy, and antibiotics.

Notes:

- Quantity limits may apply.
- The *Plan* has designated home infusion *Providers* for a select number of specialty pharmacy products and drug administration services, including, but not limited to, medications used to treat hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. These *Providers* offer clinical drug therapy management, nursing support, and care coordination to *Members* with acute and chronic conditions. Please contact Member Services at 800-870-9488 or visit tuftshealthplan.com for more information.
- 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.
- Some injectable, infused, or inhaled medications may be covered under the pharmacy benefit administered by Express Scripts. These medications are not covered under the “Injectable, infused or inhaled medications” benefit. For more information, call Express Scripts at 855-283-7679 or visit express-scripts.com.

Covered Services, Continued

Other Health Services – continued

Medical Appliances and Equipment

(1) ***Durable Medical Equipment***

Durable Medical Equipment includes devices or instruments of a durable nature that are:

- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not useful in the absence of illness or injury
- Able to withstand repeated use
- Intended to be used in the home.

Please call Member Services at 800-870-9488 if you need *Durable Medical Equipment*. *Tufts Health Plan* 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 Health Plan*.

To be eligible for coverage, the equipment must be the most appropriate available amount, supply or level of service for the *Member*, considering potential benefits and harms to that individual.

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

Note: You may be responsible for paying a *Deductible* or *Coinsurance* towards the cost of *Durable Medical Equipment* covered at the *Unauthorized Level of Benefits*. To determine whether your *Durable Medical Equipment* benefit is subject to *Member Cost Sharing* at the *Unauthorized Level of Benefits*, please see the “Benefit Overview” section earlier in this *Member Handbook* or call Member Services at 800-870-9488.

Examples of covered items (list is not all-inclusive). Please call Member Services at 800-870-9488 with questions about whether a particular piece of equipment is covered:

- *Prosthetic Devices* (such as artificial legs, arms, eyes, or breasts) **(may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Levels of Benefits*)**
 - Breast prostheses provided in connection with a mastectomy do not require prior approval from an *Authorized Reviewer*.
 - Coverage for breast prostheses and prosthetic arms and legs (in whole or in part) is provided for the most appropriate *Medically Necessary* model, and includes coverage for the cost of repairs.
- Purchase of a manual or electric (non-hospital grade) breast pump, or the rental of a hospital grade electric breast pump for pregnant or post-partum *Members* (when prescribed by a *Provider*) (**Note:** Breast pumps are covered in full at the *Authorized Level of Benefits*)
- Gradient stockings (up to three pairs per *Contract Year*)
- Devices that extract oxygen from the air (for example, stationary and portable oxygen concentrators)
- Orthotic devices (such as knee and back braces)
- Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind
- Insulin pumps
- Oral appliances for the treatment of sleep apnea
- Hospital beds, wheelchairs, power/electric wheelchairs, crutches, and walkers

(continued on next page)

Covered Services, Continued

Other Health Services – continued

Medical appliances and equipment, continued

Below are examples of excluded items (list is not all-inclusive). Please call Member Services for all questions regarding coverage of medical appliances and equipment:

- Articles of special clothing, except for gradient pressure support aids for lymphedema or venous disease and clothing necessary to wear a covered device (e.g., mastectomy bras and stump socks)
- Bed-related items, including, but not limited to, bed cradles, bed trays, bed pans, over-the-bed tables, and bed wedges
- Car/van modifications
- Comfort or convenience devices, including, but not limited to, air conditioners, air purifiers, and dehumidifiers
- Dentures
- Exercise equipment
- Externally powered exoskeleton assistive devices and orthoses
- Fixtures to real property (e.g., ceiling lifts, elevators, ramps, stair climbers)
- Foot orthotics and arch supports, except for therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease
- Heating pads
- Home blood pressure apparatus (manual) with cuff and stethoscope
- Hot tubs, Jacuzzis, shower chairs, swimming pools, or whirlpools
- Hot water bottles
- 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.
- Saunas
- Self-monitoring devices, except for certain devices that *Tufts Health Plan* determines would provide a *Member* with the ability to detect or prevent the onset of a sudden life-threatening condition
- Thermal therapy devices
- Wheelchair trays

(2) Other Medical Appliances and Equipment

- The first pair of eyeglass lenses (frames are not covered) or contact lenses following cataract surgery
- Contact lenses, including the fitting of the lenses, when required to treat keratoconus
- Hearing aids, including the fitting of the hearing aid, are covered when prescribed by a physician and obtained from a hearing aid supplier.
 - *Children* 21 and under: the *Plan* provides full coverage for hearing aid evaluations, the fitting and adjusting of hearing aids, and supplies (including ear molds) for one hearing aid per ear per prescription change. Limit of \$2,000 per ear every 24 months.
 - *Members* 22 and over: the *Plan* covers the first \$500 in full and 80% of the next \$1,500, up to a limit of \$1,700 per *Member* every 24 months. The *Member* is responsible for paying 20% of charges from \$500-\$2,000 (plus any balance).

When there is a pathological change in the *Member's* hearing or the hearing aid is lost, benefits for a replacement hearing aid are also covered subject to the benefit limit.

Note: Over-the-counter replacement hearing aid batteries are not covered.

Covered Services, Continued

Other Health Services -- continued

Personal Emergency Response Systems (PERS)

Covered Services are provided only for installation and rental charges for a hospital-based Personal Emergency Response System when:

- The system is used as an alternative to reduce or divert *Inpatient* admissions.
- The *Member* is homebound and medically at risk, as determined by *Tufts Health Plan*.
- The *Member* is alone for at least four (4) hours each day, five (5) days a week and is functionally impaired.

Covered Services do not include the purchase of a Personal Emergency Response System.

Note: Covered PERS benefits are limited to a total of \$50 per *Member* for installation charges and \$40 per *Member* each month for rental of the system. The Navigator Plan pays 80% of the charges up to these maximum allowed installation and rental charges. You are responsible for paying the remaining 20% of those charges, as well as any additional fees or charges for the system.

Private duty nursing

Inpatient private duty nursing services qualify as *Covered Services* when:

- The *Member* is a Hospital *Inpatient* for the treatment of a medical condition,
- The health care facility's regular nursing staff could not perform the services, due to the frequency and complexity of the skilled nursing care
- The services are *Medically Necessary*, as determined by *Tufts Health Plan*

Private duty nursing services provided in the *Member's* home qualify as *Covered Services* when:

- The administration of treatment and the evaluation of the patient's response to the treatment require the skills of a registered nurse, due to the frequency and complexity of the skilled nursing care.
- The services are *Medically Necessary*, as determined by *Tufts Health Plan*.
- The services are approved by an *Authorized Reviewer*.

Note: Covered private duty nursing services (whether as an *Inpatient*, at home, or both) are limited to a total of \$8,000 per *Member* in a *Contract Year* (*Authorized* and *Unauthorized Levels* combined).

Scalp hair prostheses or wigs

Covered Services include scalp hair prostheses or wigs worn for hair loss due to (1) alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury; or (2) the treatment of any form of cancer or leukemia.

Special medical formulas

This benefit includes special medical formulas, nonprescription enteral formulas, and low protein foods, when prescribed by a physician to treat the below conditions:

- Special Medical Formulas (**may require prior approval from an *Authorized Reviewer* at both the *Authorized* and *Unauthorized Level of Benefits***)
 - Phenylketonuria
 - Tyrosinemia
 - Homocystinuria
 - Maple syrup urine disease
 - Propionic acidemia
 - Methylmaloric acidemia
- Nonprescription enteral formulas (**may require prior approval from an *Authorized Reviewer***)
 - Malabsorption caused by Crohn's disease
 - Ulcerative colitis
 - Gastroesophageal reflux or gastrointestinal motility
 - Chronic intestinal pseudo-obstruction
 - Inherited diseases of amino acids and organic acids
 - *Medically Necessary* formulas, including infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure
- Low Protein Foods, when given to treat inherited diseases of amino acids and organic acids

Exclusions from Benefits

The *Plan* does not cover a service, supply, or medication that is:

- Not *Medically Necessary*, as determined by *Tufts Health Plan*
- Not a *Covered Service*
- Not essential to treat an injury, illness, or pregnancy, except for preventive care services
- Able to be safely and effectively provided to you via a (a) less intensive level of service, supply, setting, or medication or (b) more cost-effective alternative
- Primarily for personal comfort or convenience
- Obtained outside of the 50 United States. The only exceptions to this rule are for *Emergency* care services or *Urgent Care* services while traveling
- *Custodial Care*
- Related to non-covered services
- Charges for missed appointments that you do not cancel in advance, if the *Provider's* office policy is to charge for such appointments
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*, or for any related treatments

Note: This exclusion does not apply to the following services, as per Massachusetts law: long-term antibiotic treatment of chronic Lyme disease when administered as described under "Injectable, infused or inhaled medications" earlier in this Part 5 (for drugs administered under the separate "Prescription Drug Benefit", contact Express Scripts); bone marrow transplants for breast cancer or patient care services provided pursuant to a qualified clinical trial.

- Drugs, medicines, materials or supplies for use outside the hospital or any other facility.
- Medications and other products that can be purchased without a prescription.
- Laboratory tests ordered by a *Member* (online or through the mail), even if performed at a licensed laboratory.
- Provided by an immediate family member (by blood or marriage), even if the relative is a *Tufts HP Provider* and the services are authorized by your own *PCP*. If you are a *Tufts HP Provider*, you cannot provide or authorize services for yourself, be your own *PCP*, or be the *PCP* of a member of your immediate family (by blood or marriage).
- Required by a third party (i.e., employer, insurance company, school or court) and not otherwise *Medically Necessary*.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid
- Care for conditions that state or local law requires to be treated in a public facility
- Any additional fee a *Provider* may charge as a condition of access or any amenities that access fee is represented to cover. Refer to the *Directory of Health Care Providers* to determine if your *Provider* charges such a fee.
- Charges incurred when the *Member*, for his or her convenience, chooses to remain an *Inpatient* beyond the discharge hour
- Charges or claims incurred as a result, in whole or in part, of fraud or misrepresentation (e.g., claims for services not actually rendered and/or able to be validated)
- Facility charges or related services for a non-Covered Service
- Dental care and treatment, except as provided under "Oral health services" on page 60. Exclusions include, but are not limited to, preventive dental care; periodontal treatment; orthodontics; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea), including those for TMJ disorders.

