This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see next page for additional information.
Capitalized words are defined in Appendix A.

To contact Member Services, call 1-800-462-0224, or see our Web site at www.tuftshealthplan.com.
MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

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

This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.

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

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

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

**Liability Recovery**
Call the TUFTS HEALTH PLAN Liability and Recovery Department at 1-888-880-8699, x. 1098 for questions about coordination of benefits and workers' compensation. For example, call the Liability and Recovery Department if you have any questions about how TUFTS HEALTH PLAN coordinates coverage with other health care coverage that you may have. The Liability and Recovery Department is available from 8:30 a.m. - 5:00 p.m. Monday through Thursday, and 10:00 a.m. - 5:00 p.m. on Friday.

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

**Member Services Department**
Call the TUFTS HEALTH PLAN Member Services Department at 1-800-462-0224 for general questions, assistance in choosing a PRIMARY CARE PROVIDER (PCP), benefit questions, and information regarding eligibility for enrollment and billing.

**Mental Health Services**
If you need assistance in receiving information regarding mental health benefits, please contact the Mental Health Department at 1-800-208-9565.

**Services for Hearing Impaired MEMBERS**
If you are hearing impaired, the following services are provided:

**Telecommunications Device for the Deaf (TDD)**
If you have access to a TDD phone, call 1-800-868-5850. You will reach our Member Services Department.

**Massachusetts Relay (MassRelay)**
1-800-720-3480

**IMPORTANT ADDRESSES:**

**Appeals and Grievances Department**
If you need to call us about a concern or appeal, contact a Member Specialist at 1-800-462-0224. To submit your appeal or grievance in writing, send your letter to:

TUFTS HEALTH PLAN
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown MA 02471-9193

**Web site**
For more information about TUFTS HEALTH PLAN and to learn more about the self-service options that are available to you, please see the TUFTS HEALTH PLAN Web site at www.tuftshealthplan.com.
Translating services for 140 languages

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

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

Capitalized words are defined in Appendix A.
Overview
Welcome to TUFTS HEALTH PLAN. We are pleased you have chosen us. We look forward to working with you to help you meet your health care needs. We are a health maintenance organization which arranges for your health care through a network of health care professionals and hospitals. When you join TUFTS HEALTH PLAN, you will need to choose a PRIMARY CARE PROVIDER (PCP) to manage your care. Your PCP is a physician or nurse practitioner in private practice who personally cares for your health needs, and if the need arises, refers you to a specialist within our network.

This book will help you find answers to your questions about TUFTS HEALTH PLAN benefits. Capitalized words are defined in the Glossary in Appendix A.

Your satisfaction with TUFTS HEALTH PLAN is important to us. If at any time you have questions, please call a Member Specialist and we will be happy to help you.

Tufts Associated Health Maintenance Organization, Inc. is licensed as a health maintenance organization in Massachusetts, but does business under the name TUFTS HEALTH PLAN.

Eligibility for Benefits
When you join TUFTS HEALTH PLAN, you agree to receive your care from TUFTS HEALTH PLAN PROVIDERS. We cover only the services and supplies described as COVERED SERVICES in Chapter 3. There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your EFFECTIVE DATE.

IMPORTANT NOTE FOR MEMBERS IN GROUP CONTRACTS ONLY:
If you live in Rhode Island or New Hampshire, your benefits under this plan also include benefits required under applicable Rhode Island or New Hampshire law. For more information, please call Member Services.

Calls to Member Services
The Member Services Department is committed to excellent service. Calls to our Member Services Department may, on occasion, be monitored to assure quality service.

Capitalized words are defined in Appendix A.

To contact Member Services, call 1-800-462-0224, or see our Web site at www.tuftshealthplan.com.
Chapter 3 - COVERED SERVICES

Covered Services...

Emergency care...

Outpatient care...

Auscultation disorders – diagnosis and treatment...

Chiropractic care...

Diabetes self-management training and educational services...

Early intervention services for a dependent child...

Family planning...

Hemodialysis...

Infertility services...

Maternity care...

Oral health services...

Outpatient medical care...

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

Preventive health care for members under age 6...

Preventive health care for members age 6 and older...

Routine annual gynecological exam...

Short term physical and occupational therapy services...

Spinal manipulation...

Vision care services...

Day surgery...

Inpatient care...

Acute hospital services...

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

Extended care...

Maternity care...

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

Reconstructive surgery and procedures...

Mental health and substance abuse services (outpatient, inpatient, and intermediate)...

Outpatient mental health and substance abuse services for mental disorders...

Inpatient and intermediate mental health and substance abuse services for mental disorders...

Other Health Services...

Ambulance services...

Durable medical equipment...

Home health care...

Hospice care services...

Injectable, infused, or inhaled medications...

To contact Member Services, call 1-800-462-0224, or see our website at www.tuftshealthplan.com.
Benefit Overview

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

### COPAYMENTS

**EMERGENCY Care:**
- **EMERGENCY room**: $75.00 COPAYMENT applies per visit.
- **In PROVIDER's office**: $25.00 COPAYMENT applies per visit.

**Note:**
- An EMERGENCY Room COPAYMENT may apply if you register in an EMERGENCY room but leave that facility without receiving care.
- A DAY SURGERY COPAYMENT may apply if DAY SURGERY services are received.

**Other COVERED SERVICES**
- **Office Visits**: $25.00 COPAYMENT applies per visit.
- **INPATIENT Services**: $600.00 COPAYMENT applies per admission.
- **DAY SURGERY**: $600.00 COPAYMENT applies per admission.

### INPATIENT AND DAY SURGERY COPAYMENT MAXIMUM COPAY

- **COPAYMENT Maximum per MEMBER**: $2,400.00

Most of the services listed in the table below are subject to an INPATIENT or DAY SURGERY COPAYMENT. You are responsible to pay an INPATIENT or DAY SURGERY COPAYMENT up to your $2,400.00 INPATIENT and DAY SURGERY COPAYMENT Maximum per CALENDAR YEAR.

The $2,400.00 INPATIENT and DAY SURGERY COPAYMENT Maximum is the most money you will have to pay for INPATIENT COVERED SERVICES or DAY SURGERY in a CALENDAR YEAR. The $2,400.00 INPATIENT and DAY SURGERY COPAYMENT Maximum consists of INPATIENT and DAY SURGERY COPAYMENTS only. It does not include COPAYMENTS for OUTPATIENT services (such as office visits) or EMERGENCY room COPAYMENTS. It also does not include payments you make for non-COVERED SERVICES. When the COPAYMENT Maximum is reached, no more INPATIENT or DAY SURGERY COPAYMENTS will be taken in that CALENDAR YEAR.

All INPATIENT and DAY SURGERY COPAYMENTS paid by individual family MEMBERS will contribute to the family COPAYMENT Maximum. The family COPAYMENT Maximum is two times the $2,400.00 individual COPAYMENT Maximum per CALENDAR YEAR. When the family COPAYMENT Maximum is reached, all MEMBERS in that family will have met their individual COPAYMENT Maximum for that CALENDAR YEAR.

---

Important Note about your coverage under the Patient Protection and Affordable Care Act ("PPACA"): Under PPACA, preventive care services are now covered in full as of this plan's ANNIVERSARY DATE on or after September 23rd, 2010. These services are listed in the following Benefit Overview. For more information on what services are now covered in full, please see our Web site at http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf.
**Benefit Overview, continued**

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

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EMERGENCY Care</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment in an EMERGENCY room</td>
<td>$75.00 COPAYMENT per visit. (waived if admitted as an INPATIENT) Note: Observation services will take an EMERGENCY Room COPAYMENT.</td>
</tr>
<tr>
<td>Treatment in a PROVIDER's office</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
</tbody>
</table>

You should call TUFTS HEALTH PLAN within 48 hours after EMERGENCY care is received. If you are admitted as an INPATIENT, you or someone acting for you must call your PCP or TUFTS HEALTH PLAN within 48 hours. Note: A DAY SURGERY COPAYMENT may apply if DAY SURGERY services are rendered.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTPATIENT CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Autism spectrum disorders - diagnosis and treatment (AR)</td>
<td>Habilitative or rehabilitative care (including applied behavioral analysis): When provided by a PARAPROFESSIONAL: $25.00 COPAYMENT per visit. When provided by a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA): $25.00 COPAYMENT per visit. Prescription medications: Covered as described under &quot;Prescription Drug Benefit&quot; in Chapter 3. Therapeutic care: Covered as described under &quot;Therapy for speech, hearing and language disorders&quot; and &quot;Short term physical and occupational therapy services&quot;.</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>See &quot;Spinal manipulation&quot;.</td>
</tr>
<tr>
<td>Diabetes self-management training and educational service</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>Early intervention services</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>Family planning (procedures, services and contraceptives)</td>
<td><strong>Office Visit:</strong> $25.00 COPAYMENT per visit <strong>DAY SURGERY:</strong> $600.00 COPAYMENT (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM)</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>Infertility services (AR)</td>
<td>$25.00 per visit.</td>
</tr>
</tbody>
</table>

(AR) - These services may require approval by an AUTHORIZED REVIEWER.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Capitalized words are defined in Appendix A.
**Benefit Overview, continued**

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

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity care</td>
<td>$25.00 per visit.</td>
</tr>
<tr>
<td>Note: PROVIDERS may collect COPAYMENTS in a variety of ways for this coverage (for example at the time of your first visit, at the end of your pregnancy or in installments). Please check with your PROVIDER. Please note that laboratory tests associated with routine prenatal care are covered in full, in accordance with ACA.</td>
<td></td>
</tr>
<tr>
<td>Note: This Office Visit COPAYMENT will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.</td>
<td></td>
</tr>
</tbody>
</table>

**Oral health services (AR)**

<table>
<thead>
<tr>
<th></th>
<th>Office Visit:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td><strong>EMERGENCY room:</strong></td>
<td>$75.00 COPAYMENT per visit.</td>
</tr>
<tr>
<td><strong>INPATIENT SERVICES:</strong></td>
<td>$600.00 COPAYMENT</td>
</tr>
<tr>
<td><strong>DAY SURGERY:</strong></td>
<td>$600.00 COPAYMENT (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM)</td>
</tr>
<tr>
<td>*Note: This COPAYMENT also applies for COVERED DAY SURGERY SERVICES at a free standing facility.</td>
<td></td>
</tr>
</tbody>
</table>

**OUTPATIENT medical care**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Injections</td>
<td>$5.00 per injection.</td>
</tr>
<tr>
<td>Allergy testing and treatment</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Cytology examinations (Pap Smears)</td>
<td><strong>Routine annual cytology screenings:</strong> Covered in full.</td>
</tr>
<tr>
<td></td>
<td><strong>Diagnostic cytology examinations:</strong> Covered in full</td>
</tr>
</tbody>
</table>

(AR) - These services may require approval by an AUTHORIZED REVIEWER.

(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Capitalized words are defined in Appendix A.
## Benefit Overview, continued

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

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>YOUR COST</th>
</tr>
</thead>
</table>
| Diagnostic Imaging (AR) | General imaging:
- General imaging (such as x-rays and ultrasounds); and
- MRI / MRA, CT/CTA, PET and nuclear cardiology. |
|                   | MRI/MRA: $125.00 COPAYMENT. |
|                   | CT/CTA: $125.00 COPAYMENT. |
|                   | PET: $125.00 COPAYMENT. |
|                   | Nuclear cardiology: $125.00 COPAYMENT. |
|                   | **Note:** Diagnostic imaging, except for general imaging, will be covered in full when the imaging is required as part of an active treatment plan for a cancer diagnosis. |

| Diagnostic or preventive screening procedures (AR) | Preventive screening procedure only: Covered in full. |
| For example, endoscopies, proctosigmoidoscopies, colonoscopies and sigmoidoscopies are covered under this benefit. |
| Diagnostic screening procedure only: Covered in full. |
| Diagnostic or preventive screening procedure accompanied by treatment/surgery (for example, polyp removal)*: $600.00 |
| *Note: This COPAYMENT also applies for COVERED DAY SURGERY SERVICES at a free standing facility. |

<table>
<thead>
<tr>
<th>Human leukocyte antigen (HLA) testing</th>
<th>Covered in full</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Routine preventive immunizations: Covered in full.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All other immunizations: Covered in full.</td>
</tr>
</tbody>
</table>

| Laboratory tests (AR) | Covered in full |
| Note: In compliance with ACA, laboratory tests performed as part of preventive care are covered in full. |

<table>
<thead>
<tr>
<th>Lead screenings</th>
<th>Covered in full</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mammograms</th>
<th>Routine mammograms: Covered in full.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diagnostic mammograms: Covered in full.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiation therapy</th>
<th>Covered in full</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Respiratory therapy and pulmonary rehabilitation services</th>
<th>Covered in full</th>
</tr>
</thead>
</table>

(AR) - These services may require approval by an AUTHORIZED REVIEWER.
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Capitalized words are defined in Appendix A.

To contact Member Services, call 1-800-462-0224, or see our Web site at [www.tuftshealthplan.com](http://www.tuftshealthplan.com).
**Benefit Overview, continued**

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

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy for speech, hearing and language disorders (AR)</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>Office visits to diagnose and treat illness and injury</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>OUTPATIENT surgery in a PROVIDER's office</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>Patient care services provided as part of a qualified clinical trial (for treatment of cancer)</td>
<td>$25.00 COPAYMENT per visit</td>
</tr>
<tr>
<td>Preventive health care for MEMBERS under age 6</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Note:</strong> Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS.</td>
<td></td>
</tr>
<tr>
<td>Preventive health care for MEMBERS age 6 and older</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Note:</strong> Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to COST SHARING AMOUNTS.</td>
<td></td>
</tr>
<tr>
<td>Routine annual gynecological exams</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Note:</strong> Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine annual gynecological exam is subject to COST SHARING AMOUNTS.</td>
<td></td>
</tr>
<tr>
<td>Short term physical and occupational therapy services (AR) (BL)</td>
<td>$25.00 COPAYMENT</td>
</tr>
<tr>
<td><strong>Note:</strong> Visits limits do not apply to the treatment of autism spectrum disorders.</td>
<td></td>
</tr>
<tr>
<td>Spinal manipulation (BL)</td>
<td>$25.00 COPAYMENT</td>
</tr>
</tbody>
</table>

(AR) - These services may require approval by an AUTHORIZED REVIEWER.  
(BL) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

**Capitalized words are defined in Appendix A.**
Benefit Overview, continued

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

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision care services</td>
<td></td>
</tr>
<tr>
<td>Routine eye examination (BL)</td>
<td>$25.00 COPAYMENT per visit.</td>
</tr>
<tr>
<td>Other vision care services</td>
<td>$25.00 COPAYMENT per visit.</td>
</tr>
<tr>
<td><strong>DAY SURGERY</strong></td>
<td></td>
</tr>
<tr>
<td>DAY SURGERY</td>
<td>$600.00 COPAYMENT</td>
</tr>
<tr>
<td>(subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM)</td>
<td></td>
</tr>
<tr>
<td>*Note: This COPAYMENT also applies for COVERED DAY SURGERY SERVICES at a free standing facility.</td>
<td></td>
</tr>
</tbody>
</table>

| **INPATIENT CARE**                    |                                                                           |
| Acute hospital services (AR)          | $600.00 COPAYMENT per admission.                                          |
| (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM) |                                   |
| Bone marrow transplants for breast cancer, hematopoietic stem cell transplants and human solid organ transplants (AR) | $600.00 COPAYMENT per admission.                                          |
| (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM) |                                   |
| Extended Care (AR) (BL)               | Covered in full.                                                          |
| Maternity care                        | $600.00 COPAYMENT per admission.                                          |
| (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM) |                                   |
| Patient care services provided as part of a qualified clinical trial (for treatment of cancer) | $600.00 COPAYMENT per admission.                                          |
| (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM) |                                   |
| Reconstructive surgery and procedures (AR) | $600.00 COPAYMENT per admission.                                          |
| (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM) |                                   |

**Mental Health and Substance Abuse Services**

To contact the TUFTS HEALTH PLAN Mental Health Department, call 1-800-208-9565.
(See "Benefit Limits" and Chapter 3 for visit, day and dollar limits.)

| OUTPATIENT services (AR) (BL)         | $25.00 COPAYMENT per visit.                                               |
| Intermediate care (AR) (BL)           | Covered in full                                                           |
| INPATIENT services (AR) (BL)          | $600.00 per admission.                                                    |
| (subject to the INPATIENT and DAY SURGERY COPAYMENT MAXIMUM) |                                   |

(A) - These services may require approval by an AUTHORIZED REVIEWER.
(B) - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

**Capitalized words are defined in Appendix A.**

To contact Member Services, call 1-800-462-0224, or see our Web site at [www.tuftshealthplan.com](http://www.tuftshealthplan.com).
**Benefit Overview, continued**

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

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>YOUR COST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulance services <em>(AR)</em></td>
<td>Covered in full</td>
</tr>
<tr>
<td><em><em>DURABLE MEDICAL EQUIPMENT</em>(AR)</em>**</td>
<td>MEMBER pays 30% COINSURANCE</td>
</tr>
<tr>
<td>Home health care <em>(AR)</em></td>
<td>Covered in full</td>
</tr>
<tr>
<td>Hospice care services <em>(AR)</em></td>
<td>Covered in full</td>
</tr>
<tr>
<td>Injectable, infused, or inhaled medications <em>(AR)</em></td>
<td>Covered in full</td>
</tr>
<tr>
<td>Low protein foods</td>
<td>MEMBER pays 30% COINSURANCE</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Nonprescription Enteral Formulas <em>(AR)</em></td>
<td>Covered in full</td>
</tr>
<tr>
<td>Prosthetic devices <em>(AR)</em></td>
<td>MEMBER pays 20% COINSURANCE</td>
</tr>
<tr>
<td>Scalp hair prostheses or wigs for cancer or leukemia patients <em>(BL)</em></td>
<td>Covered in full</td>
</tr>
<tr>
<td>Special Medical Formulas <em>(AR)</em></td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Prescription Drug Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>For information about your COPAYMENTS and/or COINSURANCE for covered prescription drugs, see the &quot;Prescription Drug Benefit&quot; section in Chapter 3.</td>
<td></td>
</tr>
</tbody>
</table>

**TUFTS HEALTH PLAN MEMBER Discounts**

For information on how you can take advantage of discounts on a variety of health products, services, and treatments, such as acupuncture, massage therapy, and wellness programs, see “TUFTS HEALTH PLAN MEMBER Discounts” in Chapter 3.