Note: This exclusion does not apply to the treatment of cleft lip or cleft palate for *Members* under 18, as described under "Cleft lip or cleft palate treatment and services for *Children*" earlier in this chapter.

Exclusions from Benefits, continued

- Surgical removal or extraction of teeth, except as provided under “Oral health services” on page 60
- Cosmetic (i.e., meant to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under “Reconstructive surgery and procedures” on page 65

Note: Breast reconstruction following a *Medically Necessary* mastectomy is covered, as described in “Reconstructive surgery and procedures” on page 65.

- Rhinoplasty, except as provided under “Reconstructive surgery and procedures” on page 65; liposuction; the removal of tattoos; brachioplasty
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo
- Hair removal (e.g., electrolysis, laser hair removal), except when *Medically Necessary* to treat an underlying skin condition or in relation to transgender genital surgery (with prior approval by an *Authorized Reviewer*).
- Costs associated with home births or services provided by a doula.
- Circumcisions performed in any setting other than a hospital, *Day Surgery* facility, or a physician’s office.
- Infertility services, infertility medications, and associated reproductive technologies (such as IVF, GIFT and ZIFT) for *Members* who do not meet the definition of Infertility as described in the “Infertility services” benefit on page 54. Exclusions include, but are not limited to:
 - *Experimental* infertility procedures
 - The costs of surrogacy, including: (1) all costs (including, but not limited to, costs for drugs necessary to achieve implantation, embryo transfer, and cryo-preservation of embryos) incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile *Member*; (2) use of donor egg and a gestational carrier; and (3) costs for maternity care if the surrogate is not a *Member*.

Notes: A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo. A gestational carrier is a surrogate with no biological connection to the embryo/child.

- Reversal of voluntary sterilization.
 - Long-term (longer than 90 days) sperm or embryo cryopreservation not associated with active infertility treatment

Note: *Tufts HP* may authorize short-term (less than 90 days) cryopreservation of sperm, oocytes, or embryos for certain medical conditions that may impact a *Member’s* future fertility. **(Prior approval from an *Authorized Reviewer* is required.)**
 - Donor recruitment fee for donor egg or donor sperm
 - Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
 - Costs associated with donor recruitment and compensation
 - Infertility services that are necessary for conception as a result of voluntary sterilization or after an unsuccessful reversal of a voluntary sterilization
 - Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an *Authorized Reviewer* and the *Member* is the sole recipient of the donor’s eggs.
- Reversal of gender reassignment surgery.
 - Reversal of voluntary sterilization.
 - Over-the-counter contraceptive agents.
 - The purchase of an electric, hospital-grade breast pump; donor breast milk.
 - Human organ transplants, except as described on page 61. Expenses for transportation and lodging in connection with human organ transplants are not covered.
 - Services provided to a non-*Member*, except as described earlier in Part 5 for the following:
 - Organ donor charges under “Bone Marrow Transplants for Breast Cancer, Hematopoietic Stem Cell Transplants, and Human Solid Organ Transplants” (see page 61)
 - Bereavement counseling services under “Hospice care services” (see page 68);
 - Procurement and processing of donor sperm or eggs under “Infertility services” (to the extent such costs are not covered by the donor’s health coverage, if any).

Exclusions from Benefits, continued

- Acupuncture.
- Psychoanalysis.
- *Inpatient* and *Outpatient* weight-loss programs and clinics, except as described earlier in this chapter.
- Biofeedback, except for the treatment of urinary incontinence; neuromuscular stimulators and related supplies; chiropractic services, except as described in "Chiropractic services" on page 52; chiropractic services (spinal manipulation) for *Members* age 12 and under; any type of thermal therapy device.
- Hypnotherapy; relaxation therapies; massage therapies, except as described earlier in this chapter; services by a personal trainer; exercise classes; cognitive rehabilitation programs or cognitive retraining programs, except as described earlier in this chapter. Also excluded are diagnostic services related to any of these procedures or programs.
- All *Non-Conventional Medicine* services, provided independently or together with conventional medicine, and all related testing, laboratory testing, services, supplies, procedures, and supplements associated with this type of medicine.
- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts; educational, vocational, or recreational settings; Outward Bound; or wilderness, camp or ranch programs), even if performed or provided by licensed *Providers* (including, but not limited to, nutritionists, nurses or physicians)
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products
 - Note:** This exclusion does not apply to the following blood services and products:
 - Blood processing
 - Blood administration
 - Monoclonal and recombinant Factor products for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (**prior approval from an *Authorized Reviewer* is required**)
 - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (**prior approval from an *Authorized Reviewer* is required**)
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Multi-purpose general electronic devices, including, but not limited to, laptop computers, desktop computers, personal assistive devices (PADs), tablets, and smartphones. All accessories for multi-purpose general electronic devices, including USB devices and direct connect devices (e.g., speakers, microphones, cables, cameras, batteries, etc.). Internet and modem connection/access including, but not limited to, Wi-Fi®, Bluetooth®, Ethernet and all related accessories.
- Examinations, evaluations or services for educational purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in Part 5. Vocational rehabilitation services and vocational retraining. Also services to treat learning disabilities, behavioral problems, and services to treat speech, hearing and language disorders in a school-based setting.
- Eyeglasses, lenses or frames; or refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described in "Medical Appliances and Equipment" on page 71, the Navigator Plan will not pay for eyeglasses, contact lenses or contact lens fittings.
- Hearing aids or hearing aid fittings, except as described under "Medical appliances and equipment" on page 71.

Exclusions from Benefits, Continued

- 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.

Note: This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes. It also does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when (1) the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and (2) 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" on page 67.
- Lodging related to receiving any medical service, including lodging related to obtaining gender reassignment surgery or related services.

Part 6 – How to File a Claim and the Member Satisfaction Process

How to File a Claim

Tufts HP Providers

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

Non-Tufts HP Providers

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

Hospital Admission or Day Surgery

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

Outpatient Medical Expenses

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

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

To Obtain Claim Forms

Claim forms are available by calling the *Tufts HP* Member Services Department at 800-462-0224.

Where to Send Medical Claim Forms

Send completed claim forms to:

Tufts Health Plan
POS Claims
P.O. Box 9171
Watertown, MA 02471-9171

Separate claim forms should be submitted for each family member. If you have any questions about filing forms, call Member Services at 800-870-9488.

Note: Italicized words are defined in Part 8.

Member Appeals Process

Tufts Health Plan (“*Tufts HP*”) has a Member Satisfaction Process to address your concerns promptly. This process addresses:

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

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

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

All calls should be directed to the Member Services Department at **800-870-9488**. Alternatively, you may submit your grievance or appeal at the address listed above.

Internal Inquiry

Call the Member Services Department at 800-870-9488 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.

Grievances

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

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 Grievance

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

Member Appeals Process, continued

Administrative Grievance Timeline

- If you file your grievance in writing, *Tufts HP* 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 concern 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 within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended 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 from a *Tufts HP Provider*. 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 written confirmation of our understanding of your concerns within 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 30 calendar days of receipt. The review period may be extended up to an additional 30 days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

Internal Member Appeals

Requests for coverage that was denied as specifically excluded in this Navigator *Member Handbook* (or subsequent updates) or for coverage that was denied based on *medical necessity* determinations are reviewed as appeals through *Tufts Health Plan's* Internal Appeals Process. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

- (i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the address listed above under "Grievances". *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
 - A detailed description of your concern
 - Copies of any supporting documentation

You may also submit your appeal in person at the address listed at the beginning of this chapter.

(continued on next page)

Member Appeals Process, continued

Internal Member Appeals, continued

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

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

- (iii) The *Tufts Health Plan* Benefits Committee will review appeals concerning specific benefits and exclusions and make determinations. The *Tufts Health Plan* Appeals Committee will make utilization management (*medical necessity*) decisions. If your appeal involves an adverse determination (*medical necessity* determination), it will be reviewed by a medical director and/or a practitioner in the same or in a similar specialty that typically manages the medical condition, performs the procedure, or provides the treatment that is under review. The medical director and/or practitioner will not have previously reviewed your case.
- (iv) The Appeals and Grievances Analyst will notify you in writing of the Committee's decision within no more than 30 calendar days of the receipt of your appeal. A copy of the decision will be sent to your physician, unless you request otherwise. A determination of claim denial will set forth:
- *Tufts Health Plan's* understanding of the request
 - The reason(s) for the denial
 - The specific contract provisions on which the denial is based
 - The clinical rationale for the denial, if the appeal involves a *medical necessity* determination.

Tufts Health Plan maintains records of each inquiry made by a *Member* or by that *Member's* designated representative.

Expedited (Fast) Appeals

Tufts HP recognizes that there are urgent 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 your health may be in serious jeopardy or, in the opinion of your treating *Provider* (the practitioner responsible for the treatment or proposed treatment), you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If your request meets the guidelines for an expedited (fast) appeal, it will be reviewed by a Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner in the same (or in a similar) specialty that typically manages the medical condition, performs the procedure or provides the treatment that is under review. This Medical Affairs Department Physician, Psychological Testing Reviewer, and/or practitioner will not have previously reviewed your case.

Your review will generally be conducted within two (2) business days, but not later than 72 hours (whichever is less) after *Tufts HP's* receipt of the request. If your appeal meets the guidelines for an expedited appeal, you may also file a request for a simultaneous external review as described below.