*(AR)* - These services may require approval by an AUTHORIZED REVIEWER.
*(BL)* - Benefit Limit applies. See "COVERED SERVICES" in Chapter 3 for more information.

Capitalized words are defined in Appendix A.
Capitalized words are defined in Appendix A.

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

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

Mental Health INPATIENT Services
In a general hospital, a mental health hospital, or a substance abuse facility, the maximum benefit payable in each CALENDAR YEAR is 60 days.* See Chapter 1 for information on our DESIGNATED FACILITY PROGRAM.

*With respect to Intermediate Mental Health Care Services described in Chapter 3:

- Two mental health day treatment/partial hospital days count as one of the 60 INPATIENT days you get per CALENDAR YEAR.

Important Note: This benefit limit does not apply to INPATIENT diagnosis and treatment of BIOLOGICALLY BASED MENTAL DISORDERS (as defined by Massachusetts law); Certain Mental, behavioral or emotional Disorders for CHILDREN under the age of 19; and Rape-related Mental or emotional Disorders. (See Chapter 3 for more information.)

Mental Health OUTPATIENT Services
There is no visit limit for OUTPATIENT mental health care services for BIOLOGICALLY BASED MENTAL DISORDERS (as defined by Massachusetts law); Certain Mental, behavioral or emotional Disorders for CHILDREN under age 19; or Rape related Mental or emotional Disorders.

OUTPATIENT mental health care services for all other MENTAL DISORDERS are covered up to 24 visits per CALENDAR YEAR.

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of $350 per CALENDAR YEAR.

Short-term occupational therapy
Short term occupational therapy services covered up to 30 visits per CALENDAR YEAR.

Short-term physical therapy
Short term physical therapy services covered up to 30 visits per CALENDAR YEAR.

Spinal Manipulation
Covered up to 12 visits per CALENDAR YEAR Note: Spinal manipulation services are not covered for MEMBERS age 12 and under.

Vision Care Services
Coverage is provided for one routine eye examination every 24 months (no PCP referral required).
Chapter 1 - How Your HMO Plan Works

How the Plan Works

PRIMARY CARE PROVIDERS

Each MEMBER must choose a PRIMARY CARE PROVIDER (PCP). The PCP is responsible for providing or authorizing all of your health care services. If you do not choose a PCP, we will not pay for any services or supplies except for EMERGENCY care.

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

MEDICALLY NECESSARY COVERED SERVICES and supplies

We will pay for COVERED SERVICES and supplies when they are MEDICALLY NECESSARY. For more information about your MEMBER costs for medical services, see "Benefit Overview" at the front of this EVIDENCE OF COVERAGE.

SERVICE AREA (see Appendix A)

In most cases, you must receive your care in the TUFTS HEALTH PLAN SERVICE AREA. Please note that the SERVICE AREA, which is defined in Appendix A, includes both the Standard and Extended SERVICE AREA. The exceptions are for an EMERGENCY, or URGENT CARE while traveling outside of the SERVICE AREA. See the TUFTS HEALTH PLAN DIRECTORY OF HEALTH CARE PROVIDERS for TUFTS HEALTH PLAN's SERVICE AREA.

In the rare event that a service cannot be provided by a TUFTS HEALTH PLAN PROVIDER in either the Standard or Extended SERVICE AREA, please call a Member Specialist for assistance or visit our Web site at www.tuftshealthplan.com.

PROVIDER network

Under TUFTS HEALTH PLAN's HMO Select plans, we offer MEMBERS access to a select network of physicians, hospitals, and other PROVIDERS in the SERVICE AREA. Under all other HMO options, we offer MEMBERS access to an extensive network of physicians, hospitals, and other PROVIDERS throughout the SERVICE AREA.

Changes to our PROVIDER network

Although we work to ensure the continued availability of our PROVIDERS, our network of PROVIDERS may change during the year.

This can happen for many reasons, including a PROVIDER's retirement, moving out of the SERVICE AREA, or failure to continue to meet our credentialing standards. In addition, because PROVIDERS are independent contractors who do not work for TUFTS HEALTH PLAN, this can also happen if TUFTS HEALTH PLAN and the PROVIDER are unable to reach agreement on a contract.

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

Coverage

<table>
<thead>
<tr>
<th>If you....</th>
<th>AND you are....</th>
<th>THEN....</th>
</tr>
</thead>
<tbody>
<tr>
<td>receive routine health care services, visit a specialist, or receive covered elective procedures</td>
<td>in the Standard or Extended SERVICE AREA</td>
<td>you are covered, if you receive care through your PCP, or with PCP referral</td>
</tr>
<tr>
<td></td>
<td>outside the Standard or Extended SERVICE AREA</td>
<td>you are not covered.</td>
</tr>
<tr>
<td>are ill or injured</td>
<td>in the Standard or Extended SERVICE AREA</td>
<td>you are covered. Contact your PCP first.</td>
</tr>
<tr>
<td></td>
<td>outside the Standard or Extended SERVICE AREA</td>
<td>you are covered for URGENT CARE.</td>
</tr>
<tr>
<td>have an EMERGENCY</td>
<td>in the Standard or Extended SERVICE AREA</td>
<td>you are covered.</td>
</tr>
<tr>
<td></td>
<td>outside the Standard or Extended SERVICE AREA</td>
<td>you are covered.</td>
</tr>
</tbody>
</table>

Capitalized words are defined in Appendix A.
Coverage, continued

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

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

EMERGENCY Care and URGENT CARE

EMERGENCY Care

Definition of EMERGENCY: See Appendix A.

Follow these guidelines for receiving EMERGENCY care

- If needed, call 911 for EMERGENCY medical assistance. If 911 services are not available in your area, call the local number for EMERGENCY medical services.
- Go to the nearest EMERGENCY medical facility.
- You do not need approval from your PCP before receiving EMERGENCY care.
- If you receive OUTPATIENT EMERGENCY care at an EMERGENCY facility, you or someone acting for you should call your PCP or TUFTS HEALTH PLAN within 48 hours after receiving care. You are encouraged to contact your PRIMARY CARE PROVIDER so your PCP can provide or arrange for any follow-up care that you may need.
- If you receive EMERGENCY COVERED SERVICES from a non-TUFTS HEALTH PLAN PROVIDER, we will pay up to the REASONABLE CHARGE. You pay the applicable COST SHARING AMOUNT.

URGENT CARE

Definition of URGENT CARE: See Appendix A

Follow these guidelines for receiving URGENT CARE

If you are in the Standard or Extended SERVICE AREA

Contact your PCP first. You may seek URGENT CARE in your PCP’s office, in an EMERGENCY room, or at an URGENT CARE center affiliated with TUFTS HEALTH PLAN.

If you are outside the Standard or Extended SERVICE AREA

- You may seek URGENT CARE in a PROVIDER’s office, an URGENT CARE center, or the EMERGENCY room.
- You do not need the approval of your PCP before receiving URGENT CARE.

Important notes about EMERGENCY Care and URGENT CARE

- If you are admitted as an INPATIENT after receiving EMERGENCY or URGENT CARE COVERED SERVICES, you or someone acting for you must call your PCP or TUFTS HEALTH PLAN within 48 hours after receiving care. (Notification from the attending PROVIDER satisfies this requirement.)
- If you receive URGENT CARE outside of the SERVICE AREA, you or someone acting for you must contact your PCP to arrange for any necessary follow-up care.
- EMERGENCY or URGENT CARE services are covered, whenever you need it, anywhere in the world. Continued services after the EMERGENCY or Urgent condition has been treated and stabilized may not be covered if we determine, in coordination with the MEMBER's PROVIDER, that the MEMBER is safe for transport back into the SERVICE AREA and it is appropriate and cost-effective to transport the MEMBER back into the SERVICE AREA.
- If you receive care outside the Standard or Extended SERVICE AREA, the EMERGENCY or URGENT CARE PROVIDER may bill TUFTS HEALTH PLAN directly or may require you to pay at the time of service. If you are required to pay, we will reimburse you up to the REASONABLE CHARGE for EMERGENCY or URGENT CARE services received outside of the SERVICE AREA. You are responsible for the applicable COST SHARING AMOUNT. Please see "Bills from PROVIDERS" in Chapter 6 for more information about how to get reimbursed for EMERGENCY or URGENT CARE COVERED SERVICES received outside of the SERVICE AREA.
INPATIENT Hospital Services

- If you need INPATIENT services, in most cases, you will be admitted to your PCP’s TUFTS HEALTH PLAN HOSPITAL.
- Charges after the discharge hour: If you choose to stay as an INPATIENT after a TUFTS HEALTH PLAN PROVIDER has scheduled your discharge or determined that further INPATIENT services are no longer MEDICALLY NECESSARY, we will not pay for any costs incurred after that time.
- If you are admitted to a facility which is not the TUFTS HEALTH PLAN HOSPITAL in your PCPs PROVIDER ORGANIZATION, and your PCP determines that transfer is appropriate, you will be transferred to the TUFTS HEALTH PLAN HOSPITAL in your PCP’s PROVIDER ORGANIZATION or another TUFTS HEALTH PLAN HOSPITAL. Important: We may not pay for INPATIENT care provided in the facility to which you were first admitted after your PCP has decided that a transfer is appropriate and transfer arrangements have been made.

Mental Health/Substance Abuse Services

INPATIENT and intermediate mental health/substance abuse services

For INPATIENT and intermediate mental health/substance abuse services, each MEMBER may be assigned to a DESIGNATED FACILITY or another INPATIENT facility. Assignment is based on each MEMBER's age (adult or CHILD), as well as the PROVIDER ORGANIZATION affiliation of that MEMBER's PCP.

- If you live in an area where TUFTS HEALTH PLAN's DESIGNATED FACILITIES are available, you will be assigned to one. In this case, the following will apply:
  - You must call your DESIGNATED FACILITY to receive INPATIENT/intermediate mental health/substance abuse services. Call a TUFTS HEALTH PLAN Mental Health Service Coordinator at 1-800-208-9565 for the name and telephone number of your DESIGNATED FACILITY.
  - Your DESIGNATED FACILITY will provide or authorize such services for you.
  - If you are admitted to a facility which is not your DESIGNATED FACILITY, and the DESIGNATED FACILITY decided that transfer is appropriate, you will be transferred to your DESIGNATED FACILITY or another PROVIDER as authorized by the DESIGNATED FACILITY.

Important Notes:

- We will not pay for INPATIENT care provided in the facility to which you were first admitted after your DESIGNATED FACILITY has decided that a transfer is appropriate and transfer arrangements have been made.
- If you choose to stay as an INPATIENT after your DESIGNATED FACILITY has scheduled your discharge or determined that further INPATIENT services are no longer MEDICALLY NECESSARY, we will not pay for any costs incurred after that time.

- If you are not assigned to a DESIGNATED FACILITY, you must call the Mental Health Department at TUFTS HEALTH PLAN at 1-800-208-9565 for information on where you may receive INPATIENT/intermediate mental health/substance abuse services at a TUFTS HEALTH PLAN facility.

OUTPATIENT mental health/substance abuse services

Your mental health and substance abuse PROVIDER will obtain the necessary authorization for OUTPATIENT mental health/substance abuse services by calling TUFTS HEALTH PLAN's OUTPATIENT Mental Health/Substance Abuse Program at 1-800-208-9565. You or your PCP may also call TUFTS HEALTH PLAN's Mental Health/Substance Abuse Program for authorization.
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 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, we will provide you notice at least 30 days in advance. If the disenrollment is for reasons other than quality or fraud, you may continue to see your PCP for up to 30 days after the disenrollment.

To choose a new PCP, call a Member Specialist. The Member Specialist will help you to select one from the TUFTS HEALTH PLAN DIRECTORY OF HEALTH CARE PROVIDERS. You can also visit the TUFTS HEALTH PLAN Web site at www.tuftshealthplan.com to choose a PCP.

If you are enrolling as a new MEMBER

- When you enroll as a MEMBER, if none of the health plans offered by the GROUP at that time include your PROVIDER you are undergoing a course of treatment. In this instance, you may continue to see your PROVIDER for up to 30 days from your EFFECTIVE DATE.
- the PROVIDER is your PCP. In this instance, you may continue to see your PCP for up to 30 days from your EFFECTIVE DATE;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your PROVIDER through your first postpartum visit;
- you are terminally ill. In this instance, you may continue to see your PROVIDER as long as necessary.

Conditions for coverage of continued treatment

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

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

Importance of choosing a PCP
Each MEMBER must choose a PCP when he or she enrolls. The PCP you choose will be associated with a specific TUFTS HEALTH PLAN PROVIDER ORGANIZATION. This means that you will usually receive COVERED SERVICES from health care professionals and facilities associated with that TUFTS HEALTH PLAN PROVIDER ORGANIZATION.

Once you have chosen a PCP, you are eligible for all COVERED SERVICES.

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

What a PCP does
A PCP provides routine health care (including routine physical examinations), arranges for your care with other TUFTS HEALTH PLAN PROVIDERS, and provides referrals for other health care services, except for mental health and substance abuse services. See "INPATIENT mental health/substance abuse services" and "OUTPATIENT mental health/substance abuse services" later in this chapter for more information about obtaining referrals for these services.

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

Choosing a PCP
You must choose a PCP from the list of PCPS in our DIRECTORY OF HEALTH CARE PROVIDERS. If you already have a PROVIDER who is listed as a PCP, in most instances you may choose him or her as your PCP. Once you have chosen a PCP who is part of our network, you must inform us of your choice in order to be eligible for all COVERED SERVICES.

If you do not have a PCP or your PCP is not listed in our DIRECTORY OF HEALTH CARE PROVIDERS, call a Member Specialist for help in choosing a PCP.

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

Contacting your new PCP
If you have chosen a new PROVIDER as your PCP, you should:
- contact your new PCP as soon as you join and identify yourself as a new TUFTS HEALTH PLAN MEMBER,
- ask your previous PROVIDER to transfer your medical records to your new PCP, and
- make an appointment for a check-up or to meet your PCP.

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

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

Note: If you are experiencing a medical EMERGENCY, you do not have to contact your PCP or a COVERING PROVIDER; instead, proceed to the nearest EMERGENCY medical facility for treatment (see "EMERGENCY Care and URGENT CARE" below for more information).
About Your PRIMARY CARE PROVIDER, continued

Changing your PCP

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

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

Note: You may not change your PCP while you are an INPATIENT or in a partial hospitalization program, except when approved by TUFTS HEALTH PLAN in limited circumstances.

Canceling appointments

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

Referrals for specialty services

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

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

If you require specialty care which is not available through any TUFTS HEALTH PLAN PROVIDER (this is a rare event), your PCP may refer you, with the prior approval of an AUTHORIZED REVIEWER, to a PROVIDER not associated with TUFTS HEALTH PLAN. TUFTS HEALTH 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 COINSURANCE or COPAYMENT).

Notes:

- A referral to a specialist must be obtained from your PCP before you receive any COVERED SERVICES from that specialist. If you do not obtain a referral prior to receiving services, you will be responsible for the cost of those services.
- COVERED SERVICES provided by non-TUFTS HEALTH PLAN PROVIDERS are not paid for unless authorized in advance by your PCP and approved by an AUTHORIZED REVIEWER.
- For mental health and substance abuse services, you do not need a referral from your PCP; however, you may need authorization from a TUFTS HEALTH PLAN Mental Health AUTHORIZED REVIEWER. See "INPATIENT and intermediate mental health/substance abuse services" and "OUTPATIENT mental health/substance abuse services" later in this chapter for more information.

Capitalized words are defined in Appendix A.
Referral forms for specialty services

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

AUTHORIZED REVIEWER approval

If the specialist refers you to a non-TUFTS HEALTH PLAN PROVIDER, the referral must be approved by your PCP and an AUTHORIZED REVIEWER. In addition, certain COVERED SERVICES described in Chapter 3 must be authorized in advance by an AUTHORIZED REVIEWER, or, for mental health and substance abuse services, from a TUFTS HEALTH PLAN Mental Health AUTHORIZED REVIEWER. If you do not obtain that authorization, we will not cover those services and supplies.