Member Satisfaction Process, continued

External Review

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

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

In some cases, *Members* may have the right to an expedited (fast) external review. An expedited external review may be appropriate in urgent situations. An urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. Additionally, if *Tufts Health Plan* has not met all of our major procedural requirements (as listed above under internal appeals) for matters subject to external review, you can immediately file an external appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the appeal decision, the service or supply will be covered under the *Plan*.

If You Have Questions or Need Help Submitting a Grievance or Appeal, please call the Member Services Department at 800-870-9488 for assistance.

Bills from *Providers*

Bills from *Providers*

Occasionally, you may receive a bill from a *Non-Network 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* website or by contacting the *Tufts HP* Member Services Department
- The documents listed on the Member Reimbursement Medical Claim Form

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

Note: You must contact *Tufts HP* regarding your bill(s) or send your bill(s) to *Tufts HP* within 24 months from the date of service. If you do not submit them in this timeframe, the bill cannot be considered for payment. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

If you receive *Covered Services* from a *Non-Network Provider*, the *Plan* will pay up to the *Reasonable Charge* for the services. You are responsible for any amounts in excess of the *Reasonable Charge*, as well as any applicable *Deductible*, *Coinsurance*, and/or *Copayments*.

Important Note:

Certain services you receive from *Non-Network Providers* at a *Tufts HP* facility may be reimbursable. Some examples of these types of *Providers* include *Emergency* room specialists and radiologists, pathologists, and anesthesiologists who work in *Tufts HP Hospitals*.

If you receive *Covered Services* from a *Non-Network Provider* outside of the *Service Area*, in most instances, we will directly reimburse the *Non-Network Provider*.

The *Plan* reserves the right to be reimbursed by the *Member* for payments made due to *Tufts HP's* error.

Limitation on Actions

You cannot file a lawsuit against either Navigator or *Tufts Health Plan* for any claim under this health care program more than two (2) years after the Navigator *Plan* denies the claim, unless you do it within two (2) years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under the Navigator *Plan*, you must first complete our *Member Satisfaction Process* and then file your lawsuit within two years of first being sent a notice of the denial. Going through our *Member Satisfaction Process* does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage.

Part 7 - Other *Plan* Provisions

Subrogation and Right of Recovery

The provisions of this section apply to all current and former plan participants and also to the parents, guardians, or other representatives of a *Dependent Child* who incurs claims and is or has been covered by the *Plan*. This *Plan's* right to recover (whether by subrogation or reimbursement) shall apply to the personal representative or administrator of your estate, your decedents, your heirs, your descendants, your beneficiaries, minors, and incompetent or disabled persons. These provisions will apply to all claims arising from your illness or injury, including, but not limited to, wrongful death, survival, or survivorship claims brought on your, your estate's, or your heirs' behalf, regardless of whether medical expenses were or could be claimed. "You" and "your" includes anyone on whose behalf the *Plan* pays benefits. No adult *Subscriber* hereunder may assign any rights that it may have to recover medical expenses from any person or entity responsible for causing your injury, illness, or condition or any other person or entity to any minor child or children of said adult *Subscriber* without the prior express written consent of the *Plan*.

The *Plan's* right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness, or condition for which the *Plan* has paid medical claims (including, but not limited to, any disability award or settlement, premises or homeowners' medical payments coverage, premises or homeowners' insurance coverage, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no fault automobile coverage or any first party insurance coverage).

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

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interests are fully satisfied.

Subrogation

The right of subrogation means the *Plan* is entitled to pursue any claims that you may have in order to recover the benefits paid by the *Plan*. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the *Plan*. The *Plan* may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The *Plan* is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the *Plan* first from such payment for all amounts the *Plan* has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. Benefit payments made under the plan are conditioned upon your agreement to reimburse the plan in full from any recovery you receive for your injury, illness, or condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any *Provider*), you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the *Plan*. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the *Plan's* subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the *Plan* will automatically have a lien to the extent of benefits paid by the *Plan* for the treatment of illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury, or condition for which the *Plan* paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan*, including, but not limited to, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the *Plan*.

Subrogation and Right of Recovery, continued

Subrogation Agent

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

Assignment

In order to secure the *Plan's* recovery rights, you agree to assign to the *Plan* any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the *Plan's* subrogation and reimbursement claims. This assignment allows the *Plan* to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the *Plan*, you acknowledge that the *Plan's* recovery rights are a first priority claim and are to be repaid to the *Plan* before you receive any recovery for your damages. The *Plan* shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the *Plan* will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The *Plan* is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical payments the *Plan* provided or purports to allocate any portion of such settlement or judgment to payments of expenses other than medical expenses. The *Plan* is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The *Plan's* claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the *Plan's* efforts to recover benefits paid. It is your duty to notify the *Plan* within 30 days of the date when any notice given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness, or condition. You and your agents agree to provide the *Plan* or its representatives notices of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice information requested by the *Plan*, *Tufts Health Plan* or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the *Plan* may reasonably request and all documents related to or filed in personal injury protection. Failure to provide this information, failure to assist the *Plan* in pursuit of its subrogation rights or failure to reimburse the *Plan* from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the *Plan* is reimbursed in full, termination of your health benefits, or the institution of court proceedings against you.

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

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

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

Subrogation and Right of Recovery, continued

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the *Plan* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the *Plan*, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the *Plan* may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the *Plan* incurs in successful attempts to recover amounts the *Plan* is entitled to under this section.

Workers' Compensation

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

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

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

Future Benefits

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

Coordination of Benefits

Benefits under other plans

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

The Navigator Plan has a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for *Covered Services* with benefits payable by other plans, consistent with Massachusetts law, 211 CMR 38.00 *et seq.* and *Tufts Health Plan* Coordination of Benefits (COB) processing guidelines.

Primary and secondary plans

The *Plan* will coordinate benefits by determining:

- Which plan (Navigator or your other plan(s)) has to pay first when you make a claim; and
- Which plan (Navigator or your other plan(s)) has to pay second.

These determinations will be made using the first applicable rule set forth in 211 CMR 38.05 and benefits will be paid or provided pursuant to the rules set forth in 211 CMR 28.04 and 211 CMR 38.06. These regulations are available on the Massachusetts state website, www.mass.gov/code-of-massachusetts-regulations-cmr.

Right to receive and release necessary information

When you complete your membership application, you must include information on your membership application about other health coverage you have. After you enroll, you must notify *Tufts Health Plan* of new coverage, termination of other coverage, or if you are enrolled in any high deductible health plan with a health savings account (HSA). *Tufts Health Plan* may ask for and give out information needed to coordinate benefits.

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

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, call the Liability and Recovery Department at 888-880-8699, x. 21098.

Use and Disclosure of Medical Information

Use and disclosure of medical information

For information about how *Tufts Health Plan* uses and discloses your medical information, please contact the Member Services Department. Information is also available on the *Tufts Health Plan* website at tuftshealthplan.com.

For information about how the *GIC* uses and discloses your medical information, please contact the *GIC*.

Additional Plan Provisions

Tufts Health Plan and Providers

Tufts Health Plan arranges for health care services. *Tufts Health Plan* does not provide health care services. *Tufts Health Plan* has agreements with *Providers* practicing in their private offices throughout the *Service Area*. These *Providers* are independent. They are not Navigator's or *Tufts Health Plan's* employees, agents or representatives. *Providers* are not authorized to change this *Member Handbook*, or assume or create any obligation for either Navigator or *Tufts Health Plan*.

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

Acceptance of the terms of the Agreement

By enrolling in Navigator, *Subscribers* agree, on behalf of themselves and their enrolled *Dependents*, to all the terms and conditions of the Agreement between the *GIC* and *Tufts Health Plan*, including this *Member Handbook*.

Payments for coverage

Navigator is a self-funded plan. This means that the *GIC* is responsible for funding *Covered Services* for *Members* in accordance with the terms of the *Plan*.

Changes to this Member Handbook

The *GIC* may change this *Member Handbook*. Changes do not require any *Member's* consent. The *Plan* is responsible for notifying you of changes. Changes will apply to all benefits for services received on or after the effective date.

Notice

Notice to Members: When *Tufts Health Plan* sends a notice to you, it will be sent to your last address on file with the *Group Insurance Commission*. For this reason, it is important for *Members* to keep their address current with the *GIC*.

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

**Tufts Health Plan
Navigator Plan
705 Mt. Auburn Street
P.O. Box 9173
Watertown, MA 02471-9173**

No Third Party Rights

The *Plan* grants rights to *Members*. It is not deemed to create rights in any third parties.

When this Member Handbook is Issued and Effective

This *Member Handbook* is issued and effective July 1, 2018 and supersedes all previous *Member Handbooks*.

Circumstances beyond Tufts HP's reasonable control

Tufts Health Plan is not responsible for a failure or delay to arrange for the provision of services due to circumstances beyond the reasonable control of *Tufts HP*. Such circumstances include, but are not limited to: major disaster, epidemic, war, riot, and civil insurrection. In such circumstances, *Tufts HP* will make a good faith effort to arrange for the provision of services.

Part 8 - Terms and Definitions

Terms and Definitions

This section defines the terms used in this *Member Handbook*.

Adoptive Child

A *Child* is an Adoptive *Child* as of the date he or she:

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

Annual Enrollment Period

The period each year when the *Group Insurance Commission* allows eligible persons to apply for and change coverage under Navigator and any other health plans the *GIC* offers.

Authorized Level of Benefits

The level of benefits that a *Member* receives when care is provided or authorized by his or her *PCP* (or, with respect to *Inpatient* behavioral health or *Inpatient* substance use disorder care, when care is provided by a *Tufts Health Plan Hospital*). See Part 3 for more information.

Authorized Reviewer

Authorized Reviewers review and approve certain services and supplies to *Members*. *Authorized Reviewers* are either *Tufts Health Plan's Chief Medical Officer* (or equivalent) or someone he or she names to perform this function.