When referrals are not required

The following COVERED SERVICES do not require a referral or prior authorization from your PRIMARY CARE PROVIDER. Except as detailed earlier in this chapter, or for URGENT CARE outside of our SERVICE AREA, or for EMERGENCY care, you must obtain these services from a TUFTS HEALTH PLAN PROVIDER:

- EMERGENCY care in an EMERGENCY room or PROVIDER's office. (Note: If you are admitted as an INPATIENT, you or someone acting for you must call your PCP or TUFTS HEALTH PLAN within 48 hours after receiving care. Notification from the attending PROVIDER satisfies this requirement.)
- URGENT CARE outside of our SERVICE AREA (Note: You must contact your PCP after URGENT CARE COVERED SERVICES are rendered for any follow-up care.)
- Mammography screenings at the following intervals:
  - one baseline at 35-39 years of age;
  - one every year at age 40 and older; or
  - as otherwise MEDICALLY NECESSARY.
- pregnancy terminations.
- Routine eye exams.
- Spinal manipulation.
- Medical treatment provided by an optometrist.
- Care in a limited service medical clinic, if available.
- The following specialty care provided by a TUFTS HEALTH PLAN PROVIDER who is an obstetrician, gynecologist, certified nurse midwife or family practitioner:
  - Maternity Care.
  - MEDICALLY NECESSARY evaluations and related health care services for acute or EMERGENCY gynecological conditions.
- Routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be MEDICALLY NECESSARY as a result of that exam.
Financial Arrangements between TUFTS HEALTH PLAN and TUFTS HEALTH PLAN PROVIDERS

Methods of payment to TUFTS HEALTH PLAN PROVIDERS

Our goal in compensation of PROVIDERS is to encourage preventive care and active management of illnesses. We strive to be sure that the financial reimbursement system we use encourages appropriate access to care and rewards PROVIDERS for providing high quality care to our MEMBERS. We use a variety of mutually agreed upon methods to compensate TUFTS HEALTH PLAN PROVIDERS.

The TUFTS HEALTH PLAN DIRECTORY OF HEALTH CARE PROVIDERS indicates the method of payment for each PROVIDER. Regardless of the method of payment, we expect all participating PROVIDERS to use sound medical judgment when providing care 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.

We review the quality of care provided to our MEMBERS through its Quality of Health Care Program. You should feel free to discuss with your PROVIDER specific questions about how he or she is paid.

MEMBER Identification Card

Introduction

TUFTS HEALTH PLAN gives each MEMBER a MEMBER identification card (MEMBER ID card).

Reporting errors

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

Identifying yourself as a TUFTS HEALTH PLAN MEMBER

Your MEMBER ID card is important because it identifies you as a TUFTS HEALTH PLAN MEMBER. Please:

● carry your MEMBER ID card at all times;
● have your MEMBER ID card with you for medical, hospital and other appointments; and
● show your MEMBER ID card to any PROVIDER before you receive health care services.

When you receive services, you must tell the office staff that you are a TUFTS HEALTH PLAN MEMBER.

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

● we may not pay for the services provided; and
● you would be responsible for the costs.

Membership requirement

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

Membership identification number

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

TUFTS HEALTH PLAN has a utilization management program. The purpose of the program is to control health care costs by evaluating whether health care services provided to MEMBERS are MEDICALLY NECESSARY and provided in the most appropriate and efficient manner. Under this program, we sometimes engage in prospective, concurrent, and retrospective review of health care services.

We use prospective review to determine whether proposed treatment is MEDICALLY NECESSARY before that treatment begins. It is also referred to as "pre-service review".

We engage in concurrent review to monitor the course of treatment as it occurs and to determine when that treatment is no longer MEDICALLY NECESSARY.

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, we engage in retrospective review to more accurately determine the appropriateness of health care services provided to MEMBERS. Retrospective review is also referred to as "post-service review".

### TIMEFRAMES FOR TUFTS HEALTH PLAN TO REVIEW YOUR REQUEST FOR COVERAGE

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Timeframe for Determinations*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective (Pre-service) review</td>
<td>Within 2 working days of receiving all necessary information but no later than 15 days from receipt of the request.</td>
</tr>
<tr>
<td>Concurrent review</td>
<td>Within 1 working day of receiving all necessary information.</td>
</tr>
<tr>
<td>Retrospective (Post-service) review</td>
<td>30 days</td>
</tr>
</tbody>
</table>

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

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

We make coverage determinations. You and your PROVIDER make all treatment decisions.

**IMPORTANT NOTE:** MEMBERS can call TUFTS HEALTH PLAN at the following numbers to determine the status or outcome of utilization review decisions:

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

Specialty case management

Some MEMBERS with Severe Illnesses or Injuries may warrant case management intervention under our specialty case management program. Under this program:

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

We may contact that MEMBER and his or her TUFTS HEALTH PLAN PROVIDER to discuss a treatment plan and establish short and long term goals. The TUFTS HEALTH PLAN Specialty Case Manager may suggest alternative treatment settings available to the MEMBER.

We may periodically review the MEMBER's treatment plan. We will contact the MEMBER and the MEMBER's TUFTS HEALTH PLAN PROVIDER if we identify alternatives to the MEMBER's current treatment plan that qualify as COVERED SERVICES, are cost effective, and are appropriate for the MEMBER.

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

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

Individual case management (ICM)

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

As a part of the ICM plan, we may authorize coverage for alternative services and supplies that do not otherwise constitute COVERED SERVICES for that MEMBER. This will occur only if we determine, in its sole discretion, that all of the following conditions are satisfied:

- the MEMBER's condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are MEDICALLY NECESSARY;
- the alternative services and supplies are provided directly to the MEMBER with the condition;
- the alternative services and supplies are in place of more expensive treatment that qualifies as COVERED SERVICES;
- the MEMBER and an AUTHORIZED REVIEWER agree to the alternative treatment program; and
- the MEMBER continues to show improvement in his or her condition, as determined periodically by an AUTHORIZED REVIEWER.

When we authorize an ICM plan, we will also indicate the COVERED SERVICE that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the MEMBER would have received for the Covered Service.

We 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, we may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.

Information Resources for MEMBERS

Obtaining information about TUFTS HEALTH PLAN

The following information about TUFTS HEALTH PLAN will be available from the Massachusetts Department of Public Health's Office of Patient Protection:

- A list of sources of independently published information assessing MEMBER satisfaction and evaluating the quality of health care services offered by TUFTS HEALTH PLAN.
- The percentage of PROVIDER's who voluntarily and involuntarily terminated participation contracts with TUFTS HEALTH PLAN during the previous calendar year for which such data has been compiled. This information will contain the 3 most common reasons for voluntary and involuntary disenrollment of those PROVIDER's.
- The percentage of premium revenue spent by TUFTS HEALTH PLAN for health care services provided to MEMBERS for the most recent year for which information is available.
- A report that details the following information for the previous calendar year:
  - the total numbers of filed grievances, grievances denied internally, and grievances withdrawn before resolution;
  - the total number of external appeals pursued after exhausting the internal grievance process, as well as the resolution of all those external appeals.

How to obtain this information about TUFTS HEALTH PLAN

Contact the Massachusetts Department of Public Health's Office of Patient Protection.

- Phone: 1-800-436-7757.
- Fax #: 1-617-624-5046.
- Web site: www.state.ma.us/dph/opp/.
- Write a letter to the Office:

  Department of Public Health, Office of Patient Protection
  99 Chauncy St.
  Boston, MA 02111

Capitalized words are defined in Appendix A.
Chapter 2 - Eligibility, Enrollment and Continuing Eligibility

Eligibility

Eligibility rule under GROUP CONTRACTS
You are eligible as a SUBSCRIBER only if you are an employee of a GROUP; and you
● meet your GROUP’s and TUFTS HEALTH PLAN
● ‘s eligibility rules; and maintain primary residence in the SERVICE AREA; and
● live in the SERVICE AREA for at least 9 months in each period of 12 months*.

Your SPOUSE or your CHILD is eligible as a DEPENDENT only if you are a SUBSCRIBER and that SPOUSE or CHILD:
● qualifies as a DEPENDENT, as defined in this EVIDENCE OF COVERAGE; and
● meets your GROUP’s and TUFTS HEALTH PLAN’s eligibility rules; and
● maintains primary residence in the SERVICE AREA; and
● lives in the SERVICE AREA for at least 9 months in each period of 12 months*.

*Notes:
● CHILDREN are not required to maintain primary residence in the SERVICE AREA. However, care outside the SERVICE AREA is limited to EMERGENCY or URGENT CARE only.
● The 12-month period begins with the first month in which you are not living in the SERVICE AREA.

Eligibility rule under INDIVIDUAL CONTRACTS
You are eligible as a SUBSCRIBER only if you:
● meet the eligibility rules of TUFTS HEALTH PLAN and your INDIVIDUAL CONTRACT and;
● maintain primary residence in the SERVICE AREA; and
● live in the SERVICE AREA for at least 9 months in each period of 12 months*.

Your SPOUSE or your CHILD is eligible as a DEPENDENT only if you are a SUBSCRIBER and that SPOUSE or CHILD:
● qualifies as a DEPENDENT, as defined in this EVIDENCE OF COVERAGE; and
● meet the eligibility rules of TUFTS HEALTH PLAN and your INDIVIDUAL CONTRACT and;
● maintains primary residence in the SERVICE AREA; and
● lives in the SERVICE AREA for at least 9 months in each period of 12 months*.

*Notes:
● CHILDREN are not required to maintain primary residence in the SERVICE AREA. However, care outside the SERVICE AREA is limited to EMERGENCY or URGENT CARE only.
● The 12-month period begins with the first month in which you are not living in the SERVICE AREA.

If you live outside our SERVICE AREA
If you live outside our SERVICE AREA, you can be covered only if:
● you are a CHILD attending school full-time outside of the SERVICE AREA;
● you are a DEPENDENT subject to a Qualified Medical CHILD Support Order (QMCSO); or
● you are a divorced SPOUSE for whom TUFTS HEALTH PLAN is required to provide coverage.
  Note: See "Coverage outside the SERVICE AREA" in Chapter 1 for more information.

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

When to enroll

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

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

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

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

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

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

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

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

**EFFECTIVE DATE of coverage**

If we accept your application and receive the needed PREMIUM, coverage starts on either the date chosen by your GROUP or in accordance with your INDIVIDUAL CONTRACT, whichever applies. Enrolled DEPENDENT’s coverage starts when the SUBSCRIBER’s coverage starts, or at a later date if the DEPENDENT becomes eligible after the SUBSCRIBER became eligible for coverage. A DEPENDENT’s coverage cannot start before the SUBSCRIBER’s coverage starts.

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

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

Adding DEPENDENTS under FAMILY COVERAGE

When DEPENDENTS may be added

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

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

How to add DEPENDENTS

The process for adding DEPENDENTS to this coverage will differ, depending on whether you enrolled under this plan directly with TUFTS HEALTH PLAN or through the Commonwealth Health Insurance Connector Authority ("the Connector").

IF YOU ENROLLED DIRECTLY WITH TUFTS HEALTH PLAN, FOLLOW THIS PROCESS:
1. If you have FAMILY COVERAGE, fill out a membership application form listing the DEPENDENTS. Give the form to your GROUP (if you are enrolled in a GROUP CONTRACT) or to TUFTS HEALTH PLAN (if you have an INDIVIDUAL CONTRACT), whichever applies, either during your OPEN ENROLLMENT PERIOD or within 30 days after the date of an event listed above, under "When DEPENDENTS may be added."
2. If you don't have FAMILY COVERAGE, ask your GROUP or TUFTS HEALTH PLAN, whichever applies, to change your INDIVIDUAL COVERAGE to FAMILY COVERAGE and then follow the procedure above.

IF YOU ENROLLED THROUGH THE CONNECTOR, FOLLOW THIS PROCESS:
For more information about adding DEPENDENTS, contact the Connector either by phone (1-877-MA-ENROLL) or on its Web site (www.mahealthconnector.org).

EFFECTIVE DATE of DEPENDENTS coverage

If we accept your application to add DEPENDENTS, we will send you a MEMBER ID card for each DEPENDENT. EFFECTIVE DATES will be no later than:

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

Availabilty of benefits after enrollment

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

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

Newborn CHILDREN and ADOPTIVE CHILDREN

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

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

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

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

1. Choose a PCP from the list of PCPs in the DIRECTORY OF HEALTH CARE PROVIDERS or call a Member Specialist for help.
2. Call the PROVIDER and ask him or her to be the newborn or ADOPTIVE CHILD's PCP.
3. If he or she agrees, call a Member Specialist to report your choice.
Continuing Eligibility for DEPENDENTS

Introduction
This topic explains continuing eligibility for DEPENDENTS.

When Coverage ends
DEPENDENT coverage for a CHILD ends on the CHILD's 26th birthday.

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

What the SUBSCRIBER must do to continue coverage for DISABLED DEPENDENTS
1 About 30 days before the CHILD no longer meets the definition of DEPENDENT, call Member Services.
2 Give proof, acceptable to us, of the CHILD's disability.

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

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

Rule for former SPOUSES for GROUP CONTRACT (Also see Chapter 5)
If you and your SPOUSE divorce or legally separate, your former SPOUSE may continue coverage as a DEPENDENT under your FAMILY COVERAGE in accordance with Massachusetts law.

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

How to continue coverage for former SPOUSES for GROUP CONTRACT
Follow these steps to continue coverage for a former SPOUSE:
- Call a Member Specialist within 30 days after the divorce decree is issued to tell us about your divorce.
- Send us proof* of your divorce or separation when asked.

*Important Note about DISABLED DEPENDENT and former SPOUSES coverage: If you enrolled for coverage directly with TUFTS HEALTH PLAN, this proof must be provided to us. If you enrolled through the Connector, please call 1-877-MA-ENROLL.

Keeping our records current
You must notify us of any changes that affect you or your DEPENDENTS' eligibility. Examples of these changes are:
- birth, adoption, changes in marital status, or death;
- your remarriage or the remarriage of your former SPOUSE, when the former SPOUSE is an enrolled DEPENDENT under your FAMILY COVERAGE;
- moving out of the SERVICE AREA or temporarily residing out of the SERVICE AREA for more than 90 consecutive days;
- address changes; and
- changes in an enrolled DEPENDENT's status as a CHILD or DISABLED DEPENDENT.

Capitalized words are defined in Appendix A.
If you enrolled for coverage directly with TUFTS HEALTH PLAN, forms to report these changes are available from your GROUP (only if your coverage is under a GROUP CONTRACT) or from the Member Services Department. If you enrolled through the Connector, please call 1-877-MA-ENROLL.
Chapter 3 - COVERED SERVICES

When health care services are COVERED SERVICES

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

- listed as COVERED SERVICES in this chapter;
- MEDICALLY NECESSARY;
- consistent with applicable state or federal law;
- consistent with TUFTS HEALTH PLAN's Clinical Coverage Guidelines in effect at the time the services or supplies are provided. This information is available to you on our Web site at www.tuftshealthplan.com or by calling Member Services;
- provided to treat an injury, illness or pregnancy, except for preventive care;
- provided or authorized in advance by your PCP, except in an EMERGENCY or for URGENT CARE (see "When You Need EMERGENCY or URGENT CARE" earlier in this EOC for more information);
- approved by an AUTHORIZED REVIEWER, in some cases; and
- in the case of INPATIENT or intermediate mental health/substance abuse services, provided or authorized by:
  - your DESIGNATED FACILITY, if you have one; or
  - another TUFTS HEALTH PLAN HOSPITAL, if you are not assigned to a DESIGNATED FACILITY.

AUTHORIZED REVIEWER approval: Certain COVERED SERVICES described in this chapter must be authorized in advance by an AUTHORIZED REVIEWER. If such authorization is not received, we will not cover those services and supplies.
COVERED SERVICES

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

Notes:

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

EMERGENCY care

- EMERGENCY room (no PCP referral required);
- In PROVIDER’s office (no PCP referral required).

Notes:

- The EMERGENCY Room COPAYMENT is waived if the EMERGENCY room visit results in immediate hospitalization.
- If you receive EMERGENCY COVERED SERVICES from a non-TUFTS HEALTH PLAN PROVIDER, we will pay up to the REASONABLE CHARGE. You pay the applicable COPAYMENT.
- An EMERGENCY Room COPAYMENT may apply if you register in an EMERGENCY room but leave that facility without receiving care.
- DAY SURGERY COPAYMENT may apply if DAY SURGERY services are received. DEDUCTIBLE and COINSURANCE may apply if DAY SURGERY services are received.
- Observation services will take an EMERGENCY Room COPAYMENT.
OUTPATIENT CARE

Autism spectrum disorders – diagnosis and treatment
(prior approval by an AUTHORIZED REVIEWER is required)

Coverage is provided for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive DEVELOPMENTAL disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of MENTAL DISORDERS, and include:

- autistic disorder;
- Asperger's disorder; and
- pervasive DEVELOPMENTAL DISORDERS not otherwise specified.

TUFTS HEALTH PLAN provides coverage for the following COVERED SERVICES:

- habilitative or rehabilitative care, which are 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 behavioral analysis (ABA)* supervised by a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA). For more information about these programs, call the TUFTS HEALTH PLAN Mental Health Department at 1-800-208-9565.
- prescription drugs, covered under your "Prescription Drug Benefit, described in Chapter 3;
- psychiatric and psychological care, covered under your "Mental Health and Substance Abuse Services" benefit, described in Chapter 3;
- Therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your "Short term physical and occupational therapy services" and "Therapy for speech, hearing and language disorders" benefits, described in Chapter 3. Revise benefit names if GROUP does not have a separate speech therapy benefit.

*For the purposes for 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.

Cardiac rehabilitation services

Services for OUTPATIENT treatment of documented cardiovascular disease that:

- meet the standards promulgated by the Massachusetts Commissioner of Public Health; and
- are initiated within 26 weeks after diagnosis of cardiovascular disease.

We cover only the following services:

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

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

Chiropractic care

See "Spinal manipulation".

Diabetes self-management training and educational services

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

Important Note: We will only cover these services when provided by a TUFTS HEALTH PLAN PROVIDER who is a certified diabetes health care PROVIDER.
Early intervention services for a DEPENDENT CHILD
Services provided by early intervention programs that meet the standards established by the Massachusetts Department of Public Health. Early intervention services include, but are not limited to:

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

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

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

- Procedures:
  - sterilization; and
  - pregnancy terminations only as permitted under Massachusetts law (no PCP referral required).
- Services:
  - medical examinations;
  - consulations;
  - birth control counseling; and
  - genetic counseling.
- Contraceptives:
  - cervical caps;
  - implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants);
  - intrauterine devices (IUDs);
  - Depo-Provera or its generic equivalent; and
  - any other MEDICALLY NECESSARY contraceptive device that has been approved by the United States Food and Drug Administration*.