Behavioral Health Disorders

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

Board-Certified Behavior Analyst (BCBA)

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

Child (Children)

The *Subscriber's* or *Spouse's Child* by birth, stepchild, or *Adoptive Child*, or any other *Child* for whom the *Subscriber* or *Spouse* has legal guardianship until the end of the month following their 26th birthday.

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. You are responsible for costs in excess of the *Reasonable Charge*.
- For services provided by a *Tufts HP Provider*, your share is the lesser of:
 - A percentage of the applicable *Tufts Health Plan* fee schedule amount for those services; or
 - A percentage of the *Tufts HP Provider's* actual charges for those services.

Contract Year

The 12-month period in which benefit limits and *Deductibles* are calculated. The *Contract Year* (sometimes referred to as a plan year) runs from July 1st through June 30th and is designated by the *Group Insurance Commission*.

Copayment

Fees you pay for certain *Covered Services* provided or authorized by your *Tufts HP PCP*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. *Copayments* are not applied towards any *Deductible* or *Coinsurance*.

Terms and Definitions, Continued

Copayment Tier 1 PCP

A Massachusetts *Primary Care Provider*, whose provider group (a) participates in the GIC's Centered Care Program, and (b) provides the most efficient care.

Copayment Tier 2 PCP

A Massachusetts *Primary Care Provider* whose provider group (a) participates in the GIC's Centered Care Program, and (b) provides less efficient care.

Copayment Tier 3 PCP

A Massachusetts *Primary Care Provider* whose provider group does not participate in the GIC's Centered Care Program.

Copayment Tier 1 Specialist

A Massachusetts *Tufts HP Provider* that is an adult or pediatric specialist and whose provider group (a) participates in the GIC's Centered Care Program, and (b) provides the most efficient care.

Copayment Tier 2 Specialist

A Massachusetts *Tufts HP Provider* that is an adult or pediatric specialist, and whose provider group (a) participates in the GIC's Centered Care Program, and (b) provides less efficient care.

Copayment Tier 3 Specialist

A Massachusetts *Tufts HP Provider* that is an adult or pediatric specialist and whose provider group does not participate in the GIC's Centered Care Program.

Cosmetic Services

Services performed solely for the purposes of improving appearance, which appearance is not the result of accidental injury, congenital anomaly or a previous surgical procedure or disease.

Cost Sharing Amount

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

Covered Services

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

- Described in Part 5 of this *Member Handbook* (see pages 50-76)
- *Medically Necessary*, as determined by *Tufts Health Plan*
- In some cases, approved by an *Authorized Reviewer*

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

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

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
- Adult and pediatric day care

In cases of behavioral health care or substance use disorder care, *Inpatient* care or intermediate care provided primarily:

- for maintaining the *Member's* or anyone else's safety, or
- for the maintenance and monitoring of an established treatment program,

when no other aspects of treatment require an acute hospital level of care or intermediate care.

Note: *Custodial Care* is not covered by the *Plan*.

Terms and Definitions, Continued

Day Surgery

Any surgical procedure(s) provided to a *Member* at a facility licensed by the state to perform surgery, and with an expected departure the same day. For hospital census purposes, the *Member* is an *Outpatient*, and not an *Inpatient*.

Deductible

The amount incurred by the *Member* for *Covered Services* before any payments are made under this *Member Handbook*. *Copayments* do not count towards any *Deductible*, nor do costs in excess of the *Reasonable Charge* for services received at the *Unauthorized Level of Benefits*. See “Benefit Overview” at the front of this *Member Handbook* for more information.

Note: The amount credited towards the *Member’s Deductible* is based on the *Tufts HP Provider* negotiated rate at the time the services are rendered and does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.

Dependent

The *Subscriber’s Spouse*, former *Spouse*, *Child*, stepchild, eligible foster child, or *Handicapped Child*.

Developmental

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 Provider* physicians and their affiliated *Tufts HP Hospital*
- Hospitals in the *Tufts Health Plan* network (*Tufts HP Hospitals*)
- Certain other *Tufts HP Providers*

Note: This booklet is updated from time to time to show changes in *Providers* affiliated with *Tufts Health Plan*. For information about the *Providers* listed in the *Directory of Health Care Providers*, please call Member Services or check the website at tuftshealthplan.com/gic.

Durable Medical Equipment

Devices or instruments of a durable nature that are:

- *Medically Necessary*
- Prescribed by a physician
- Reasonable and necessary to sustain a minimum threshold of independent daily living
- Made primarily to serve a medical purpose
- Not useful in the absence of illness or injury
- Able to withstand repeated use
- Used in the home

Effective Date

The date, according to *Tufts Health Plan’s* records, when you become a *Member* and are first eligible for *Covered Services*

Terms and Definitions, Continued

Emergency

An illness or medical condition, whether physical, behavioral, related to behavioral health or substance use disorder, or mental, characterized by symptoms of sufficient severity 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 behavioral health of a *Member*, another person, or a pregnant *Member's* unborn child;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions, inadequate time to safely transfer to another hospital before delivery, or a threat to the safety of the *Member* or her unborn child if they were transferred 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 worsening.

Experimental or Investigative

A service, supply, treatment, procedure, device, or medication (collectively "treatment") is considered *Experimental or Investigative* and therefore, not *Medically Necessary*, if **any** of the following apply:

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

This definition is fully explained in the corresponding Medical Necessity Guidelines.

Family Plan

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

Group Insurance Commission (GIC)

The Massachusetts state agency that provides health insurance for state and *Participating Municipality* employees, retirees, and their *Dependents*.

Habilitative

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

Terms and Definitions, Continued

Handicapped Child

The *Subscriber's Child* who:

- Became permanently, physically or mentally disabled before age 19
- Is incapable of supporting himself or herself due to disability
- Was covered under the *Subscriber's Family Plan* immediately before reaching age 19 and who receives approval from the *GIC* to continue coverage under the *Family Plan*.

Individual Contract

An agreement between *Tufts Health Plan* and the *Subscriber* under which *Tufts HP* agrees to provide individual coverage, and the *Subscriber* agrees to pay a premium to *Tufts HP*

Individual Plan

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 a day by that facility

Inpatient Copayment Tier 1

The *Copayment* you are responsible for paying for an *Inpatient* admission in a *Tufts HP* Hospital whose provider group (a) participates in the *GIC's* Centered Care Program and (b) provides the most efficient care.

Inpatient Copayment Tier 2

The *Copayment* you are responsible for paying for an *Inpatient* admission in a *Tufts HP* Hospital whose provider group (a) participates in the *GIC's* Centered Care Program and (b) provides less efficient care.

Inpatient Copayment Tier 3

The *Copayment* you are responsible for paying for an *Inpatient* admission in a *Tufts HP* Hospital whose provider group does not participate in the *GIC's* Centered Care Program.

Inpatient Notification (formerly known as "Preregistration")

Tufts Health Plan's process of validating all information required for all *Inpatient* admissions and transfers. *Inpatient Notification* is not a guarantee of payment. See Part 3 for more information.

Limited Service Medical Clinic

A walk-in medical clinic licensed to provide limited services, generally based in a retail store. Care is provided by a nurse practitioner. A *Limited Service Medical Clinic* offers an alternative to certain emergency room visits for a patient who needs less urgent care or is not able to visit his or her *Primary Care Provider* due to scheduling or other challenges. The services at a *Limited Service Medical Clinic* are only available to patients 24 months or older.

A *Limited Service Medical Clinic* does not provide *Emergency* or wound care, or treatment for injuries. It is not appropriate for people who need x-rays or stitches or who have life-threatening conditions. *Members* experiencing these conditions should go to an *Emergency* room.

Medically Necessary

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

- The most appropriate available supply or level of service for the *Member* in question considering potential benefits and harms to that individual
- Known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes
- Based on scientific evidence, for services and interventions not in widespread use.
- In determining coverage for *Medically Necessary Services*, *Tufts HP* uses *Medical Necessity* coverage guidelines which are: developed with input from practicing *Providers* in the *Tufts HP Service Area* and in accordance with the standards adopted by national accreditation organizations; updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and scientific evidence-based, if practicable.

Terms and Definitions, Continued

Medical Supplies and Equipment

Items prescribed by a physician and which are *Medically Necessary* to treat disease and injury.

Member

A person enrolled in the Navigator Plan. Also referred to as "you"

Member Handbook

This document, including any future amendments, which describe the Navigator Plan

Non-Conventional Medicine

A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine and are generally not based on scientific evidence. Since these services are not based on scientific evidence, they do not meet the *Tufts Health Plan* definition of *Medical Necessity* and are not covered. Providers of these non-covered services may be contracting or non-contracting traditional medical providers. These services may be offered in conjunction with a traditional office visit. Providers of *Non-Conventional Medicine* services often request payment up front because health insurance typically does not cover these services.

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

- holistic, naturopathic, energy medicine (e.g., Reiki, Ayurvedic, magnetic fields);
- manipulative and body-based practices (e.g., reflexology, yoga, exercise therapy, tai-chi);
- mind-body medicine (e.g., hypnotherapy, meditation, stress management);
- whole medicine systems (e.g., naturopathy, homeopathy);
- biologically based practices (e.g., herbal medicine, dietary supplements, probiotics); and
- other related practices when provided in connection with *Non-Conventional Medicine* services (e.g., animal therapy, art therapy, dance therapy, sleep therapy, light therapy, energy-balancing, breathing exercises).

Non-Tufts HP Provider

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

Notification Penalty (formerly known as "Preregistration Penalty")

The amount a *Member* will be required to pay if he or she does not follow the *Inpatient Notification* guidelines described in Part 3. The *Notification Penalty* does not count toward *Coinsurance*, *Deductibles*, or the *Out-of-Pocket Maximum*. The *Notification Penalty* is shown in "Benefit Overview" at the front of this *Member Handbook*.