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

Hemodialysis
- OUTPATIENT hemodialysis, including home hemodialysis; and
- OUTPATIENT peritoneal dialysis, including home peritoneal dialysis.
Infertility services

Diagnosis and treatment of Infertility* in accordance with Massachusetts law.

Oral and injectable drug therapies used in the treatment of infertility associated with the COVERED SERVICES below are considered COVERED SERVICES only when the MEMBER is covered by a Prescription Drug Benefit and the MEMBER has been approved for associated infertility treatment. If applicable, see your Prescription Drug Benefit section for your COST SHARING AMOUNTS.

Infertility services include:

(I). the following services and supplies provided in connection with an infertility evaluation:
- diagnostic procedures and tests;
- artificial insemination (intrauterine or intracervical) when done with non-donor (partner) sperm;
- procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.

(II). the following procedures when approved in advance by an AUTHORIZED REVIEWER:
- artificial insemination (intrauterine or intracervical) when done with donor sperm and/or gonadotropins;
- procurement and processing of eggs or inseminated eggs and banking of inseminated eggs when associated with active infertility treatment.
  *Note: Donor sperm is only covered when the partner has a diagnosis of male factor infertility.

(III). the following Assisted Reproductive Technology (“ART”) procedures when approved in advance by an AUTHORIZED REVIEWER **:
- I.V.F. (in-vitro fertilization and embryo transfer);
- D.O. (donor oocyte);
- F.E.T. (frozen embryo transfer);
- G.I.F.T. (gamete intra-fallopian transfer);
- Z.I.F.T. (zygote intra-fallopian transfer);

**Note: These ART procedures will only be considered COVERED SERVICES for MEMBERS with Infertility:
- who are Massachusetts residents;
- who meet our eligibility requirements, which are based on the MEMBER’s medical history;
- who meet the eligibility requirements of our contracting Infertility Services PROVIDERS; and
- with respect to the procurement and processing of donor sperm, eggs, or inseminated eggs or banking of donor sperm or inseminated eggs, to the extent such costs are not covered by the donor’s health care coverage, if any.

*Infertility is defined as the condition of a MEMBER who has been unable to conceive or produce conception during a period of one year if the female is age 35 or younger or during a period of six months if the female is over the age of 35. For purposes of meeting the criteria for infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period, as applicable.

Maternity Care

(no PCP referral required)
- prenatal care, exams, and tests; and
- postpartum care provided in a PROVIDER’s office

*Capitalized words are defined in Appendix A.*
COVERED SERVICES, continued

Oral health services

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

- Non-EMERGENCY care

<table>
<thead>
<tr>
<th>Important Note: All Non-EMERGENCY oral health services performed in an INPATIENT or DAY SURGERY setting must be approved in advance by an AUTHORIZED REVIEWER and meet MEDICAL NECESSITY guidelines in order to be covered. For more information or to review the MEDICAL NECESSITY guidelines, please call Member Services or see our Web site at <a href="http://www.tuftshealthplan.com">www.tuftshealthplan.com</a>.</th>
</tr>
</thead>
</table>

- Hospital, PROVIDER, and surgical charges for the following conditions:
  - Surgical treatment of skeletal jaw deformities; or
  - Surgical treatment for Temporomandibular Joint Disorder (TMJ).

- In certain specific instances, the costs of INPATIENT services and DAY SURGERY for certain additional oral health services are covered. In order for these services (described in the chart below) to be covered, the following clinical criteria must be met:
  - the MEMBER cannot safely and effectively receive oral health services in an office setting because of a specific and serious nondental organic impairment (for example, hemophilia), AND
  - the MEMBER requires these services in order to maintain his/her health (and the services are not cosmetic or EXPERIMENTAL).

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

Note: Non-EMERGENCY oral health services are not covered when performed in an office setting.
OUTPATIENT medical care

- allergy testing (including antigens) and treatment, and allergy injections;
- chemotherapy;
- cytology examinations (Pap Smear); (Note: Covered for one annual screening for women age 18 and older or as otherwise MEDICALLY NECESSARY.)
- diagnostic imaging, including:
  - general imaging (such as x-rays and ultrasounds); and
  - MRI / MRA, CT/CTA, PET tests and nuclear cardiology.
    Important Note: Prior approval by an AUTHORIZED REVIEWER is required for MRI / MRA, CT/CTA, and PET tests and nuclear cardiology.
  - diagnostic screening procedures (for example, colonoscopies, endoscopies, sigmoidoscopies, and proctosigmoidoscopies). Prior approval by an AUTHORIZED REVIEWER is required.
  - human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation when necessary to establish a MEMBER's bone marrow transplant donor suitability. Includes:
    - costs of testing for A, B or DR antigens, or
    - any combination consistent with the rules and criteria established by the Department of Public Health;
  - immunizations;
  - laboratory tests including, but not limited to, blood tests, urinalysis, throat cultures, glycosylated hemoglobin (HbA1c) tests, genetic testing, and urinary protein/microalbumin and lipid profiles (Important: Some laboratory tests (e.g. genetic testing) may require the approval of an AUTHORIZED REVIEWER);
  - lead screenings;
  - mammograms (no PCP referral required) at the following intervals:
    - one baseline at 35-39 years of age,
    - one every year at age 40 and older, or
    - as otherwise MEDICALLY NECESSARY;
  - radiation therapy;
  - respiratory therapy and pulmonary rehabilitation services;
  - MEDICALLY NECESSARY diagnosis and treatment of speech, hearing and language disorders (services may require the approval of an AUTHORIZED REVIEWER);
  - Nutritional counseling;
  - Office visits to diagnose and treat illness or injury;
    Note: This includes MEDICALLY NECESSARY evaluations and related health care services for acute or EMERGENCY gynecological conditions (no PCP referral required).
- OUTPATIENT surgery in a PROVIDER's office.

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

As required by Massachusetts law, patient care services provided as part of a qualified clinical trial for the treatment of cancer are covered to the same extent as those OUTPATIENT services would be covered if the MEMBER did not receive care in a qualified clinical trial.
COVERED SERVICES, continued

Preventive health care for MEMBERS under age 6

- Preventive care services from the date of birth until age 6, including:
  - physical examination, including limited DEVELOPMENTAL testing with interpretation and report history;
  - measurements;
  - sensory screening;
  - neuropsychiatric evaluation; and
  - DEVELOPMENTAL screening and assessment at the following intervals:
    - 6 times during the first year after birth,
    - 3 times during the second year after birth, and
    - annually from age 2 until age 6.
- Coverage is also provided for:
  - hereditary and metabolic screening at birth;
  - appropriate immunizations and tuberculin tests;
  - hematocrit, hemoglobin, or other appropriate blood tests;
  - urinalysis as recommended by a TUFTS HEALTH PLAN PROVIDER; and
  - newborn auditory screening tests, as required by state law.
Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to an COST SHARING AMOUNTS.

Preventive health care for MEMBERS age 6 and older

- routine physical examinations, including appropriate immunizations and lab tests as recommended by a TUFTS HEALTH PLAN PROVIDER;
- hormone replacement therapy services; and
- hearing examinations and screenings.
Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine physical exam is subject to an COST SHARING AMOUNTS.

Routine annual gynecological exam

Includes any follow-up obstetric or gynecological care determined to be MEDICALLY NECESSARY as a result of that exam (no PCP referral required).
Note: Any follow-up care determined to be MEDICALLY NECESSARY as a result of a routine annual gynecological exam is subject to COST SHARING AMOUNTS.

Short term physical and occupational therapy services

(Services may require the approval of an AUTHORIZED REVIEWER)

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

Massage therapy may be covered as a treatment modality when administered as part of a physical therapy visit that is:
- provided by a licensed physical therapist; and
- in compliance with TUFTS HEALTH PLAN's MEDICAL NECESSITY guidelines, and, if applicable, prior authorization guidelines.

Note: Short term physical therapy services are covered up to a combined maximum of 30 visits per CALENDAR YEAR. Please note that visit limits do not apply to the treatment of autism spectrum disorders.

Note: Short term occupational therapy services are covered up to a combined maximum of 30 visits per CALENDAR YEAR. Please note that visit limits do not apply to the treatment of autism spectrum disorders.
COVERED SERVICES, continued

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

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

Vision care services

- Routine eye examination: Coverage is provided for one routine eye examination every 24 months (no PCP referral required)
  
  Note: You must receive routine eye examinations from a PROVIDER in the EyeMed Vision Care network in order to obtain coverage for these services. Please go to www.tuftshealthplan.com or contact Member Services for more information. Except as described below, in order to be covered for services to treat a medical condition of the eye, you must obtain a referral from your PCP for services from a TUFTS HEALTH PLAN PROVIDER.

- Other vision care services: Coverage is provided for eye examinations and necessary treatment of a medical condition (no PCP referral required for medical treatment performed by an optometrist).

DAY SURGERY

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

INPATIENT CARE

Acute hospital services

- anesthesia;
- diagnostic tests and lab services;
- drugs;
- dialysis;
- intensive care/coronary care;
- nursing care.

*requires prior approval by an AUTHORIZED REVIEWER

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

(Services require the approval of an AUTHORIZED REVIEWER)

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

Notes:

- We do not cover donor charges of MEMBERS who donate stem cells or solid organs to non-MEMBERS.
- We cover a MEMBER's donor search expenses for donors related by blood.
- We cover the MEMBER's donor search expenses for up to 10 searches for donors not related by blood. Additional donor search expenses for unrelated donors must be approved by an AUTHORIZED REVIEWER.
- We cover a MEMBER's human leukocyte antigen (HLA) testing. See “OUTPATIENT medical care” earlier in this chapter for more information.
INPATIENT CARE, continued

Extended care

(Services require the approval of an AUTHORIZED REVIEWER)

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

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

Note: Covered up to 100 days per CALENDAR YEAR

Maternity Care

(no PCP referral required)

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

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

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

Notes:

COVERED SERVICES will include one home visit by a registered nurse, physician, or certified nurse midwife; and additional home visits, when MEDICALLY NECESSARY and provided by a licensed health care PROVIDER. COVERED SERVICES will also include, but not be limited to, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.

These COVERED SERVICES will be available to a mother and her newborn CHILD regardless of whether or not there is an early discharge (hospital discharge less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery).

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

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

Reconstructive surgery and procedures

Coverage is provided for the cost of:

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

*Breast prostheses are covered as described under "Prosthetic devices" later in this chapter.

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

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

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

Note: Cosmetic surgery is not covered.

Capitalized words are defined in Appendix A.
Mental Health and Substance Abuse Services (OUTPATIENT, INPATIENT, and Intermediate)

Diagnosis and treatment of Biologically-based MENTAL DISORDERS (as defined by Massachusetts law); Certain Mental, behavioral or emotional Disorders for CHILDREN under age 19; Rape-related Mental or emotional Disorders; and all other MENTAL DISORDERS in accordance with Massachusetts law.

- Biologically-based MENTAL DISORDERS are: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; eating disorders; post-traumatic stress disorder; substance abuse disorders; autism; and any other MENTAL DISORDERS added by the Commissioners of the Department of Mental Health and the Division of Insurance.

- Certain Mental, behavioral or emotional Disorders for CHILDREN under age 19 are MENTAL DISORDERS which substantially interfere with or substantially limit the functioning and social interactions of the CHILD:
  - when documented by the CHILD's PCP or treating mental health PROVIDER and authorized by the TUFTS HEALTH PLAN Mental Health Department; or
  - when evidenced by, as a result of or caused by the Mental Disorder: an inability to attend school, the need to be hospitalized, or a pattern of conduct which poses a serious danger to the CHILD or others.

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

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

OUTPATIENT mental health and substance abuse services for MENTAL DISORDERS

Services to diagnose and treat MENTAL DISORDERS (including diagnosis, detoxification, and treatment of substance abuse disorders) given by the following TUFTS HEALTH PLAN PROVIDERS:

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

Psychopharmacological services and neuropsychological assessment services are covered as "Office visits to diagnose and treat illness or injury" as described earlier in this chapter.

Notes:

- OUTPATIENT mental health and substance abuse services require prior authorization. Please see "OUTPATIENT mental health/substance abuse services" in Chapter 1 for more information.
- No visit limit applies to OUTPATIENT care services for: Biologically-based MENTAL DISORDERS (as defined by Massachusetts law); Certain Mental, behavioral or emotional Disorders for CHILDREN under age 19; and Rape-related Mental or emotional Disorders.
- OUTPATIENT mental health care services for all other MENTAL DISORDERS are covered up to 24 visits per CALENDAR YEAR.
- Prior authorization by a TUFTS HEALTH PLAN Mental Health AUTHORIZED REVIEWER is required for psychological testing and neuropsychological assessment services.

INPATIENT and intermediate mental health and substance abuse services for MENTAL DISORDERS

(These services must be provided or authorized in advance by your DESIGNATED FACILITY, if you have one. See "INPATIENT and intermediate mental health/substance abuse services" in Chapter 1 for more information.)
INPATIENT mental health and substance abuse services for MENTAL DISORDERS in a general hospital, a mental health hospital, or a substance abuse facility.

Intermediate mental health and substance abuse services. These services are more intensive than traditional OUTPATIENT mental health and substance abuse services, but less intensive than 24-hour hospitalization. Some examples of covered intermediate mental health and substance abuse services are:

- level III community-based detoxification;
- intensive OUTPATIENT programs;
- acute residential treatment* (longer term residential treatment is not covered);
- crisis stabilization;
- day treatment/partial hospital programs; and
- acute residential treatment* (longer term residential treatment is not covered);

**Two mental health day treatment/partial hospital days count as one of the 60 INPATIENT days you get per CALENDAR YEAR.

Notes:

- No visit limit applies to INPATIENT or intermediate care services for: Biologically-based MENTAL DISORDERS (as defined by Massachusetts law); Certain Mental, behavioral or emotional Disorders for CHILDREN under age 19; and Rape-related Mental or emotional Disorders.
- INPATIENT mental health care services for all other MENTAL DISORDERS are limited to 60 days per CALENDAR YEAR.

**Capitalized words are defined in Appendix A.**

To contact Member Services, call 1-800-462-0224, or see our Web site at [www.tuftshealthplan.com](http://www.tuftshealthplan.com).
Other Health Services

Ambulance services

- Ground, sea, and helicopter ambulance transportation for EMERGENCY care.
- Airplane ambulance services (e.g., Medflight) when approved by an AUTHORIZED REVIEWER.
- Non-EMERGENCY, MEDICALLY NECESSARY ambulance transportation between covered facilities.
- Non-EMERGENCY ambulance transportation for MEDICALLY NECESSARY care when the medical condition of the MEMBER prevents safe transportation by any other means. Prior approval by an AUTHORIZED REVIEWER is required.

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

DURABLE MEDICAL EQUIPMENT

Equipment must meet the following definition of "DURABLE MEDICAL EQUIPMENT":

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

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

In order to be eligible for coverage, the equipment must also be the most appropriate available amount, supply or level of service for the MEMBER in question considering potential benefits and harms to that individual, as determined by TUFTS HEALTH PLAN.

Equipment that TUFTS HEALTH PLAN determines to be non-medical in nature and used primarily for non-medical purposes (even though that equipment may have some limited medical use) will not be considered DURABLE MEDICAL EQUIPMENT and will not be covered under this benefit.

(Note: Certain DURABLE MEDICAL EQUIPMENT may require AUTHORIZED REVIEWER approval.)

Important Note: You may be responsible for paying towards the cost of DURABLE MEDICAL EQUIPMENT covered under this plan. To determine whether your DURABLE MEDICAL EQUIPMENT benefit is subject to a DEDUCTIBLE, COINSURANCE, or a benefit limit, please see the "Benefit Overview" and "Benefit Limits" sections at the front of this EVIDENCE OF COVERAGE.
Other Health Services, continued

DURABLE MEDICAL EQUIPMENT, continued

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

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

- contact lenses or eyeglass lenses (one pair per prescription change) to replace the natural lens of the eye or following cataract surgery. Note: Eyeglass frames provided in association with these lenses are covered up to a maximum of $69 per CALENDAR YEAR;
- cranial helmets;
- gradient stockings (up to three pairs per calendar year);
- the following equipment when used to diagnose or treat diabetes mellitus Type 1 (insulin-dependent diabetes), diabetes mellitus Type 2 (insulin or non-insulin dependent diabetes), or gestational diabetes:
  - blood glucose monitors, including voice synthesizers for blood glucose monitors for use by the legally blind,
  - therapeutic/molded shoes and shoe inserts for MEMBERS with severe diabetic foot disease, and
  - visual magnifying aids;
- oral appliances for the treatment of sleep apnea;
- prosthetic devices, except for arms, legs or breasts*;
  *Important Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Prosthetic Devices" benefit later in this chapter.
- scalp hair prostheses made specifically for an individual or a wig, and provided for hair loss due to alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury. (Note: Please see "Scalp hair prostheses or wigs for cancer or leukemia patients" later in this Chapter); and
- power/motorized wheelchairs.

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

Below are examples of non-covered items (this list is not all-inclusive).