Observation

The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within forty-eight (48) hours or a verified diagnosis and concurrent treatment plan. At times, an *Observation* stay may be followed by an *Inpatient* admission to treat a diagnosis revealed during the period of *Observation*.

Outpatient

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

- A physician's office
- A *Day Surgery* or ambulatory care unit
- An *Emergency* room or outpatient clinic

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

Terms and Definitions, Continued

Out-of-Pocket Maximum

The *Out-of-Pocket Maximum* is the maximum amount of money paid by a *Member* during a *Contract Year* for *Covered Services*.

An *Out-of-Pocket Maximum* consists of the *Deductible*, *Coinsurance* and *Copayments* at the *Authorized Level of Benefits*, and consists of the *Deductible* and *Coinsurance* at the *Unauthorized Level of Benefits*. It does not include any *Notification Penalties*, costs for health care services that are not *Covered Services*, costs in excess of the *Reasonable Charge*, or services or supplies listed in the “Note” for the “*Out-of-Pocket Maximum*” provisions on pages 31 and 33.

Paraprofessional

As it pertains to the treatment of autism and autism spectrum disorders, a *Paraprofessional* is an individual who performs applied behavior analysis (ABA) services under the supervision of a *Board-Certified Behavior Analyst (BCBA)*.

Participating Municipality

A city, town or district of the Commonwealth of Massachusetts that participates in the health coverage offered by the *Group Insurance Commission*

Plan

Navigator by Tufts Health Plan™, the *Group Insurance Commission's* self-funded plan administered by *Tufts Health Plan*, which provides you with the benefits described in this *Member Handbook*

Primary Care Provider (also referred to as PCP or Tufts HP PCP)

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

Prosthetic Devices

Medically Necessary items (i.e., breast prostheses and artificial limbs) prescribed by a physician that replace all or part of a bodily organ or limb.

Terms and Definitions, Continued

Provider

A health care professional or facility licensed in accordance with applicable law including, but not limited to, hospitals, *Limited Service Medical Clinics* (if available), *Urgent Care Centers* (if available), physicians, doctors of osteopathy, physician assistants, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed marriage and family therapists, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing; Licensed Alcohol and Drug Counselor I; licensed speech-language pathologists, and licensed audiologists.

The Navigator Plan will only cover services of a *Provider*, if those services are listed as *Covered Services* in Part 5 of this *Member Handbook* (see pages 50-76) and within the scope of the *Provider's* license.

Reasonable Charge

For care received at the *Authorized Level of Benefits* from a *Tufts HP Provider*, the *Reasonable Charge* is based upon *Tufts HP's* contracted rate with the *Tufts HP Provider* (applicable *Authorized Deductible* and *Coinsurance* or *Copayment* will apply).

For care received from a *Non-Tufts HP Provider*, the *Reasonable Charge* is the lesser of the:

- Amount charged by the *Non-Tufts HP Provider*; 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 coding and clinical guidelines.

Routine Nursery Care

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

Service Area

The geographical area approved by the Massachusetts Commissioner of Insurance within which *Tufts Health Plan* has developed a network of *Providers* to give *Members* adequate access to *Covered Services*

Spouse

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

Subscriber

The person who:

- Is an employee, a non-Medicare eligible retired employee, or non-Medicare eligible surviving spouse of an employee or retiree of the Commonwealth of Massachusetts or a *Participating Municipality*
- Enrolls in Navigator and signs the membership application form on behalf of himself or herself and any *Dependents*
- In whose name the premium contribution is paid

Tobacco Cessation Counselor

Providers who are not physicians but who have completed at least eight (8) hours of instruction in tobacco cessation from an accredited institute of higher learning. Tobacco cessation counselors must work under the supervision of a physician.

Tufts Health Plan or Tufts HP

Total Health Plans, Inc., a Massachusetts Corporation d/b/a Tufts Health Plan. Tufts Health Plan enters into arrangements with groups or payers underwriting health benefit plans to make available a network of *Providers* and to provide certain administrative services to the health benefit plans including, but not limited to, processing claims for benefits and performing preregistration. *Tufts HP* does not insure the Navigator Plan.

Tufts HP Hospital

A hospital that 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 agents or representatives of *Tufts Health Plan*, and their staffs are not *Tufts Health Plan's* employees.

Terms and Definitions, Continued

Tufts HP Provider

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

Unauthorized Level of Benefits

The level of benefits that a *Member* receives when care is not provided or authorized by his or her *Tufts HP PCP*. See “Benefit Overview” at the front of this *Member Handbook* and Part 3 earlier in this *Member Handbook* for more information.

Urgent Care

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

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

Urgent Care Center

A medical facility (or clinic or medical practitioner office) that offers an alternative to certain emergency room visits for *Members* who are not able to visit their *Primary Care Provider* or health care *Provider* in a timely enough manner as warranted by their condition or symptoms. To find an *Urgent Care Center* in our network, please visit our website atttuftshealthplan.com, and click on “Find a Doctor”.

You, Your

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

Part 9 – Navigator Plan *Inpatient Hospital Copayment Levels*

Under the Navigator Plan, *Copayments* for *Inpatient* hospital stays at *Tufts HP Hospitals* are grouped into three *Inpatient Hospital Copayment Tiers*, which are based upon whether the hospital's provider group participates in the *GIC's Centered Care Program*, and the efficiency of care it provides (Please call Member Services for more information about hospital groupings.)

- *Tufts HP Hospitals* whose provider group (a) participates in the *GIC's Centered Care Program* and (b) provides the most efficient care are in ***Inpatient Copayment Tier 1***. *Inpatient* services at a *Tufts HP Hospital* included in *Inpatient Copayment Tier 1* are subject to a **\$275 Copayment** per admission.*
- *Tufts HP Hospitals* that participate in the *GIC's Centered Care Program* and are determined to provide less efficient care are grouped in ***Inpatient Copayment Tier 2***. *Inpatient* services at a *Tufts HP Hospital* included in *Inpatient Copayment Tier 2* are subject to a **\$500 Copayment** per admission.*
- *Tufts HP Hospitals* that do not participate in the *GIC's Centered Care Program* are grouped in ***Inpatient Copayment Tier 3***. *Inpatient* services at a *Tufts HP Hospital* included in *Inpatient Copayment Tier 3* are subject to a **\$1500 Copayment** per admission*.

*Subject to the *Inpatient Care Copayment Limit* listed in the "*Inpatient Care Copayment Limit*" provision on page 30 of this Navigator *Member Handbook*.

Important Note: *Copayments* for admissions to *Tufts HP Hospitals* that do not participate in the *Centered Care Program*, but to whom *Centered Care Providers* refer, are based on the tier of the referring *Provider*.

There are other services for which the *Inpatient Hospital Copayment Tiers* do not apply at the *Authorized Level of Benefits*. These include:

- Services for newborn *Children* who stay in the hospital beyond the mother's discharge **are subject to the Authorized Deductible, then covered in full**.
- Covered transplant services for *Members* **are subject to a \$275 Copayment per admission*** when performed at a facility in *Tufts Health Plan's* designated transplant network. Any additional *Inpatient* admission to a *Tufts HP Hospital* for *Covered Services* related to the transplant procedure(s) is subject to the applicable *Inpatient Hospital Copayment*. Please see pages 97-102 of this Navigator *Member Handbook* for those *Copayment* amounts in effect as of July 1, 2018.
- Covered *Inpatient* behavioral health and substance use disorder services **are subject to a \$200 Copayment*** when provided at any *Tufts HP Hospital*.
- *Copayments* are waived for readmissions within 30 days of discharge in the same *Contract Year*. If you are billed an *Inpatient Copayment* for a readmission within 30 days of discharge within the same *Contract Year*, please call Member Services to have your claim adjusted.

*Subject to the *Inpatient Care Copayment Limit* listed in the "*Inpatient Care Copayment Limit*" provision on page 30 of this Navigator *Member Handbook*.

The Navigator *Inpatient Hospital Copayment List*, which appears in the following table, lists hospitals and their applicable *Copayments*.

Navigator *Inpatient* Hospital Copayment List

Eastern Massachusetts

Hospital Name	Inpatient Copayment
Anna Jaques Hospital	\$275
Beth Israel Deaconess Hospital – Milton Hospital	\$275
Beth Israel Deaconess Hospital – Needham	\$275
Beth Israel Deaconess Hospital – Plymouth	\$275
Beth Israel Deaconess Medical Center	\$275
Boston Children’s Hospital	\$500
Boston Medical Center	\$275
Brigham and Women’s Hospital	\$1,500
Brigham and Women’s Faulkner Hospital	\$1,500
Cambridge Hospital (part of Cambridge Health Alliance)	\$275
Cape Cod Hospital	\$275
Dana-Farber Cancer Institute	\$1,500
Emerson Hospital	\$1,500
Falmouth Hospital	\$275
Hallmark Health Systems (Lawrence Memorial or Melrose Wakefield Hospitals)	\$500
Lahey Hospital and Medical Center	\$500
Lawrence General Hospital	\$275
Lowell General Hospital	\$275
Martha’s Vineyard Hospital	\$1,500
Massachusetts Eye and Ear Infirmary	\$500
Massachusetts General Hospital	\$1,500
Metrowest Medical Center - Framingham	\$275

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2018. For the most up-to-date status, please contact Member Services at 800-870-9488.