Please call Member Services for all questions regarding coverage of DURABLE MEDICAL EQUIPMENT:

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

Home health care

(must be approved by an AUTHORIZED REVIEWER)

We will cover the following services for MEMBERS who are homebound*:

- home visits by a TUFTS HEALTH PLAN PROVIDER;
- SKILLED nursing care and physical therapy; and
- the following services, if determined to be a MEDICALLY NECESSARY component of SKILLED nursing or physical therapy:
  - speech therapy,
  - occupational therapy,
  - medical/psychiatric social work,
  - nutritional consultation,
  - the use of DURABLE MEDICAL EQUIPMENT (coverage is not subject to limits described in the "DURABLE MEDICAL EQUIPMENT" benefit in this chapter), and
  - the services of a part-time home health aide.

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

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

Hospice care services

(must be approved by an AUTHORIZED REVIEWER)

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

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

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

- in a home setting;
- on an OUTPATIENT basis; and
- on a short-term INPATIENT basis, for the control of pain and management of acute and severe clinical problems which cannot, for medical reasons, be managed in a home setting.
Other Health Services, continued

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

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

Low Protein Foods
When provided to treat inherited diseases of amino acids and organic acids

Medical supplies
We cover the cost of certain types of medical supplies from an authorized vendor, including:
- ostomy, tracheostomy, catheter, and oxygen supplies; and
- insulin pumps and related supplies.

Notes:
These medical supplies must be obtained from a vendor that has an agreement with us to provide such supplies. Contact a Member Specialist with coverage questions.
Other Health Services, continued

Nonprescription Enteral Formulas
(prior approval by an AUTHORIZED REVIEWER may be required)
Coverage is provided:
- for home use for treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.
- when MEDICALLY NECESSARY: infant formula for milk or soy protein intolerance; formula for premature infants; and supplemental formulas for growth failure

Prosthetic devices
We cover the cost (including repairs) of breast prostheses and prosthetic arms and legs. Coverage is provided for the most appropriate MEDICALLY NECESSARY model that adequately meets the MEMBER's needs. Prior approval by an AUTHORIZED REVIEWER is required*.

*Important Note: Prior approval by an AUTHORIZED REVIEWER is not required for breast prostheses provided in connection with a mastectomy.

Scalp hair prostheses or wigs for cancer or leukemia patients
Scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. (Please also see "DURABLE MEDICAL EQUIPMENT" earlier in this Chapter.)
Note: Covered up to a maximum benefit of $350 per CALENDAR YEAR.

Special Medical Formulas
(prior approval by an AUTHORIZED REVIEWER may be required)
For the treatment of:
- phenylketonuria (PKU)
- tyrosinemia,
- homocystinuria,
- maple syrup urine disease
- propionic acidemia, and
- methylmalonic acidemia;
or, when MEDICALLY NECESSARY, to protect the unborn fetuses of women with PKU.

Capitalized words are defined in Appendix A.
TUFTS HEALTH PLAN MEMBER Discounts

In addition to your covered benefits, as a MEMBER you may take advantage of TUFTS HEALTH PLAN MEMBER Discounts. These include discounts on:

- fitness center memberships;
- nutritional supplements;
- mind and body treatments; and
- a variety of services related to good health.

Current examples of these discounts include:

- Fitness discounts
  - Save 20% on annual memberships and pay no initiation fee at TUFTS HEALTH PLAN network fitness centers in Massachusetts, New Hampshire, and Rhode Island. The network includes 80 health and fitness centers.
  - Save 50% when you join a participating New England Curves® club.
  - Save 10% on personal training packages at Fitness Together and receive a free initial fitness evaluation.
  - Save 20% on Appalachian Mountain Club membership rates and receive discounts on accommodations, subscriptions and programs.
  - MEMBERS 18 and younger pay no membership fee to enroll at participating Boys & Girls Clubs in Massachusetts and Rhode Island. Young members also receive a 20% discount on the cost of most programs.
  - As an alternative to annual memberships, you and your family can visit a fitness center in the TUFTS HEALTH PLAN network and pay a small COPAYMENT ($3-$6) for each visit, up to five visits a month.
  - New Balance of Burlington and Mashpee, Massachusetts, offers Members a 15% discount on fitness-related apparel, footwear, and accessories.

- Fitness Club Rebate*  
  You may be eligible for a $150 mail-in fitness rebate for using a qualified fitness club. If you are eligible for this rebate, just complete at least four consecutive months of membership in TUFTS HEALTH PLAN and at a qualified fitness center. Then, submit the Fitness Rebate Form, along with proof of fitness center membership and proof of payment, and we will reimburse up to $150 of your fitness club fees for the year.

*Notes:
- Certain GROUPS may not offer this fitness rebate. If you are enrolled in a GROUP plan, check with your employer or contact TUFTS HEALTH PLAN to confirm whether you are eligible for this rebate.
- The rebate applies once per family, per year, after you have incurred up to $150 of fitness club membership fees and have met the eligibility requirements. The fitness reimbursement is paid to the TUFTS HEALTH PLAN SUBSCRIBER.

- Nutritional Services
  - Nutritional Counseling - In addition to your health plan coverage for MEDICALLY NECESSARY counseling, you can receive 25% off the cost of unlimited visits with a registered dietitian or licensed nutritionist in our network. Learn more about diets that promote good health.
  - Weight Watchers® - Pay no joining fee for the traditional Weight Watchers program and receive a $10 discount on the price of a Weight Watchers Deluxe at Home Kit. Join Weight Watchers Online and receive a $10 discount.
  - Dietary and Nutrition Supplements -- Save up to 40% on a wide variety of vitamins, supplements, and popular energy and protein bars through ChooseHealthy.com. Standard shipping is also free for MEMBERS.

- Mind and Body
  - Save 25% on acupuncture treatments and massage therapy. To find a participating PROVIDER, click on Member Discounts at tuftshealthplan.com.
  - Hospital-Based Health and Wellness Seminars - Save up to 30% on wellness seminars and workshops at participating facilities. Topics include smoking cessation, stress management, aging and parenting.
  - Natural Therapies - Learn more about aromatherapy, homeopathic remedies, meditation, yoga, and other natural remedies at ChooseHealth.com, and save up to 40% on purchases.

Capitalized words are defined in Appendix A.
Other Health Services, continued

TUFTS HEALTH PLAN Member Discounts, continued

- Eyewear
  - With the EyeMed Vision Care program, MEMBERS can receive 35% off the retail price of frames, along with discounts on lenses and lens options, with the purchase of a complete pair of eyeglasses from a participating EyeMed provider.
  - EyeMed Vision Care also offers a contact lens replacement program, 20% off the retail price of nonprescription sunglasses, and 15% off the retail price (or 5% off the promotional price) of LASIK and PRK laser vision correction.

- Home Instead Senior Care
  - Provides home support services you or an elderly family MEMBER, such as light housekeeping or meal preparation. Receive a $100 one-time credit towards charges for these and other non-medical home care services through participating offices.
  - A free home-safety inspection is also provided once you contract for services. It includes a review of the home entrance, kitchen, bathrooms, and more.

These discounts and savings may change over time without notice to MEMBERS. To check on current TUFTS HEALTH PLAN MEMBER Discounts:

- call Member Services at the number listed on your MEMBER ID card, or
- go to www.tuftshealthplan.com
Covered Services, continued

Prescription Drug Benefit

Introduction
This section describes the Prescription Drug Benefit. The following topics are included in this section to explain your prescription drug coverage:

- How Prescription Drugs Are Covered
- Prescription Drug Coverage Table
- What is Covered
- What is Not Covered
- TUFTS HEALTH PLAN Pharmacy Management Programs
- Filling Your Prescription

How Prescription Drugs Are Covered
Prescription drugs will be considered COVERED SERVICES only if they comply with the "TUFTS HEALTH PLAN Pharmacy Management Programs" section described below and are:

- listed below under "What is Covered";
- provided to treat an injury, illness, or pregnancy;
- MEDICALLY NECESSARY; and
- written by a TUFTS HEALTH PLAN participating PROVIDER, except in cases of authorized referral or in Emergencies.

For a current list of covered drugs, please go to our Web site at www.tuftshealthplan.com, or call a Member Specialist.

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

- Tier-1 drugs have the lowest level COST SHARING AMOUNT; many generic drugs are on tier-1.
- Tier-2 drugs have the middle level COST SHARING AMOUNT.
- Tier-3 drugs have the highest level COST SHARING AMOUNT.
**Prescription Drug Coverage Table**

**DRUGS OBTAINED AT A RETAIL PHARMACY:**
Covered prescription drugs (including both acute and maintenance drugs) when you obtain them directly from a TUFTS HEALTH PLAN designated retail pharmacy.

<table>
<thead>
<tr>
<th>TIER-1 drugs:</th>
<th>TIER-2 drugs:</th>
<th>TIER-3 drugs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15.00 Copayment for up to a 30-day supply</td>
<td>$30.00 Copayment for up to a 30-day supply</td>
<td>$50.00 Copayment for up to a 30-day supply</td>
</tr>
<tr>
<td>$30.00 Copayment for a 31-60-day supply</td>
<td>$60.00 Copayment for a 31-60-day supply</td>
<td>$100.00 Copayment for a 31-60-day supply</td>
</tr>
<tr>
<td>$45.00 Copayment for a 61-90-day supply</td>
<td>$90.00 Copayment for a 61-90-day supply</td>
<td>$150.00 Copayment for a 61-90-day supply</td>
</tr>
</tbody>
</table>

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

**DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY:**
Most maintenance medications, when mailed to you through a TUFTS HEALTH PLAN designated mail services pharmacy.

<table>
<thead>
<tr>
<th>TIER-1 drugs:</th>
<th>TIER-2 drugs:</th>
<th>TIER-3 drugs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30.00 Copayment for up to a 90 day supply</td>
<td>$60.00 Copayment for up to a 90 day supply</td>
<td>$100.00 Copayment for up to a 90 day supply</td>
</tr>
</tbody>
</table>
Covered Services, continued

Prescription Drug Benefit, continued

What is Covered
We cover the following under this Prescription Drug Benefit:

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

Prescription Drug Benefit, continued

What is not Covered
We do not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for CHILDREN).
- Topical and oral fluorides for adults.
- Medications for the treatment of idiopathic short stature.
- Cervical caps, IUDs, implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants, Depo-Provera or its generic equivalent (these are covered under your OUTPATIENT care benefit earlier in this Chapter)
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under Preventive health care earlier in this chapter.
- Prescriptions written by PROVIDERS who do not participate in TUFTS HEALTH PLAN, except in cases of authorized referral or EMERGENCY care.
- Prescriptions filled at pharmacies other than TUFTS HEALTH PLAN designated pharmacies, except for EMERGENCY care.
- Smoking cessation agents.
- Drugs for asymptomatic onychomycosis, except for MEMBERS with diabetes, vascular compromise, or immune deficiency status.
- Acne medications for individuals 26 years of age or older, unless MEDICALLY NECESSARY.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent to a covered prescription medication becomes available over-the-counter. In this case, the specific medication may not be covered and the entire class of prescription medications may also not be covered. Some examples of these excluded medications are: topical acne medications with benzoyl peroxide ≤ 10%; H2 blockers with nizatidine, famotidine, cimetidine, or ranitidine; and oral non-sedating antihistamines. For a complete list of these excluded medications, call Member Services or check our Web site at www.tuftshealthplan.com.
- Prescription medications with packaged with non-prescription products.
- Oral non-sedating antihistamines.
Covered Services, continued

Prescription Drug Benefit, continued

TUFTS HEALTH PLAN Pharmacy Management Programs

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

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

Prior Authorization Program:
We restrict the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing PROVIDER to obtain prior approval from us for such drugs. Step therapy is a type of prior authorization program which allows coverage for certain drugs only after specific preferred medications are tried first.

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

Special Designated Pharmacy Program (Mail Order):
We have designated special pharmacies to supply a select number of medications via mail order, including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C, growth hormone deficiency, rheumatoid arthritis, and cancers treated with oral medications. These pharmacies specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for MEMBERS. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time via mail order.
Covered Services, continued

Prescription Drug Benefit, continued

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

New-To-Market Drug Evaluation Process:
TUFTS HEALTH PLAN's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. We then make a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation.

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

IMPORTANT NOTES:
- If your PROVIDER feels it is MEDICALLY NECESSARY for you to take medications that are not on a formulary or restricted under any of the "TUFTS HEALTH PLAN Pharmacy Management Programs" described above, he or she may submit a request for coverage. We will approve the request if it meets our guidelines for coverage. For more information, you can call a Member Specialist.
- The TUFTS HEALTH PLAN Web site has a list of covered drugs with their tiers. We may change a drug's tier during the year. For example, if a brand drug's patent expires, we may change the drug's status by either (a) moving the brand drug from Tier-2 to Tier-3 or (b) moving the brand drug to our list of non-covered drugs in Appendix C when a generic alternative becomes available.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check our Web site at www.tuftshealthplan.com, or call a Member Specialist.
Filling Your Prescription

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

How to Fill Prescriptions:
- Make sure the prescription is written by a TUFTS HEALTH PLAN participating PROVIDER, except in cases of authorized referral or in Emergencies.
- When you fill a prescription, provide your MEMBER ID to any TUFTS HEALTH PLAN designated pharmacy and pay your COST SHARING AMOUNT.
- If the cost of your prescription is less than your COPAYMENT, then you are only responsible for the actual cost of the prescription.
- If you have any problems using this benefit at a TUFTS HEALTH PLAN designated pharmacy, call our Member Services Department.

Important: Your prescription drug benefit is honored only at TUFTS HEALTH PLAN designated pharmacies. In cases of EMERGENCY, please call the Member Services Department for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:
If you are required to take a maintenance medication, we offer you two choices for filling your prescription:
- you may obtain your maintenance medication directly from a TUFTS HEALTH PLAN designated retail pharmacy; or
- you may have most maintenance medications* mailed to you through a TUFTS HEALTH PLAN designated mail services pharmacy.

The following may not be available to you through a TUFTS HEALTH PLAN designated mail services pharmacy:
- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of our Quantity Limitations program; or
- medications that are part of our Special Designated Pharmacy program.

NOTE: Your COST SHARING AMOUNTS for covered prescription drugs are shown in the “Prescription Drug Coverage Table” above.
Exclusions
We will not pay for the following services, supplies, or medications:

- A service, supply or medication which is not MEDICALLY NECESSARY.
- A service, supply or medication which is not a COVERED SERVICE.
- A service, supply or medication received outside our SERVICE AREA, except as described under "How the PLAN Works" in Chapter 1.
- A service, supply or medication that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- CUSTODIAL CARE.
- Services related to non-COVERED SERVICES.
- A drug, device, medical treatment or procedure (collectively "treatment") that is EXPERIMENTAL OR INVESTIGATIVE.

This exclusion does not apply to:

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

If the treatment is EXPERIMENTAL OR INVESTIGATIVE, we will not pay for any related treatments which are provided to the MEMBER for the purpose of furnishing the EXPERIMENTAL OR INVESTIGATIVE treatment.

- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter.
- The following exclusions apply to services provided by the relatives of a MEMBER:
  - Services provided by a relative who is not a TUFTS HEALTH PLAN PROVIDER, whether or not the services are authorized by your PCP, are not covered.
  - Services provided by an immediate family MEMBER (by blood or marriage), even if the relative is a TUFTS HEALTH PLAN PROVIDER and the services are authorized by your PCP, are not covered.
  - If you are a TUFTS HEALTH PLAN PROVIDER, you cannot provide or authorize services for yourself, be your own PCP, or be the PCP of a MEMBER of your immediate family (by blood or marriage).
  - Services, supplies, or medications required by a third party which are not otherwise MEDICALLY NECESSARY. Examples of a third party are: employer; insurance company; school; or court.
  - Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
  - Care for conditions for which we determine that 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.
  - Facility charges or related services if the procedure being performed is not a Covered Service, except as provided under "Oral health services" earlier in this chapter.
  - Preventive dental care, periodontal treatment; orthodontia, even when it is an adjunct to other surgical or medical procedures; dental supplies; dentures; restorative services including, but not limited to, crowns, fillings, root canals, and bondings; skeletal jaw surgery, except as provided under "Oral health services" earlier in this chapter; alteration of teeth; care related to deciduous (baby) teeth; splints and oral appliances (except for sleep apnea, as described in this chapter), including those for TMJ disorders. TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or other TMJ appliance-related therapies, are not covered.
  - Surgical removal or extraction of teeth, except as provided under "Oral health services" earlier in this chapter.

Capitalized words are defined in Appendix A. 60 To contact Member Services, call 1-800-462-0224, or see our Web site at www.tuftshealthplan.com.
Exclusions

- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided under “Reconstructive surgery and procedures” earlier in this chapter.
- Rhinoplasty, except as provided under "Reconstructive Surgery and Procedures” earlier in this chapter; liposuction; and brachioplasty.
- Treatment of spider veins; removal or destruction of skin tags; treatment of vitiligo.
- Hair removal, except when MEDICALLY NECESSARY to treat an underlying skin condition.
- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcisions performed in any setting other than a hospital, DAY SURGERY, or a PROVIDERS office.
- Infertility services for MEMBERS who do not meet the definition of Infertility as described in the “OUTPATIENT Care” section earlier in this chapter; EXPERIMENTAL infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days) sperm or embryo cryopreservation unless the MEMBER is in active infertility treatment; costs associated with donor recruitment and compensation; and Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization; and donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.

**Note:** We may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a MEMBER's future fertility. Prior approval by an AUTHORIZED REVIEWER is required.