Navigator *Inpatient Hospital Copayment List*, continued

Eastern Massachusetts, continued

Hospital Name	Inpatient Copayment
Metrowest Medical Center – Leonard Morse	\$275
Mount Auburn Hospital	\$275
Nantucket Cottage Hospital	\$1,500
New England Baptist Hospital	\$275
Newton-Wellesley Hospital	\$1,500
North Shore Medical Center (Salem or Union Campuses)	\$1,500
Northeast Hospital Corporation (Addison Gilbert or Beverly Hospitals)	\$500
Signature Healthcare Brockton Hospital	\$1,500
Southcoast Hospitals Group – Charlton Memorial Hospital	\$500
Southcoast Hospitals Group – St. Luke's Hospital	\$500
Southcoast Hospitals Group – Tobey Hospital	\$500
South Shore Hospital	\$500
Steward Carney Hospital	\$275
Steward Good Samaritan Medical Center	\$275
Steward Holy Family Hospital	\$275
Steward Holy Family Hospital at Merrimack Valley	\$275
Steward Morton Hospital and Medical Center	\$275
Steward Norwood Hospital	\$275
Steward Saint Anne's Hospital	\$275
Steward St. Elizabeth's Medical Center	\$275
Sturdy Memorial Hospital	\$500
Tufts Medical Center	\$500
Winchester Hospital	\$500

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2018. For the most up-to-date status, please contact Member Services at 800-870-9488

Navigator *Inpatient Hospital Copayment List*, continued

Central Massachusetts

Hospital Name	<i>Inpatient Copayment</i>
Athol Memorial Hospital	\$1,500
Clinton Hospital	\$1,500
Harrington Memorial Hospital	\$1,500
HealthAlliance Hospital	\$1,500
Heywood Hospital	\$1,500
Marlborough Hospital	\$1,500
Milford Regional Medical Center	\$1,500
Steward Nashoba Valley Medical Center	\$275
St. Vincent Hospital	\$275
UMass Memorial Medical Center	\$1,500

Western Massachusetts

Hospital Name	<i>Inpatient Copayment</i>
Baystate Franklin Medical Center	\$275
Baystate Medical Center	\$275
Baystate Noble Hospital	\$275
Baystate Wing Hospital	\$275
Berkshire Medical Center	\$275
Cooley Dickinson Hospital	\$1,500
Fairview Hospital	\$275
Holyoke Medical Center	\$1,500
Mercy Medical Center	\$275

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2018. For the most up-to-date status, please contact Member Services at 800-870-9488.

Navigator *Inpatient Hospital Copayment List*, continued

Maine

Hospital Name	<i>Inpatient Copayment</i>
Maine Medical Center	\$500
Southern Maine Medical Center	\$500
York Hospital	\$500

New Hampshire

Hospital Name	<i>Inpatient Copayment</i>
Alice Peck Day Hospital	\$500
Androscoggin Valley Hospital	\$500
Catholic Medical Center	\$500
Cheshire Medical Center	\$500
Concord Hospital	\$500
Cottage Hospital	\$500
Dartmouth-Hitchcock Medical Center	\$500
Elliot Hospital	\$500
Exeter Hospital	\$500
Franklin Regional Hospital	\$500
Frisbie Memorial Hospital	\$500
Huggins Hospital	\$500
Lakes Region General Hospital	\$500
Littleton Regional Hospital	\$500
Memorial Hospital	\$500
Monadnock Community Hospital	\$500
New London Hospital	\$500
Parkland Medical Center	\$500
Portsmouth Regional Hospital	\$500
Southern New Hampshire Regional Medical Center	\$500
Speare Memorial Hospital	\$500
St. Joseph Hospital	\$500
Upper Connecticut Valley Hospital	\$500
Valley Regional Hospital	\$500
Weeks Medical Center	\$500
Wentworth-Douglass General Hospital	\$500

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2018. For the most up-to-date status, please contact Member Services at 800-870-9488.

Navigator *Inpatient Hospital Copayment List*, continued

Rhode Island

Hospital Name	<i>Inpatient Copayment</i>
Kent Hospital	\$500
Landmark Medical Center	\$500
Memorial Hospital of RI	\$500
Miriam Hospital	\$500
Newport Hospital	\$500
Rhode Island Hospital – including Hasbro Children’s Hospital	\$500
Roger Williams Hospital	\$500
South County Hospital	\$500
St. Joseph Hospital – including Fatima Hospital	\$500
Westerly Hospital	\$500
Women and Infants Hospital of Rhode Island	\$500

Vermont

Hospital Name	<i>Inpatient Copayment</i>
Brattleboro Memorial Hospital	\$500
Mount Ascutney Hospital	\$500
Southwestern Vermont Medical Center	\$500

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2018. For the most up-to-date status, please contact Member Services at 800-870-9488.

Prescription Drug Benefit

Administered by



Prescription Drug Plan

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan. The Express Scripts pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail order pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact Express Scripts Member Services toll free at 855-283-7679.

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter versions of preventive drugs, medications are covered only if a prescription is required for their dispensing. Diabetes supplies and insulin are also covered by the plan.

The plan categorizes medications into seven major categories:

Generic Drugs

Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements help to assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drugs

A maintenance drug is a medication taken on a regular basis for chronic conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Brand-Name Drugs

A non-preferred drug is a medication that usually has an alternative, therapeutically equivalent drug available on the formulary.

Preferred Brand-Name Drugs

A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Preventive Drugs

Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act. See "Preventive Drugs" on page 108 for more information.

Specialty Drugs

Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- Potential for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance for effective treatment
- Limited or exclusive product distribution
- Specialized product handling and/or administration requirements

Over-the-Counter (OTC) Drugs

Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of preventive drugs (all of which are covered only if dispensed with a written prescription).

Copayments and Deductible

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (generic drugs), Tier 2 (preferred brand-name drugs), Tier 3 (non-preferred brand-name drugs), or drugs which require no copayments. The following charts show your deductible and copayment based on the type of prescription you fill and where you get it filled.

Deductible (fiscal year July through June)	
For an individual	\$100 for one person
For a family	\$200 for the entire family No more than \$100 per person will be applied to the family deductible. Multiple family members can satisfy the family deductible.

Copayment for:	Participating Retail Pharmacy up to 30-day supply	Mail Order or CVS Pharmacy up to 90-day supply
Tier 1 – Generic Drugs	\$10	\$25
Tier 2 – Preferred Brand-Name Drugs	\$30	\$75
Tier 3 – Non-Preferred Drugs	\$65	\$165
Other - Orally-administered anti-cancer drugs - Generic drugs to treat opioid use disorder (generic buprenorphine-naloxone, naloxone, and naltrexone products) - Preventive drugs: Refer to the “Preventive Drugs” section below for detailed information	\$0 Deductible does not apply	\$0 Deductible does not apply

Copayment for	Specialty drugs must be filled only through Accredo, a specialty pharmacy
Specialty Drugs: Tier 1	\$10 per 30-day supply
Specialty Drugs: Tier 2	\$30 per 30-day supply
Specialty Drugs: Tier 3	\$65 per 30-day supply
Orally-administered anti-cancer specialty drugs	\$0 per 30-day supply

Specialty medications may be dispensed up to a 30-day supply; some exceptions may apply.

Out-of-Pocket Maximum

This plan has an out-of-pocket maximum that is combined with your medical and behavioral health out-of-pocket maximum. Deductibles and copayments you pay for prescription drugs during the year count toward this out-of-pocket maximum. Once you reach the out-of-pocket maximum, your prescription drugs are covered at 100%. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket maximum.

Out-of-Pocket Maximum	
Individual	\$5,000
Family	\$10,000

How to Use the Plan

After you first enroll in the plan, Express Scripts will send you a welcome packet and Express Scripts Prescription Card(s). Your Prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any) along with a booklet that includes a prescription drug benefit overview, drug list, and a mail order claim form.

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

Register at **express-scripts.com**. As a registered user, you can check drug costs, order mail order refills and review your prescription drug history. You can access this site 24 hours a day.

Filling Your Prescriptions

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through mail order from the Express Scripts PharmacySM. Prescriptions for specialty drugs must be filled as described in the “Accredo, an Express Scripts Specialty Pharmacy” subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts Prescription Card, with the exception of the limited circumstances detailed in the “Claim Forms” subsection.

Short-Term Medications – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (for example, antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts Prescription Card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online after registering at **express-scripts.com** or by calling toll free at 855-283-7679.

If you do not have your Prescription Card, the pharmacist can also verify eligibility by contacting the Express Scripts Pharmacy Help Desk at 800-922-1557; TDD: 800-922-1557.

Maintenance Medications – Up to 30 Days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from Express Scripts explaining how you may convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy. You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail order or at a CVS Pharmacy, or if you inform Express Scripts that you instead prefer to continue to receive 30-day supplies at a participating retail pharmacy.

Express Scripts will assist you in transitioning your maintenance prescription to either mail order or a CVS Pharmacy location.

Maintenance Medications – Up to 90 Days

Filling 90-day Prescriptions Through the Express Scripts Pharmacy or CVS Pharmacy

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail order copayment, either through the Express Scripts Pharmacy or at a CVS Pharmacy.

The Express Scripts Pharmacy is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high blood pressure, and high cholesterol. Your prescriptions are filled and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection. They are delivered directly to your home or to another location that you prefer.

CVS Pharmacy is another option for getting your 90-day maintenance medications for the same copayment amount as mail order. Prescriptions can be filled at CVS Pharmacy locations across the country.

Maintenance Medications – Up to 90 Days, continued

Convenient for You

You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail order, you can order refills online or by phone, or you can use your local CVS Pharmacy.

Using Mail Order from the Express Scripts Pharmacy

To begin using mail order for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your maintenance medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a mail order form (contained in your Welcome Kit or found online after registering at **express-scripts.com**). Or call Express Scripts Member Services toll free at 855-283-7679 to request the form.
3. Put your prescription and completed order form into the return envelope (provided with the order form) and mail it to the Express Scripts Pharmacy.

Please allow 7-10 business days for delivery from the time your order is mailed. A pharmacist is available 24 hours a day to answer your questions about your medication.

If the Express Scripts Pharmacy is unable to fill a prescription because of a shortage of the medication, you will be notified of the delay in filling the prescription. You may then fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

Accredo, an Express Scripts Specialty Pharmacy

Accredo is a full-service specialty pharmacy that provides personalized care to each patient and serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple sclerosis, and rheumatoid arthritis.

You will be required to fill your specialty medications at Accredo. This means that your prescriptions can be sent to your home or your doctor's office.

Specialty medications may be filled only at a maximum of a 30-day supply; some exceptions may apply. Many specialty medications are subject to a clinical review by Express Scripts to ensure the medications are being prescribed appropriately.

Accredo offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. We ship to all 50 states using one of our preferred expedited carriers. We can also ship to a variety of alternate addresses, including physician's offices or to another family member's address. We do not ship to P.O. Boxes.

You have toll-free access to expert clinical staff who are available to answer all of your specialty drug questions. Accredo will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through Accredo, call toll free at 877-895-9697.

Accredo Pharmacy Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office, or other approved location
- **Refill Reminders** – Ongoing refill reminders from Accredo
- **Language Assistance** – Language-interpreting services are provided for non-English speaking patients.

Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your Express Scripts Prescription Card, are covered as follows:

Claims Reimbursement

Type of Claim	Reimbursement
Claims for purchases at a participating (in-network) pharmacy without an Express Scripts Prescription Card	Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copayment -or- Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.
Claim forms are available to registered users on express-scripts.com or by calling 855-283-7679.	

Other Plan Provisions

Preventive Drugs

Coverage will be provided for the following drugs¹:

Preventive Drugs	
Aspirin	Generic OTC aspirin ≤ 325mg when prescribed for adults less than 70 years of age for the prevention of heart attack or stroke and to help prevent illness and death from preeclampsia for females who are at high risk for the condition.
Bowel preparation medications	Generic and brand (Rx and OTC) products for adults ages 50 to 75 years old. Limited to 2 prescriptions at \$0 copay each year.
Contraceptives	Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products, when prescribed for women less than 50 years old.
Folic acid supplements	Generic OTC and Rx versions (0.4 mg-0.8 mg strengths only) when prescribed for women under the age of 51.
Immunization vaccines	Generic or brand versions prescribed for children or adults.
Oral fluoride supplements	Generic and brand supplements prescribed for children 6 months through five years of age for the prevention of dental caries.
Breast cancer	Generic prescriptions for raloxifene or tamoxifen are covered for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older.
Tobacco cessation	All FDA-approved smoking cessation products prescribed for adults, age 18 and older.
Vitamin D supplements	Generic OTC and Rx vitamin D products for adults ≥ 65 years old.
Statins	Generic-only, single-entity, low-to-moderate dose statin agents for adults 40-75 years old.

¹This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Call Express Scripts at 855-283-7679 for additional coverage information on specific preventive drugs.

Brand-Name Drugs with Exact Generic Equivalents

The plan encourages the use of generic drugs. There are many brand-name drugs, such as Lipitor®, Ambien®, and Fosamax®, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count towards the out-of-pocket maximum. Exceptions to this provision may apply to certain brand-name preventive drugs; contact Express Scripts for additional information.

Prescription Drugs with Over-the-Counter (OTC) Equivalents

Some prescription drugs have over-the-counter (OTC) equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for prescription drugs with OTC equivalents. This provision is not applicable to preventive drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs. Your plan does not provide benefits for prescription drugs when OTC equivalents are available. This provision is not applicable to preventive drugs.

Prior Authorization

Some drugs in your plan require prior authorization. Prior authorization ensures that you are receiving the appropriate drug for the treatment of a specific condition, in quantities approved by the FDA. For select drugs, prior authorization also includes a medical necessity review that ensures the use of less expensive first-line formulary prescription drugs before the plan will pay for more expensive prescription drugs. First-line formulary prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases.

If a drug that you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call Express Scripts at 800-417-1764.

Current Examples of Drugs Requiring Prior Authorization for Specific Conditions²

Drug Class	Products Requiring Prior Authorization (PA)
Acne	Tazorac®/Fabior® Topical tretinoin products (Retin-A®, Retin-A Micro® -Orton; Avita® - Bertek Pharmaceuticals; Tretin X™ – Triax; Atralin™ gel – Coria; other generic – various manufacturers); and clindamycin phosphate 1.2% and tretinoin 0.025 % gel, Ziana® - Medicis; Veltin® - Stiefel. <i>PA required only in adults age 36 and older.</i> Topical tazarotene products (Tazorac® 0.05% and 0.1% gel – Allergan; Fabior® 0.1% - Stiefel)
Testosterone	(Aveed®, Depo®-Testosterone [testosterone cypionate injection, generics], Delatestryl® [testosterone enanthate injection, generic], Testopel® [testosterone pellet]) (Androderm®, AndroGel®, Axiron®, Fortesta®, Natesto®, Striant®, Testim®, Vogelxo™)
Glaucoma	Lumigan®, Xalatan® [generics], Travatan®, Travatan X®, Zioptan®
Compounded Medications*	Select medications <i>*A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available</i>
Diabetes	GLP-1 agonists (Byetta®, Bydureon®, Trulicity®, Victoza®) Symlin®
Rosacea	Mirvaso®, Rhofade™ cream
Narcolepsy	Provigil®, Nuvigil®, Xyrem®
Nutritional Supplements	Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the 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.
Pain	Oral-intranasal fentanyl (Abstral®, Actiq®, Fentora®, Lazanda®, Onsolis®, Subsys®) Lidoderm®
Testosterone Products	Injectable, oral, topical/buccal/nasal products (AndroGel®, Androderm®, Axiron®, Delatestryl®, Depo®-Testosterone, Fortesta®, methyltestosterone, Natesto®, Striant®, Testim®, testosterone cream, testosterone ointment, testosterone powder, Vogelxo® topical gel)
Weight management	Adipex® [phentermine], Bontril® [phendimetrazine], Contrave® [bupropion; naltrexone], Didrex® [benzphetamine], Sanorex® [mazindol], Suprenza™ [phentermine], Tenuate® [diethylpropion], Xenical® [orlistat], Belviq®, Qsymia®, Saxenda
Dry Eyes	Restatis®, Xiidra®

² This list is not all-inclusive and is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program

Current Examples of Top Drug Classes that May Require Prior Authorization for Medical Necessity¹

- Dermatological Agents
- Diabetic Supplies
- Epinephrine Auto-Injector Systems
- Erectile Dysfunction Oral Agents
- Erythropoiesis-Stimulating Agents
- Glaucoma
- Growth Hormones
- Hepatitis C Agents
- Insulins
- Nasal Steroids
- Ophthalmic Agents
- Opioid Analgesics
- Opioid Dependence Agents
- Osteoarthritis – Hyaluronic Acid Derivatives
- Osteoarthritis Therapy
- Proton Pump Inhibitors

Select drugs within these classes require prior authorization for medical necessity to ensure formulary alternative(s) within the class have been tried. If you are a registered user on **express-scripts.com**, refer to the National Preferred Formulary or call Express Scripts toll free at 855-283-7679 for additional information.

Quantity Dispensing Limits

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- FDA-approved product labeling
- Common usage for episodic or intermittent treatment
- Nationally accepted clinical practice guidelines
- Peer-reviewed medical literature
- As otherwise determined by the plan

Examples of drugs with quantity limits currently include Cialis®, Imitrex®, and lidocaine ointment.¹

¹This list is subject to change during the year. Call Express Scripts toll free at 855-283-7679 to check if your drugs are included in the program.

Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the plan;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too-early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

Exclusions

Benefits exclude:¹

- Dental preparations (e.g., topical fluoride, Arestin®), with the exception of oral fluoride
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and preventive drugs)
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Injectable allergens
- Hair growth agents
- Special medical formulas and medical food products, except as required by state law
- Compounded medications – some exclusions apply. Examples include bulk powders, bulk chemicals and proprietary bases used in compounded medications.
- Drugs administered intrathecally, by or under the direction of health care professionals and recommended to be administered under sedation.

Definitions

Brand-Name Drug – The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection, it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Compounded Medication – A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. At least one of the ingredients must be a medication that can only be dispensed with a written prescription.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Deductible – A deductible is the dollar amount you must pay during a plan year before the copayments for covered prescriptions apply.

Diabetes Supplies – Diabetic supplies include needles, syringes, test strips, lancets, and blood glucose monitors.

FDA – The U.S. Food and Drug Administration.

Formulary -- A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts National Preferred Formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail-order settings. The formulary is developed and maintained by Express Scripts. Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Drug – A non-preferred drug is a medication that has been reviewed by Express Scripts, which determined that an alternative drug that is clinically equivalent and more cost-effective may be available.

Out-of-Pocket Maximum – The out-of-pocket maximum is the most you could pay in copayments during the year for prescription drugs that are covered by Express Scripts. Once you reach this out-of-pocket maximum, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket maximum.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of preventive drugs (all of which are covered only if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

Preferred Brand-Name Drug – A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug means any and all drugs which, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement "Caution: Federal Law prohibits dispensing without prescription" or a drug which is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.

Preventive Drugs – Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act.

Prior Authorization – Prior authorization means determination that a drug is appropriate for treatment of a specific condition. It may also mean determination of medical necessity. It is required before prescriptions for certain drugs will be paid for by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the 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. These products require prior authorization to determine medical necessity.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at 617-727-2310, extension 1.

Specialty Drugs – Specialty drugs are usually injectable or non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance for effective treatment
- Limited or exclusive product distribution
- Specialized product handling and/or administration requirements

Member Appeals

Express Scripts has processes to address:

- Inquiries concerning your drug coverage
- Appeals:
 - Internal Member Appeals
 - Expedited Appeals
 - External Review Appeals

All appeals should be sent to Express Scripts at the below address. Complete the form and fax it to 877-328-9660 or mail to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St. Louis, MO 63166-6587

All calls should be directed to Express Scripts Member Services at 855-283-7679.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Member Services phone number on the back of the prescription card.