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

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

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

- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service has been approved by an AUTHORIZED REVIEWER, is provided at a TUFTS HEALTH PLAN ART center, and the MEMBER is the sole recipient of the donor’s eggs.
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- Manual breast pumps;
- the purchase of an electric or hospital grade breast pump.
- Human organ transplants, except as described earlier in this chapter.
- Services provided to a non-MEMBER, except as described earlier in this chapter for:
  - organ donor charges under “Human organ transplants”;
  - bereavement counseling services under “Hospice care services”; and
  - the costs of procurement and processing of donor sperm, eggs, or inseminated eggs or banking of donor sperm or inseminated eggs under “Infertility services” (to the extent such costs are not covered by the donor’s health coverage, if any).
- Acupuncture; biofeedback, except for the treatment of urinary incontinence; hypnotherapy; psychoanalysis; TENS units or other neuromuscular stimulators and related supplies; electrolysis; spinal manipulation services for MEMBERS age 12 and under; INPATIENT and OUTPATIENT weight-loss programs and clinics; relaxation therapies; massage therapies, except as described under “Short term physical and occupational therapy services” earlier in this chapter; services by a personal trainer; exercise classes; cognitive rehabilitation programs; cognitive retraining programs. Also excluded are diagnostic services related to any of these procedures or programs.
- All alternative, holistic, naturopathic, and/or functional health medicine services, supplies, or procedures, and all services, procedures, labs and supplements associated with this type of medicine.
- Any service, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts, therapeutic programs, camps, and clinics).
- Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, and blood products, except as detailed in the “Note” below.

**Note:** The following blood services and products are covered:
• blood processing;
• blood administration;
• Factor products (monoclonal and recombinant) for Factor VIII deficiency (classic hemophilia), Factor IX deficiency (Christmas factor deficiency), and von Willebrand disease (prior approval by an AUTHORIZED REVIEWER is required);
• intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (prior approval by an AUTHORIZED REVIEWER is required).

- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational purposes or DEVELOPMENTAL purposes, including physical therapy, speech therapy, and occupational therapy, except as provided earlier in this chapter. Vocational rehabilitation services and vocational retraining. Also, services to treat learning disabilities, behavioral problems, and DEVELOPMENTAL delays and services to treat speech, hearing and language disorders in a school-based setting. The term "DEVELOPMENTAL" refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.
- Eyeglasses, lenses or frames, except as described under "DURABLE MEDICAL EQUIPMENT" earlier in this chapter; refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery. Except as described earlier in this chapter, we will not pay for contact lenses or contact lens fittings.
- Hearing aids;
- Methadone treatment or methadone maintenance related to substance abuse disorders.
- Routine foot care, such as trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion also does not apply to routine foot care for MEMBERS diagnosed with diabetes.

  Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a MEMBER with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the MEMBER’s treating doctor, the shoes or 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, taxi, or wheelchair van, except as described in "Ambulance services" in this chapter.
- Lodging related to receiving any medical service.
- Private duty nursing (block or non-intermittent nursing).
Chapter 4 - When Coverage Ends

Reasons coverage ends
Coverage (including federal COBRA coverage and Massachusetts continuation coverage) ends when any of the following occurs:

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

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

- you were receiving INPATIENT or OUTPATIENT care when your coverage ended; or
- you had a medical condition (known or unknown), including pregnancy, that requires medical care after your coverage ends.

Continuation and conversion
Once your coverage ends, you may be eligible to continue your coverage with your GROUP or to enroll in coverage under an INDIVIDUAL CONTRACT. See Chapter 5 for more information.

When a MEMBER is No Longer Eligible

Loss of eligibility
Your coverage ends on the date you no longer meet your GROUP's or TUFTS HEALTH PLAN's eligibility rules.

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

DEPENDENT Coverage
An enrolled DEPENDENT's coverage ends when the SUBSCRIBER's coverage ends or when the DEPENDENT no longer meets the definition of DEPENDENT, whichever occurs first. Coverage of any CHILD of an enrolled DEPENDENT CHILD ends when the enrolled DEPENDENT CHILD's coverage ends.

If you move out of the SERVICE AREA
If you move out of the SERVICE AREA, coverage ends as of the date you move*.

Before you move, tell your GROUP or call a MEMBER Specialist before you move to notify TUFTS HEALTH PLAN of the date you are moving. If you keep a residence in the SERVICE AREA but have been out of the SERVICE AREA for more than 90 days, coverage ends 90 days after the date you left the SERVICE AREA.

For more information about coverage available to you when you move out of the SERVICE AREA, contact a Member Specialist.

You choose to drop coverage
Coverage ends if you decide you no longer want coverage. To end your coverage, notify your GROUP (or TUFTS HEALTH PLAN if covered under an INDIVIDUAL CONTRACT) at least 30 days before the date you want your coverage to end. You must pay PREMIUMS up through the day your coverage ends.
Membership Termination for Acts of Physical or Verbal Abuse

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

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

Membership Termination for Misrepresentation or Fraud

Policy
TUFTS HEALTH PLAN may terminate your coverage for misrepresentation or fraud. If your coverage is terminated for misrepresentation or fraud, TUFTS HEALTH PLAN may not allow you to re-enroll for coverage with TUFTS HEALTH PLAN under any other plan (such as a non-GROUP or another employer’s plan) or type of coverage (for example, coverage as a DEPENDENT or SPOUSE).

Acts of misrepresentation or fraud
Examples of misrepresentation or fraud include:

● false or misleading information on your application;
● enrolling as a SPOUSE someone who is not your SPOUSE;
● receiving benefits for which you are not eligible;
● keeping for yourself payments made by TUFTS HEALTH PLAN that were intended to be used to pay a PROVIDER; or
● allowing someone else to use your MEMBER ID.

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

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

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

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

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

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

If the PREMIUM is more than is needed to pay for COVERED SERVICES you received after your termination date, TUFTS HEALTH PLAN will refund the excess to your GROUP or to you if enrolled under an INDIVIDUAL CONTRACT.

Voluntary and Involuntary Disenrollment Rates for MEMBERS
As required by Massachusetts law, TUFTS HEALTH PLAN conducts an annual disenrollment study. Annually, the study looks at the reasons MEMBERS leave TUFTS HEALTH PLAN, in order to track voluntary and involuntary disenrollment rates.

Voluntary Disenrollment Rate - The number of MEMBERS we disenrolled because they ceased to pay PREMIUMS. This is the voluntary disenrollment rate. For the year 2009, less than one percent of MEMBERS voluntarily disenrolled by ceasing to pay their PREMIUMS.

Involuntary Disenrollment Rate - The number of MEMBERS that we disenrolled because of fraud or acts of physical or verbal abuse. This is the involuntary disenrollment rate. For the year 2009, less than one percent of MEMBERS were involuntarily disenrolled as a result of fraud or abuse.

For additional information about the voluntary and involuntary disenrollment rates among TUFTS HEALTH PLAN MEMBERS, call Member Services.
Termination of a GROUP CONTRACT and Notice

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

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

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

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

The benefits available under Temporary Continuation of Coverage will be identical to those in your GROUP COVERAGE. TUFTS HEALTH PLAN may terminate your coverage back to the date the GROUP CONTRACT terminated, if:

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

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

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

Transfer to Other Employer GROUP Health Plans

Conditions for transfer
If you enrolled under a GROUP CONTRACT, you may transfer from TUFTS HEALTH PLAN to any other health plan offered by your GROUP only during your GROUP’s OPEN ENROLLMENT PERIOD, within 30 days after moving out of the SERVICE AREA, or as of the date your GROUP no longer offers TUFTS HEALTH PLAN.

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

Termination of an INDIVIDUAL CONTRACT

End of TUFTS HEALTH PLAN’s and SUBSCRIBER’s relationship under an INDIVIDUAL CONTRACT
If you enrolled under an INDIVIDUAL CONTRACT, coverage will terminate if your relationship with TUFTS HEALTH PLAN ends for any reason, including:

- your INDIVIDUAL CONTRACT with TUFTS HEALTH PLAN terminates;
- you fail to pay PREMIUMS on time*; or
- TUFTS HEALTH PLAN stops operating.

*If the SUBSCRIBER is terminated, he or she cannot then reinstate coverage under this plan for a period of at least one year from his or her original enrollment date.

Obtaining a Certificate of Creditable Coverage
Certificates of Creditable Coverage will be mailed to each SUBSCRIBER and/or DEPENDENT upon termination in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting the TUFTS HEALTH PLAN Member Services Department at 1-800-462-0224.

Capitalized words are defined in Appendix A.
Chapter 5 Continuation of GROUP CONTRACT Coverage

31-Day Continuation Coverage When MEMBER Leaves GROUP

Under Massachusetts law, a MEMBER who leaves a GROUP shall be able to continue his or her coverage under the GROUP CONTRACT for a period of 31 days. If that MEMBER becomes entitled to other health insurance coverage during that 31-day period, this continuation coverage shall end as of the date he or she becomes entitled to the other health insurance coverage. For more information about this continuation coverage, please call your GROUP or MEMBER Services.

Federal Continuation Coverage (COBRA)

Rules for federal COBRA continuation

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

Note: Same-sex marriages legally entered into in Massachusetts are not recognized under federal law. Federal COBRA continuation provisions therefore do not apply to same-sex SPOUSES. Check with your employer to see if COBRA-like benefits are available to you.

Qualifying Events

A MEMBER’s GROUP COVERAGE under the GROUP CONTRACT may end because he or she experiences a qualifying event. A qualifying event is defined as:

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

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

When federal COBRA coverage is effective

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

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

Cost of Coverage

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

Duration of Coverage

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

<table>
<thead>
<tr>
<th>Qualifying Event(s)</th>
<th>Qualified Beneficiaries</th>
<th>Maximum Period of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Termination of SUBSCRIBER’s employment for any reason other than gross misconduct.</td>
<td>SUBSCRIBER, SPOUSE, and DEPENDENT CHILDREN</td>
<td>18 months*</td>
</tr>
<tr>
<td>● Reduction in the SUBSCRIBER’s work hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBSCRIBER’s divorce, legal separation, entitlement to Medicare, or death.</td>
<td>SPOUSE and DEPENDENT CHILDREN</td>
<td>36 months</td>
</tr>
<tr>
<td>SUBSCRIBER’s or SPOUSE’s enrolled DEPENDENT ceases to be a DEPENDENT CHILD.</td>
<td>DEPENDENT CHILD</td>
<td>36 months</td>
</tr>
</tbody>
</table>

*Important Note: If a qualified beneficiary is determined under the federal Social Security Act to have been DISABLED within the first 60 days of federal COBRA continuation coverage for these qualifying events, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA coverage for up to an additional 11 months. You may be responsible for payment of up to 150% of the cost of COBRA coverage for this additional period of up to 11 months.

When coverage ends

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

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

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

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

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

Note: Same-sex marriages legally entered into in Massachusetts are recognized under Massachusetts law. Therefore, Massachusetts continuation, 39-week continuation, and plant closing continuation provisions do apply to same-sex SPOUSES. Contact your employer for more information.

When coverage begins
Massachusetts continuation coverage is effective on the date following the day GROUP COVERAGE ends, in most cases. Massachusetts continuation coverage would end, in most cases, 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.

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

Rules for Massachusetts continuation
Under a Massachusetts law similar to COBRA, you may be eligible to continue coverage after GROUP COVERAGE ends if: you were enrolled in TUFTS HEALTH PLAN through a Massachusetts GROUP which has 2 - 19 eligible employees; and you experience a qualifying event which would cause you to lose coverage under your GROUP; and you elect this continuation coverage by following the procedure described below.

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

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

Under Massachusetts law, when a MEMBER becomes ineligible for coverage under the GROUP CONTRACT because of involuntary layoff or death, that person may continue his or her coverage under the GROUP CONTRACT until the earlier of:

- a period of up to 39 weeks from the date of such ineligibility; or
- the date that MEMBER becomes eligible for benefits under another GROUP plan.

The GROUP is responsible for notifying the involuntarily laid-off SUBSCRIBER, the surviving SPOUSE of a deceased SUBSCRIBER, and other DEPENDENTS of their eligibility for this continuation coverage. Such MEMBER(S) may elect to this continuation coverage by providing at least 30 days written notice of that election to the GROUP. The MEMBER(S) shall then be responsible for the payment of the whole PREMIUM due for this continuation coverage. Please call your GROUP or MEMBER Services for more information about this continuation coverage.

Plant Closing

Description of continuation available under a GROUP CONTRACT

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

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Under USERRA:

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

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

For more information, please contact your GROUP.
Chapter 6 - MEMBER Satisfaction

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

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

All grievances and appeals should be sent to TUFTS HEALTH PLAN at the following address:

TUFTS HEALTH PLAN
Attn: Appeals and Grievances Dept.
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to TUFTS HEALTH PLAN's Member Services at 1-800-462-0224.

Internal Inquiry
Call a TUFTS HEALTH PLAN Member Specialist to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be explained or resolved within three (3) business days or if you tell a Member Specialist that you are not satisfied with the response you have received from TUFTS HEALTH PLAN, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

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

MEMBER Grievance Process
A grievance is a formal complaint about actions taken by TUFTS HEALTH PLAN or a TUFTS HEALTH PLAN PROVIDER. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

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

- your name and address;
- your TUFTS HEALTH PLAN MEMBER ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and TUFTS HP PROVIDER names); and
- any supporting documentation.

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

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

Administrative Grievance Timeline
- If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify TUFTS HEALTH PLAN that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your PROVIDERS to release medical information relevant to your grievance to TUFTS HEALTH PLAN. You must sign and return the form before TUFTS HEALTH PLAN can begin the review process. If you do not sign and return the form to TUFTS HEALTH PLAN within thirty (30) business days of the date you filed, TUFTS HEALTH PLAN may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance that are in the possession and control of TUFTS HEALTH PLAN.
- TUFTS HEALTH PLAN will review your grievance and will send you a letter regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and TUFTS HEALTH PLAN.

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

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

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

Capitalized words are defined in Appendix A. To contact Member Services, call 1-800-462-0224, or see our Web site at www.tuftshealthplan.com.
MEMBER Satisfaction Process, continued

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

It is important that you contact TUFTS HEALTH PLAN as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal. Appeals may be filed either verbally or in writing. If you would like to file a verbal appeal, call a TUFTS HEALTH PLAN Member Specialist who will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievances Department. To accurately reflect your concerns, you may want to put your appeal in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your TUFTS HEALTH PLAN MEMBER ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and PROVIDER names); and
- any supporting documentation.

Appeals Timeline
- If you file your appeal in writing, we will notify you in writing, 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 appeal.
- If you file your appeal verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your appeal.
- If your request for review was first addressed through the Internal Inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify TUFTS HEALTH PLAN that you are not satisfied with the response you received during the Internal Inquiry process.
- TUFTS HEALTH PLAN will review your appeal, make a decision, and send you a decision letter within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and TUFTS HEALTH PLAN. This extension may be necessary if we are waiting for medical records that are necessary for the review of your appeal and have not received them. The Appeals and Grievances Analyst handling your case will notify you in advance if an extension may be needed. In addition, a letter will be sent to you confirming the extension.

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

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

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

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

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

If you have a terminal illness, we will notify you of TUFTS HEALTH PLAN's decision within five (5) days of receiving your appeal. If TUFTS HEALTH PLAN's decision is to deny coverage, you may request a conference. We will schedule the conference within 10 days (or within 5 business days if your PROVIDER determines, after talking with a TUFTS HEALTH PLAN medical director, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date). You may bring another person with you to the conference. At the conference, you and/or your authorized representative, if any, and a representative of TUFTS HEALTH PLAN who has authority to determine the disposition of the grievance, shall review the information provided.

If the appeal is denied, the decision will include the specific medical and scientific reasons for denying the coverage, and a description of any alternative treatment, services or supplies that would be covered.

If you are Not Satisfied with the Appeals Decision

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

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

To request an external review by the Office of Patient Protection, you must file your request in writing with the Office of Patient Protection within forty-five (45) days of your receipt of written notice of the denial of your appeal by TUFTS HEALTH PLAN. The letter from TUFTS HEALTH PLAN notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection.

You, or your authorized representative, may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a PROVIDER, that delay in providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review.

Your cost for an external review by the Office of Patient Protection is $25.00. This payment should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that the payment of the fee would result in an extreme financial hardship to you. TUFTS HEALTH PLAN will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill TUFTS HEALTH PLAN the amount established pursuant to contract between the Massachusetts Department of Public Health and the assigned external review agency minus the $25 fee which is your responsibility.

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

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

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

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

Please note: if you are not satisfied with TUFTS HEALTH PLAN's Member Satisfaction Process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care at 617-521-7777 or the Department of Public Health's Office of Patient Protection at:

Department of Public Health  
Office of Patient Protection  
99 Chauncy St.  
Boston, MA 02111  
Phone: 1-800-436-7757  
Fax: 1-617-624-5046  
Internet: www.state.ma.us/dph/opp
Bills from PROVIDERS

Medical Expenses
Occasionally, you may receive a bill from a PROVIDER for COVERED SERVICES. Before paying the bill, contact the TUFTS HEALTH PLAN Member Services Department.

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

- A completed, signed MEMBER Reimbursement Medical Claim Form, which can be obtained from the TUFTS HEALTH PLAN web site or by contacting the TUFTS HEALTH PLAN Member Services Department.
- the documents listed on the MEMBER Reimbursement Medical Claim Form that are required for proof of service and payment.

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

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

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

IMPORTANT NOTE

Effective January 1, 2012, we will directly reimburse you for COVERED SERVICES you receive from most non-TUFTS HEALTH PLAN PROVIDERS. Some examples of these types of non-TUFTS HEALTH PLAN PROVIDERS include:

- radiologists, pathologists, and anesthesiologists who work in hospitals; and
- EMERGENCY room specialists.

You will be responsible to pay the non-TUFTS HEALTH PLAN PROVIDER for those COVERED SERVICES.

For more information, call Member Services or check our Web site at www.tuftshealthplan.com.

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

Pharmacy Expenses
If you obtain a prescription at a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a Member Specialist. You can also get one at our web site at www.tuftshealthplan.com.

Limitation on Actions

Limitation on Actions
You cannot file a lawsuit against TUFTS HEALTH PLAN for failing to pay or arrange for COVERED SERVICES unless you have completed the TUFTS HEALTH PLAN MEMBER Satisfaction Process and file the lawsuit within two years from the time the cause of action arose. For example, if you want to file a lawsuit because you were denied coverage under this GROUP CONTRACT or INDIVIDUAL CONTRACT, you must first complete our MEMBER Satisfaction Process, and then file your lawsuit within two years after the date you were first sent a notice of the denial. Going through our MEMBER Satisfaction Process does not extend the time limit for filing a lawsuit beyond two years after the date you were first denied coverage. However, if you choose to pursue external review by the Office of Patient Protection, the days from the date your request is received by the Office of Patient Protection, until the date you receive the response are not counted toward the two-year limit.

Capitalized words are defined in Appendix A.
Chapter 7 - Other Plan Provisions

Subrogation

TUFTS HEALTH PLAN’s right of subrogation

You may have a legal right to recover some or all of the costs of your health care from someone else, for example:

- your own or someone else’s auto or homeowner’s insurance; or
- the person who caused your illness or injury.

In that case, if TUFTS HEALTH PLAN pays or will pay for the costs of health care services provided to treat your illness or injury, TUFTS HEALTH PLAN has the right to recover those costs in your name, with or without your consent, directly from that person or company. This is called TUFTS HEALTH PLAN’s right of subrogation. TUFTS HEALTH PLAN’s right has priority, except as otherwise provided by law. TUFTS HEALTH PLAN can recover against the total amount of any recovery, regardless of whether:

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

Med Pay

You may be covered for medical expenses under optional automobile medical payments insurance (“Med Pay”). Our coverage is secondary to Med Pay benefits. If we pay benefits before Med Pay benefits have been exhausted, we may recover the cost of those benefits as described above.

Workers’ compensation

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

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

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

Tufts Health Plan’s right of reimbursement

In addition to the rights described above, if you recover money by suit, settlement, or otherwise, you are required to reimburse TUFTS HEALTH PLAN for the cost of health care services, supplies, medications, and expenses for which TUFTS HEALTH PLAN paid, or will pay. TUFTS HEALTH PLAN has the right to be reimbursed up to the amount of any payment received by you, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to reimburse you fully for the illness or injury.

Assignment of benefits

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

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

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

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

Coordination of Benefits

Benefits under other plans
You may have benefits under other plans for hospital, medical, dental or other health care expenses.
TUFTS HEALTH PLAN has a coordination of benefits (COB) program that prevents duplication of payment for the same health care services. We will coordinate benefits payable for COVERED SERVICES with benefits payable by other plans, consistent with state law.

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

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

Right to receive and release necessary information
When you enroll, you must include information on your membership application about other health coverage you have. After you enroll, you must notify TUFTS HEALTH PLAN of new coverage or termination of other coverage. 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 HEALTH PLAN’s COB program.

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

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

Capitalized words are defined in Appendix A.
To contact Member Services, call 1-800-462-0224, or see our Web site at [www.tuftshealthplan.com](http://www.tuftshealthplan.com).
Medicare Eligibility

This provision does not apply to a MEMBER enrolled under an INDIVIDUAL CONTRACT.

Medicare eligibility

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

TUFTS HEALTH PLAN will pay benefits before Medicare:

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

TUFTS HEALTH PLAN will pay benefits after Medicare:

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

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

Use and Disclosure of Medical Information

TUFTS HEALTH PLAN mails a separate “Notice of Privacy Practices” to all SUBSCRIBERS to explain how TUFTS HEALTH PLAN uses and discloses your medical information. If you have questions or would like another copy of our “Notice of Privacy Practices”, please call a Member Specialist. Information is also available on our Web site at www.tuftshealthplan.com.

Relationships between TUFTS HEALTH PLAN and PROVIDERS

TUFTS HEALTH PLAN arranges health care services. TUFTS HEALTH PLAN does not provide health care services. TUFTS HEALTH PLAN has agreements with PROVIDERS practicing in their private offices throughout the SERVICING AREA. These PROVIDERS are independent. They are not TUFTS HEALTH PLAN employees, agents or representatives. PROVIDERS are not authorized to change this EVIDENCE OF COVERAGE or assume or create any obligation for TUFTS HEALTH PLAN.

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

Circumstances Beyond TUFTS HEALTH PLAN’s Reasonable Control

Circumstances beyond TUFTS HEALTH PLAN’s reasonable control

TUFTS HEALTH PLAN shall not be responsible for a failure or delay in arranging for the provision of services in cases of circumstances beyond the reasonable control of TUFTS HEALTH PLAN. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, TUFTS HEALTH PLAN will make a good faith effort to arrange for the provision of services. In doing so, TUFTS HEALTH PLAN will take into account the impact of the event and the availability of SERVICE AREA PROVIDERS.
GROUP CONTRACT

Acceptance of the terms of the GROUP CONTRACT

By signing and returning the membership application form, you apply for GROUP COVERAGE and agree, on behalf of yourself and your enrolled DEPENDENTS, to all the terms and conditions of the GROUP CONTRACT, including this EVIDENCE OF COVERAGE.

Payments for coverage

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

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

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

Changes to this EVIDENCE OF COVERAGE

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

An amendment to this EVIDENCE OF COVERAGE describing the changes will be sent to you and will include the EFFECTIVE DATE of the change. Changes will apply to all benefits for services received on or after the EFFECTIVE DATE with one exception.

Exception: A change will not apply to you if you are an INPATIENT on the EFFECTIVE DATE of the change until the earlier of your discharge date, or the date ANNUAL COVERAGE LIMITATIONS are used up.

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

Notice

Notice to MEMBERS: When TUFTS HEALTH PLAN sends a notice to you, it will be sent to your last address on file with TUFTS HEALTH PLAN.

Notice to TUFTS HEALTH PLAN: MEMBERS should address all correspondence to:

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

Enforcement of terms

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

When this EVIDENCE OF COVERAGE Is Issued and Effective

This EVIDENCE OF COVERAGE is issued and effective on your GROUP ANNIVERSARY DATE on or January 1, 2011 and supersedes all previous EVIDENCE OF COVERAGE.

INDIVIDUAL CONTRACT

Acceptance of the terms of the INDIVIDUAL CONTRACT

By signing and returning the membership application form, you apply for coverage under an INDIVIDUAL CONTRACT and agree, on behalf of yourself and your enrolled DEPENDENTS, to all the terms and conditions of the INDIVIDUAL CONTRACT, including this EVIDENCE OF COVERAGE.
INDIVIDUAL CONTRACT, continued

Payments for coverage

TUFTS HEALTH PLAN will bill you for coverage under an INDIVIDUAL CONTRACT and you will be required to pay PREMIUMS to TUFTS HEALTH PLAN for that coverage. TUFTS HEALTH PLAN is not responsible if you fail to pay the PREMIUM.

Note: If you do not pay the PREMIUMS on time, TUFTS HEALTH PLAN may cancel your coverage in accordance with the INDIVIDUAL CONTRACT and applicable state law.

TUFTS HEALTH PLAN may change the PREMIUM. If the PREMIUM is changed, the change will apply to all MEMBERS under the INDIVIDUAL CONTRACT.

Changes to this EVIDENCE OF COVERAGE

TUFTS HEALTH PLAN may change this EVIDENCE OF COVERAGE. Changes do not require your consent. Notice of changes in COVERED SERVICES will be sent to the SUBSCRIBER at least 60 days before the EFFECTIVE DATE of the modifications and will:

- include information regarding any changes in clinical review criteria; and
- detail the effect of such changes on a MEMBER’s personal liability for the cost of such changes.

An amendment to this EVIDENCE OF COVERAGE describing the changes will be sent to you and will include the EFFECTIVE DATE of the change. Changes will apply to all benefits for services received on or after the EFFECTIVE DATE with one exception.

Exception: A change will not apply to you if you are an INPATIENT on the EFFECTIVE DATE of the change until the earlier of:

- your discharge date; or
- the date ANNUAL COVERAGE LIMITATIONS are used up.

Note: If changes are made, they will apply to all MEMBERS under the INDIVIDUAL CONTRACT, not just to you.

Notice

Notice to MEMBERS: When TUFTS HEALTH PLAN sends a notice to you, it will be sent to your last address on file with TUFTS HEALTH PLAN.

Notice to TUFTS HEALTH PLAN: MEMBERS should address all correspondence to:

TUFTS HEALTH PLAN
705 Mount Auburn Street
P.O. Box 9173
Watertown, MA 02471-9173

Enforcement of terms

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

When this EVIDENCE OF COVERAGE Is Issued and Effective

This EVIDENCE OF COVERAGE is issued and effective on your ANNIVERSARY DATE on or after January 1, 2011 and supersedes all previous EVIDENCE OF COVERAGES.
Appendix A - Glossary of Terms And Definitions

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

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

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

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

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

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

AUTHORIZED REVIEWER
AUTHORIZED REVIEWERS review and approve certain services and supplies to MEMBERS. They are TUFTS HEALTH PLAN’s Chief Medical Officer (or equivalent) or someone he or she names.

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.

CALENDAR YEAR
The 12-month period in which benefit limits, DEDUCTIBLES, OUT-OF-POCKET MAXIMUM, and COINSURANCE are calculated under this plan if applicable. Coverage is based on a calendar year runs from January 1st through December 31st within a year.

For more information, please call Member Services. If you are enrolled in a GROUP CONTRACT, you can also contact your employer.

CHILD
The following individuals until their 26th birthday:

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

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

For services provided by a Network PROVIDER, the MEMBER’s share is a percentage of

- For services provided by a non-TUFTS HEALTH PLAN PROVIDER, your share is a percentage of the REASONABLE CHARGE for those services.
- For services provided by a TUFTS HEALTH PLAN PROVIDER, your share is a percentage of:
  - the applicable TUFTS HEALTH PLAN fee schedule amount for those services; or
  - the TUFTS HEALTH PLAN PROVIDER’s actual charges for those services, whichever is less.

Note: The MEMBER’s share percentage is based on the TUFTS HEALTH PLAN PROVIDER payment at the time the claim is paid and does not reflect any later adjustments, payments or rebates.
Terms and Definitions

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

COST SHARING AMOUNT
The cost you pay for certain COVERED SERVICES. This amount may consist of DEDUCTIBLES, COPAYMENTS, and/or COINSURANCE.

COVERED SERVICE
The services and supplies for which TUFTS HEALTH PLAN will pay. They must be:

- described in Chapter 3 (subject to the "Exclusions from Benefits" section in Chapter 3); and
- MEDICALLY NECESSARY.

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

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

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

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

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

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

DAY SURGERY
Any surgical procedure(s) in an operating room under anesthesia for which the MEMBER is admitted to a facility licensed by the state to perform surgery, and with an expected discharge the same day, or in some instances, within 24 hours. For hospital census purposes, the MEMBER is an OUTPATIENT not an INPATIENT. Also referred to as "Ambulatory Surgery" or "Surgical Day Care".

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

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

DESIGNATED FACILITY for INPATIENT Mental Health/ INPATIENT Substance Abuse Services
A facility licensed to treat Mental Conditions and/or substance abuse (alcohol and drug). This facility has an agreement with us to provide INPATIENT or day treatment/partial hospitalization services to MEMBERS assigned to the facility. Also referred to as "DESIGNATED FACILITY".

DIRECTORY OF HEALTH CARE PROVIDERS
A separate booklet which lists TUFTS HEALTH PLAN PCPs and their affiliated TUFTS HEALTH PLAN HOSPITAL and certain other TUFTS HEALTH PLAN 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, you can call Member Services or check our Web site at www.tuftshealthplan.com.
Terms and Definitions, continued

DISABLED DEPENDENT
The SUBSCRIBER’s CHILD who:
- became permanently physically or mentally DISABLED before age 26;
- is incapable of supporting himself or herself due to disability;
- lives with the SUBSCRIBER or SPOUSE; and
- was covered under the SUBSCRIBER’s FAMILY COVERAGE immediately before age 26 or has been covered by
  other group health coverage since the disability began.

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

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

EMERGENCY
An illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity,
including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent lay
person, who possesses an average knowledge of health and medicine, to result in:
- serious jeopardy to the physical and/or mental health of a MEMBER or another person (or with respect to a pregnant
  MEMBER, the MEMBER’s or her unborn CHILD’s physical and/or mental health); or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions, inadequate time to effect a safe transfer to another
  hospital before delivery, or a threat to the safety of the MEMBER or her unborn CHILD in the event of transfer to
  another hospital before delivery.

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

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

FAMILY COVERAGE
Coverage for a SUBSCRIBER and his or her DEPENDENTS.
GROUP
An employer or other legal entity with which TUFTS HEALTH PLAN has an agreement to provide GROUP COVERAGE. An employer GROUP subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, is the ERISA plan sponsor. If you are covered under a GROUP CONTRACT, the GROUP is your agent and is not TUFTS HEALTH PLAN’s agent.

GROUP CONTRACT
The agreement between TUFTS HEALTH PLAN and the GROUP under which:

- TUFTS HEALTH PLAN agrees to provide GROUP COVERAGE; and
- the GROUP agrees to pay a PREMIUM to TUFTS HEALTH PLAN on your behalf.

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

INDIVIDUAL CONTRACT
The agreement between TUFTS HEALTH PLAN and the SUBSCRIBER under which:

- TUFTS HEALTH PLAN agrees to provide INDIVIDUAL COVERAGE; and
- the SUBSCRIBER agrees to pay a PREMIUM to TUFTS HEALTH PLAN.

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

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

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

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

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

In determining coverage for MEDICALLY NECESSARY Services, TUFTS HEALTH PLAN uses Clinical Coverage Guidelines which are:

- developed with input from practicing PROVIDERS in the TUFTS HEALTH PLAN SERVICE AREA;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- evidence-based, if practicable.
Terms and Definitions, continued

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

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

OPEN ENROLLMENT PERIOD
For a GROUP CONTRACT, the period each year when TUFTS HEALTH PLAN and the GROUP allow eligible persons to apply for GROUP COVERAGE in accordance with the GROUP CONTRACT. This is also the period each year when TUFTS HEALTH PLAN allows eligible individuals to apply for coverage in accordance with an INDIVIDUAL CONTRACT.

OUTPATIENT
A patient who receives care other than on an INPATIENT basis. This includes services provided in:
- a PROVIDER's office;
- a DAY SURGERY or ambulatory care unit; and
- an EMERGENCY room or OUTPATIENT clinic.
Note: You are also an OUTPATIENT when you are in a facility for observation

PARAPROFESSIONAL
As it pertains to the treatment of autism and autism spectrum disorders, a PARAPROFESSIONAL is an individual who performs applied behavioral analysis (ABA) services under the supervision of a BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA).

PREMIUM
Under a GROUP CONTRACT, the total monthly cost of Individual or FAMILY COVERAGE which the GROUP pays to TUFTS HEALTH PLAN. Under an INDIVIDUAL CONTRACT, the total monthly cost of individual or FAMILY COVERAGE which the SUBSCRIBER pays to TUFTS HEALTH PLAN.

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

PROVIDER
A health care professional or facility licensed in accordance with applicable law, including, but not limited to, hospitals, limited service medical clinics (if available), URGENT CARE centers (if available), physicians, doctors of osteopathy, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, optometrists, podiatrists, psychiatrists, psychologists, licensed mental health counselors, licensed independent clinical social workers, licensed psychiatric nurses who are certified as clinical specialists in psychiatric and mental health nursing, licensed speech-language pathologists, and licensed audiologists.
TUFTS HEALTH PLAN will only cover services of a PROVIDER, if those services are listed as COVERED SERVICES and within the scope of the PROVIDER's license.

Notes:
- With respect to OUTPATIENT Services for the treatment of alcoholism, PROVIDER means an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health or other applicable state law.
- With respect to INPATIENT Services for the treatment of alcoholism, PROVIDER means an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health; or a residential alcohol treatment program, as defined under Massachusetts law or other applicable state law.
PROVIDER ORGANIZATION
A PROVIDER ORGANIZATION is comprised of doctors and other health care PROVIDERS who practice together in the same community and who often admit patients to the same hospital in order to provide their patients with a full range of care. Also referred to as "PROVIDER GROUP".

REASONABLE CHARGE
The lesser of:

● the amount charged; or

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

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

SERVICE AREA
The SERVICE AREA (sometimes referred to as the "Enrollment SERVICE AREA"), is the geographical area within which we have developed a network of PROVIDERS to afford MEMBERS with adequate access to COVERED SERVICES. The Enrollment SERVICE AREA consists of the Standard SERVICE AREA and the Extended SERVICE AREA.

The Standard SERVICE AREA is comprised of:

● all of Massachusetts and all of Rhode Island, except Block Island; and

● the cities and towns in New Hampshire:
  ● in which TUFTS HEALTH PLAN PCPs are located; and
  ● which are a reasonable distance from TUFTS HEALTH PLAN PCP’s and specialists who provide the most-often used services, such as behavioral health practitioners and PROVIDER’s who are surgeons or OB/GYNs.

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

● surround the Standard SERVICE AREA; and

● are within a reasonable distance from TUFTS HEALTH PLAN specialists who provide the most-often used services, such as behavioral health practitioners and PROVIDER’s who are surgeons or OB/GYNs.

Note:
For a list of cities and towns in the SERVICE AREA, you can call our Member Services Department or check our Web site at www.tuftshealthplan.com.