Internal Inquiry

Call Express Scripts Member Services to discuss concerns you may have regarding your prescription drug coverage. Every effort will be made to resolve your concerns. If your concerns cannot be resolved or if you tell a Member Services representative you are not satisfied with the response you have received, Member Services will notify you of any options you may have, including the right to have your inquiry processed as an appeal. Member Services will also provide you with the steps you and your doctor must follow to submit an appeal.

Internal Member Appeals

Requests for coverage that were denied as specifically excluded in this member handbook or for coverage that was denied based on medical necessity determinations are reviewed as appeals through the Express Scripts Internal Appeals Process. You may file an appeal request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or prescription drug claim payment to file your appeal. To request an initial administrative coverage review, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

1. You must submit a written appeal to the address listed above. Your letter should include:
 - Your complete name and address;
 - Your Express Scripts ID number;
 - Your date of birth;
 - A detailed description of your concern, including the drug name(s) being requested; and
 - Copies of any supporting documentation, records or other information relating to the request for appeal.
2. The Express Scripts Appeals Department will review appeals concerning specific prescription drug benefit provisions, plan rules and exclusions and make determinations. If you are not satisfied with an Appeals Department denial related to a plan rule or exclusion (i.e., non-medical necessity), you may have the right to request an independent External Review of the decision (refer to the “External Review Appeals” section for details on this process).

For denials related to a medical necessity determination, you have the right to an additional review by Express Scripts. Express Scripts will request this review from an independent practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. If the second review is an adverse determination, you have the right to request an External Review of this decision (refer to the “External Review Appeals” section for details on this process).

3. For an appeal on a prescription drug that has not been dispensed, an Appeals Analyst will notify you in writing of the decision within no more than fifteen calendar days of the receipt of an appeal. For an appeal on a prescription drug already dispensed, an Appeals Analyst will notify you in writing of the decision within no more than thirty calendar days of the receipt of an appeal.

A copy of the decision letter will be sent to you and your physician. A determination of denial will set forth:

- Express Scripts’ understanding of the request;
- The reason(s) for the denial;
- Reference to the contract provisions on which the denial is based; and
- A clinical rationale for the denial, if the appeal involves a medical necessity determination.

Express Scripts maintains records of each inquiry made by a member or by that member’s designated representative.

Express Scripts recognizes that there are circumstances that require a quicker turnaround than allotted for the standard Appeals Process. Express Scripts will expedite an appeal when 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, Express Scripts will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. Express Scripts will notify you of its decision by telephone no later than 72 hours after Express Scripts’ receipt of the request.

If the patient or provider believes the patient’s situation is urgent, the provider must request the expedited review by phone at 800-753-2851.

External Review Appeals

In most cases, if you do not agree with the Appeals decision, you or your authorized representative have the right to request an independent, external review of the decision. Should you choose to do so, send your request within four months of your receipt of the written notice of the denial of your appeal to the below address.

To submit an external review, the request must be mailed or faxed to MCMC, LLC, an independent third party utilization management company, at:

MCMC, LLC
Attn: Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929
617-375-7700, ext. 28253
617-375-7683

In some cases, members may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. The request must be received within 4 months of the date of the final internal adverse benefit determination (if the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day). For urgent external appeals urgent external review, the IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the Appeals decision, the service or supply will be covered under the plan.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 855-283-7679.

Health and Prescription Information

GIC authorizes health and prescription information about members be used by Express Scripts to administer benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of the benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

Group Insurance Commission Notices

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA GENERAL NOTICE

This notice explains your COBRA rights and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete the GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

WHAT IS COBRA COVERAGE? The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies;
- Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents legally separate or divorce; or
- The dependent ceases to be a dependent child under GIC eligibility rules

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.** Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid *in full* when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

In considering whether to elect COBRA coverage you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your GIC coverage ends due to a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically; current COBRA rates are included with this notice.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, if you are a Massachusetts resident, you may purchase health insurance through the Commonwealth's Health Connector Authority, or for employees in other states, through a Health Insurance Marketplace where available. The GIC has no involvement in conversion programs, and only very limited involvement in Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the GIC of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
 - The employee's job terminates or his/her hours are reduced;
 - The insured dies;
 - The insured becomes legally separated or divorced;
 - The insured or insured's former spouse remarries;
 - A covered child ceases to be a dependent under GIC eligibility rules;
 - The Social Security Administration determines that the employee or a covered family member is disabled; or
 - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114.

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 1 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at www.dol.gov/ebsa or call their toll free number at 866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov or, in Massachusetts visit, www.mahealthconnector.org.

Important Notice from the Group Insurance Commission (GIC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the *Plan* and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

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FOR MOST PEOPLE, THE DRUG COVERAGE THAT YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NON-GIC MEDICARE PART D DRUG PLANS.
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There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When Can You Join A Medicare Part D Drug Plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a non-GIC Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Non-GIC Medicare Drug Plan?

- If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at www.socialsecurity.gov or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty)

as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage....

Contact the GIC at (617) 727-2310, extension 1. **NOTE:** You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for the telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Updated: November 2015

NOTICE OF GROUP INSURANCE COMMISSION PRIVACY PRACTICES

Effective September 3, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as “protected health information” or “PHI”) includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information (“PHI”) in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment Activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To Provide You Information on Health-Related Programs or Products: Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made by you or on your behalf (such as appeals);
- to enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- for data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements; and
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations That Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive notification of any breach of your unsecured PHI.
- Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at mass.gov/gic.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617)-227-8583.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

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 while in the military.

Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

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

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at <http://www.dol.gov/vets>**. An interactive online USERRA Advisor can be viewed at **<http://www.dol.gov/elaws/userra.htm>**. 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 or the Office of Special Counsel, as applicable, 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 about your GIC coverage, please contact the Group Insurance Commission at (617) 727-2310, ext. 1.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethiptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

PATIENT PROTECTION DISCLOSURE

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

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

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

YOU ARE RECEIVING THIS NOTICE AS REQUIRED BY THE NEW NATIONAL HEALTH REFORM LAW (ALSO KNOWN AS THE AFFORDABLE CARE ACT OR ACA)

On January 1, 2014, the Affordable Care Act (ACA) will be implemented in Massachusetts and across the nation. The ACA will bring many benefits to Massachusetts and its residents, helping us expand coverage to more Massachusetts residents, making it more affordable for small businesses to offer their employees healthcare, and providing additional tools to help families, individuals and businesses find affordable coverage. This notice is meant to help you understand health insurance Marketplaces, which are required by the ACA to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state Marketplace is known as the Massachusetts Health Connector. While you may or may not qualify for health insurance through the Health Connector, it may still be helpful for you to read and understand the information included here.

Overview: When key parts of the national health reform law take effect in January 2014, there will be an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: **MAhealthconnector.org**, or for non-Massachusetts residents, **Healthcare.gov** or (1-800-318-2596; TTY: 1-855-889-4325).

What is the Massachusetts Health Connector? The Health Connector is our state's health insurance Marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) Code.

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector begins Oct. 1, 2013, for coverage starting as early as Jan. 1, 2014. (And in future years, open enrollment will begin every Oct. 15.) You can find out more by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **1-877-MA ENROLL** (1-877-623-6765).

Does access to employer-based health coverage affect my eligibility for subsidized health insurance through the Health Connector?

An offer of health coverage from the Commonwealth of Massachusetts, as the employer, could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- **The Commonwealth of Massachusetts does not offer coverage to you, or**
- **The Commonwealth of Massachusetts offers you coverage, but:**
 - The coverage the Commonwealth of Massachusetts provides you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or

- The coverage the Commonwealth of Massachusetts provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs)

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by the Commonwealth of Massachusetts please note that you will lose the employer contribution (if any) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes. Health Connector premiums have different tax treatment.

As part of considering whether the ACA and Marketplaces will affect you as an employee it is important to understand what the Commonwealth of Massachusetts offers you.

- The Commonwealth offers benefited employees health coverage through the Group Insurance Commission. To be eligible for GIC health insurance, a state employee must work a minimum of 18 $\frac{3}{4}$ hours in a 37.5 hour workweek or 20 hours in a 40 hour workweek. The employee must contribute to a participating GIC retirement system, such as the State Board of Retirement, a municipal retirement board, the Teachers Retirement Board, the Optional Retirement Pension System for Higher Education, a Housing, Redevelopment Retirement Plan, or another Massachusetts public sector retirement system (OBRA is not such a public retirement system for this purpose. Visit www.mass.gov/gic or see your GIC Coordinator for more information.
- Temporary employees, contractors, less-than-half time part time workers, and most seasonal employees are not eligible for GIC health insurance benefits. These employees may shop for health insurance through the Health Connector and may be eligible for advanced premium federal tax credits and/or state subsidies if their gross family income is at or below 400% Federal Poverty Level (which is approximately \$46,000 for an individual and \$94,000 for a family of four). Visit www.MAhealthconnector.org or call 1-877-MA-ENROLL for more information.

If there is any confusion around your employment status and what you are eligible for, please email healthmarketplacenotice@massmail.state.ma.us or contact your HR department or GIC Coordinator.

ANTI-DISCRIMINATION NOTICE

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact Tufts Health Plan at 800.462.0224.

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

Tufts Health Plan

Attention: Civil Rights Coordinator Legal Dept.

705 Mount Auburn St. Watertown, MA 02472

Phone: 888.880.8699 ext. 48000, [TTY number — 800.439.2370 or 711]

Fax: 617.972.9048

Email: OCRCoordinator@tufts-health.com

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C. 20201

800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

tuftshealthplan.com | 800.462.0224

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This index lists the major benefits and limitations of the Navigator plan. Of course, it does not list everything in this *Member Handbook*. To fully understand all benefits and limitations, a *Member* must read through this *Member Handbook* carefully.

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Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

800.870.9488

For the Prescription Drug Program,
please call Express Scripts

855.283.7679

For the Employee Assistance Program Benefits,
please call Optum

844.263.1982



Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472

For additional information,
please call 800.870.9488

tuftshealthplan.com

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