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

SPOUSE
The SUBSCRIBER's legal SPOUSE, according to the law of the state in which you reside, or divorced SPOUSE as required by Massachusetts law.
SUBSCRIBER
The person:
- for a GROUP CONTRACT, is an employee of the GROUP;
- for an INDIVIDUAL CONTRACT, is a Massachusetts resident;
- who enrolls in TUFTS HEALTH PLAN and signs the membership application form on behalf of himself or herself and any DEPENDENTS; and
- in whose name the PREMIUM is paid in accordance with either a GROUP CONTRACT or an INDIVIDUAL CONTRACT (whichever applies).

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

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

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

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

Note: Care that is rendered after the URGENT condition has been treated and stabilized and the MEMBER is safe for transport is not considered URGENT CARE.
Appendix B - ERISA Information (applies to GROUP CONTRACTS only)

ERISA RIGHTS

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

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

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

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

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

- Continue health care coverage for yourself, SPOUSE or DEPENDENTS if there is a loss of coverage under the plan as a result of a qualifying event. You or your DEPENDENTS may have to pay for such coverage.
- Review your summary plan description and the documents governing the plan on the rules governing your continuation coverage rights under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Note: This plan does not include a preexisting condition exclusion.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

91
ERISA RIGHTS, continued

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

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

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

How do I designate an Authorized Claimant?
An authorized claimant can be designated at any point in the claims process - at the pre-service, post service or appeal level. Please contact a TUFTS HEALTH PLAN Member Specialist at 1-800-423-8080 for the specifics on how to appoint an authorized claimant.

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

Urgent care claim: An "urgent care claim" is a claim for medical care or treatment where the application of the claims review procedure for non-urgent claims: (1) could seriously jeopardize your life, health or ability to regain maximum function, or (2) based upon your PROVIDER's determination, would subject you to severe pain that cannot adequately be managed without the care or treatment being requested. For urgent care claims, TUFTS HEALTH PLAN will respond to you within 72 hours after receipt of the claim. If TUFTS HEALTH PLAN determines that additional information is needed to review your claim, we will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hours after that time to provide the requested information. TUFTS HEALTH PLAN will evaluate your claim within 48 hours after the earlier of our receipt of the requested information, or the end of the extension period given to you to provide the requested information.

Concurrent care decisions: A "concurrent care decision" is a determination relating to the continuation/reduction of an ongoing course of treatment. If TUFTS HEALTH PLAN has already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, TUFTS HEALTH PLAN will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the decision and obtain a determination before the treatment is reduced or terminated. If you request to extend an ongoing course of treatment that involves urgent care, TUFTS HEALTH PLAN will respond to you within 24 hours after receipt of the request (provided that you make the request at least 24 hours prior to the expiration of the ongoing course of treatment). If you reach the end of a pre-approved course of treatment before requesting additional services, the "pre-service" or "post-service" time limits will apply.

Pre-service claim: A "pre-service claim" is a claim that requires approval of the benefit in advance of obtaining the care. For pre-service claims, TUFTS HEALTH PLAN will respond to you within 15 days after receipt of the claim*. If TUFTS HEALTH PLAN determines that an extension is necessary due to matters beyond our control, we will notify you within 15 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a pre-service claim, but do not submit enough information for TUFTS HEALTH PLAN to make a determination, we will notify you within 15 days and describe the information that you need to provide to TUFTS HEALTH PLAN. You will have no less than 45 days from the date you receive the notice to provide the requested information.
Types of claims, continued

**Post-service claim:** A "post-service claim" is a claim for payment for a particular service after the service has been provided. For post-service claims, TUFTS HEALTH PLAN will respond to you within 30 days after receipt of the claim. If TUFTS HEALTH PLAN determines that an extension is necessary due to matters beyond our control, we will notify you within 30 days informing you of the circumstances requiring the extension and the date by which we expect to render a decision (up to an additional 15 days). If you make a post-service claim, but do not submit enough information for TUFTS HEALTH PLAN to make a determination, we will notify you within 30 days and describe the information that you need to provide to TUFTS HEALTH PLAN. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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

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

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

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

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

In addition, a plan or issuer may not, under federal law, require that a PROVIDER or other health care PROVIDER obtain authorization for prescribing a length of stay or up to 48 hours (or 96 hours). However, to use certain PROVIDERS or facilities, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

**FAMILY AND MEDICAL LEAVE ACT OF 1993**

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

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

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

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

- **Qualifying Exigency Leave:** Eligible employees are entitled to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the SPOUSE, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
- **Military Caregiver Leave:** An eligible employee who is the SPOUSE, son, daughter, parent, or next of kin of a covered servicemember who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the servicemember. The employee is entitled to a combined total of 26 weeks for all types of FMLA leave in the single 12-month period.

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

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

93
An employee should contact his or her employer for details about FMLA and to make payment arrangements, if applicable. Additional information is also available from the U.S. Department of Labor: (1-866-487-9243) TTY: 1-877-899-5627 or http://www.dol.gov/whd/fmla/finalrule/FMLAPoster.pdf.

**Notice of Privacy Practices**

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.

**Introduction**

Tufts Health Plan strongly believes in safeguarding the privacy of our members' protected health information (PHI). PHI is information which:

- Identifies you (or can reasonably be used to identify you); and
- Relates to your physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use and disclose your PHI, and your rights concerning your PHI. This Notice applies to all members of Tufts Health Plan's insured health benefit plans, including: HMO plans; Tufts Health Plan Medicare Preferred plans; and insured POS and PPO plans. It also applies to all members of health plans insured by Tufts Insurance Company (a Tufts Health Plan affiliate). Unless your employer has notified you otherwise, this Notice of Privacy Practices also applies to all members of self-insured group health plans that are administered by a Tufts Health Plan entity.

**How We Obtain PHI**

As a managed care plan, we engage in routine activities that result in our being given PHI from sources other than you. For example, health care providers—such as physicians and hospitals—submit claim forms containing PHI to enable us to pay them for the covered health care services they have provided to you.

**How We Use and Disclose Your PHI**

We use and disclose PHI in a number of ways to carry out our responsibilities as a managed care plan. The following describes the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

- **Treatment:** We may use and disclose your PHI to health care providers to help them treat you. For example, our care managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from a hospital.
- **Payment Purposes:** We use and disclose your PHI for payment purposes, such as paying doctors and hospitals for covered services. Payment purposes also include activities such as: determining eligibility for benefits; reviewing services for medical necessity; performing utilization review; obtaining premiums; coordinating benefits; subrogation; and collection activities.
- **Health Care Operations:** We use and disclose your PHI for health care operations. This includes coordinating/managing care; assessing and improving the quality of health care services; reviewing the qualifications and performance of providers; reviewing health plan performance; conducting medical reviews; and resolving grievances. It also includes business activities such as: underwriting; rating; placing or replacing coverage; determining coverage policies; business planning; obtaining reinsurance; arranging for legal and auditing services (including fraud and abuse detection programs); and obtaining accreditations and licenses.
- **Health and Wellness Information:** We may use your PHI to contact you with information about appointment reminders; treatment alternatives; therapies; health care providers; settings of care; or other health-related benefits, services and products that may be of interest to you. For example, we might send you information about smoking cessation programs.
- **Organizations That Assist Us:** In connection with treatment, payment and health care operations, we may share your PHI with our affiliates and third-party "business associates" that perform activities for us or on our behalf, for example,
our pharmacy benefit manager. We will obtain assurances from our business associates that they will appropriately safeguard your information.

- **Plan Sponsors:** If you are enrolled in Tufts Health Plan through your current or former place of work, you are enrolled in a group health plan. We may disclose PHI to the group health plan's plan sponsor-usually your employer-for plan administration purposes. The plan sponsor must certify that it will protect the PHI in accordance with law.

- **Public Health and Safety; Health Oversight:** We may disclose your PHI to a public health authority for public health activities, such as responding to public health investigations; when authorized by law, to appropriate authorities, if we reasonably believe you are a victim of abuse, neglect or domestic violence; when we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to your or others' health or safety; or to health oversight agencies for certain activities such as audits, disciplinary actions and licensure activity.

- **Legal Process; Law Enforcement; Specialized Government Activities:** We may disclose your PHI in the course of legal proceedings; in certain cases, in response to a subpoena, discovery request or other lawful process; to law enforcement officials for such purposes as responding to a warrant or subpoena; or for specialized governmental activities such as national security.

- **Research; Death; Organ Donation:** We may disclose your PHI to researchers, provided that certain established measures are taken to protect your privacy. We may disclose PHI, in certain instances, to coroners, medical examiners and in connection with organ donation.

- **Workers' Compensation:** We may disclose your PHI when authorized by workers' compensation laws.

- **Family and Friends:** We may disclose PHI to a family member, relative or friend-or anyone else you identify-as follows: (i) when you are present prior to the use or disclosure and you agree; or (ii) when you are not present (or you are incapacitated or in an emergency situation) if, in the exercise of our professional judgment and in our experience with common practice, we determine that the disclosure is in your best interests. In these cases we will only disclose the PHI that is directly relevant to the person's involvement in your health care or payment related to your health care.

- **Personal Representatives:** Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative has legal authority to act on your behalf in making decisions related to your health care. For example, a health care proxy, or a parent or guardian of an unemancipated minor are personal representatives.

- **Mailings:** We will mail information containing PHI to the address we have on record for the subscriber of your health benefits plan. We will not make separate mailings for enrolled dependents at different addresses, unless we are requested to do so and agree to the request. See below “Right to Receive Confidential Communications” for more information on how to make such a request.

- **Required by Law:** We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws. If one of the above reasons does not apply, we will not use or disclose your PHI without your written permission (“authorization”). You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may later change your mind and revoke your authorization in writing. However, your written revocation will not affect actions we've already taken in reliance on your authorization. Where state or other federal laws offer you greater privacy protections, we will follow those more stringent requirements. For example, under certain circumstances, records that contain information about alcohol abuse treatment; drug abuse prevention or treatment; AIDS-related testing or treatment; or certain privileged communications may not be disclosed without your written authorization. In addition, when applicable we must have your written authorization before using or disclosing medical or treatment information for a member appeal. See below, "Who to Contact for Questions or Complaints," if you would like more information.

**How We Protect PHI Within Our Organization**

Tufts Health Plan protects oral, written and electronic PHI throughout our organization. We do not sell PHI to anyone. We have many internal policies and procedures designed to control and protect the internal security of your PHI. These policies and procedures address, for example, use of PHI by our employees. In addition, we train all employees about these policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws.

**Your Individual Rights**

The following is a summary of your rights with respect to your PHI:

- **Right of Access to PHI:** You have the right to inspect and get a copy of most PHI Tufts Health Plan has about you. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice of denial.
describing the basis of our denial. We may charge a reasonable fee for the cost of producing and mailing the copies. Requests must be made in writing and reasonably describe the information you would like to inspect or copy.

- Right to Request Restrictions: You have the right to ask that we restrict uses or disclosures of your PHI to carry out treatment, payment and health care operations; and disclosures to family members or friends. We will consider the request. However, we are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made verbally or in writing to Tufts Health Plan.

- Right to Receive Confidential Communications: You have the right to ask us to send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the subscriber's address. We will accommodate your request if you state that disclosure of your PHI through our usual means could endanger you; your request is reasonable; it specifies the alternative means or location; and it contains information as to how payment, if any, will be handled. Requests may be made verbally or in writing to Tufts Health Plan.

- Right to Amend PHI: You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to Tufts Health Plan and must include a reason to support the requested amendment.

- Right to Receive an Accounting of Disclosures: You have the right to a written accounting of the disclosures of your PHI that we made in the last six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to: (i) disclosures we made for treatment, payment or health care operations; (ii) disclosures made to you or people you have designated; (iii) disclosures you or your personal representative have authorized; (iv) disclosures made before April 14, 2003; and (v) certain other disclosures, such as disclosures for national security purposes. If you request an accounting more than once in a 12-month period, we may charge you a reasonable fee. All requests for an accounting of disclosures must be made in writing to Tufts Health Plan.

- Right to This Notice: You have the right to receive a paper copy of this Notice from us upon request.

- How to Exercise Your Rights: To exercise any of the individual rights described above or for more information, please call a member services specialist at 800-462-0224 (TDD: 800-815-8580) or write to: Corporate Compliance Department, Tufts Health Plan, 705 Mount Auburn Street, Watertown, MA 02472-1508.

Effective Date of Notice
This Notice takes effect August 13, 2007. We must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to privacy of your medical information.

Changes to This Notice of Privacy Practice
We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that we maintain—whether created or received before or after the effective date of the new Notice. Whenever we make an important change, we will send subscribers an updated Notice of Privacy Practices. In addition, we will publish the updated Notice on our Website at tuftshealthplan.com.

Who to Contact for Questions or Complaints
If you would like more information or an additional paper copy of this Notice, please contact a member services specialist at the number listed above. You can also download a copy from our Website at tuftshealthplan.com. If you believe your privacy rights may have been violated, you have a right to complain to Tufts Health Plan by calling the Privacy Officer at 800-208-9549 or writing to: Privacy Officer, Corporate Compliance Department, Tufts Health Plan, 705 Mount Auburn Street, Watertown, MA 02472-1508.

You also have a right to complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Tufts Health Plan is the trade name for Tufts Associated Health Maintenance Organization, Inc. It is also a trade name for Total Health Plan, Inc. and Tufts Benefit Administrators, Inc. in each entity's capacity as an administrator for self-funded group health plans; and for Tufts Insurance Company.

© 2007 Tufts Associated Health Plans, Inc. All rights reserved.
Appendix C - Non-Covered Drugs with Suggested Alternatives

This list of non-covered drugs is effective January 1, 2011 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter or if a generic version of a drug becomes available.

**IMPORTANT NOTE:** Please see our Web site at [www.tuftshealthplan.com](http://www.tuftshealthplan.com) for the most current list or call a Member Specialist.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Suggested Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify Discmelt</td>
<td>Abilify tablets</td>
</tr>
<tr>
<td>Abilify Solution</td>
<td>Abilify tablets</td>
</tr>
<tr>
<td>Acanya</td>
<td>clindamycin gel + benzoyl peroxide gel</td>
</tr>
<tr>
<td>Accupril</td>
<td>quinapril</td>
</tr>
<tr>
<td>Accuretic</td>
<td>quinapril/hydrochlorothiazide</td>
</tr>
<tr>
<td>AcipHex</td>
<td>Prilosec OTC (OTC, not covered), omeprazole, pantoprazole</td>
</tr>
<tr>
<td>Actiq</td>
<td>Fentanyl citrate</td>
</tr>
<tr>
<td>Acuvail</td>
<td>Acular, Acular LS, ketorolac</td>
</tr>
<tr>
<td>Aczone</td>
<td>benzoyl peroxide gel</td>
</tr>
<tr>
<td>Adalat CC</td>
<td>Nifedipine extended-release</td>
</tr>
<tr>
<td>Adderall</td>
<td>Amphetamine/dextroamphetamine mixed salts</td>
</tr>
<tr>
<td>Adderall XR</td>
<td>Amphetamine/dextroamphetamine mixed salts extended release</td>
</tr>
<tr>
<td>Alcortin A Topical Gel</td>
<td>hydrocortisone/iodoquinal cream</td>
</tr>
<tr>
<td>Aldactone</td>
<td>spironolactone</td>
</tr>
<tr>
<td>Aldactazide</td>
<td>Spironolactone/hydrochlorothiazide</td>
</tr>
<tr>
<td>Altace</td>
<td>ramipril capsules</td>
</tr>
<tr>
<td>Altoprev</td>
<td>lovastatin tablets</td>
</tr>
<tr>
<td>Ambien</td>
<td>zolpidem tartrate</td>
</tr>
<tr>
<td>Ambien CR</td>
<td>zolpidem tartrate</td>
</tr>
<tr>
<td>Amrix</td>
<td>cyclobenzaprin</td>
</tr>
<tr>
<td>Anafranil</td>
<td>Clomipramine HCl</td>
</tr>
<tr>
<td>Analpram E Rectal Kit</td>
<td>Hydrocortisone/pramoxine rectal cream</td>
</tr>
<tr>
<td>Ansaid</td>
<td>flurbiprofen</td>
</tr>
<tr>
<td>Antara</td>
<td>Fenofibrate</td>
</tr>
<tr>
<td>Arava</td>
<td>leflunomide</td>
</tr>
<tr>
<td>Atacand</td>
<td>Losarten, Benicar, Cozaar, or Diovan</td>
</tr>
<tr>
<td>Atacand HCT</td>
<td>Losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT</td>
</tr>
<tr>
<td>Ativan</td>
<td>lorazepam</td>
</tr>
<tr>
<td>Auralgan</td>
<td>A/B Otic, Benzotic, Aurodex</td>
</tr>
<tr>
<td>Avalide</td>
<td>Losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT, or Hyzaar</td>
</tr>
<tr>
<td>Avar</td>
<td>Losarten, Benicar, Cozaar, Diovan</td>
</tr>
<tr>
<td>Avar LS Cleanser</td>
<td>Avar</td>
</tr>
<tr>
<td>Avar-E LS cream</td>
<td>Avar E</td>
</tr>
<tr>
<td>Axid capsules</td>
<td>cimetidine, famotidine, nizatidine, ranitidine</td>
</tr>
<tr>
<td>Beconase AQ</td>
<td>fluticasone nasal spray, flunisolide nasal spray, Nasonex</td>
</tr>
<tr>
<td>BenzE Foam</td>
<td>Benzoil peroxide</td>
</tr>
<tr>
<td>Benziq</td>
<td>benzoil peroxide</td>
</tr>
<tr>
<td>Benziq LS</td>
<td>benzoil peroxide</td>
</tr>
<tr>
<td>Bepreve</td>
<td>Azelastine eye drops, Patanol</td>
</tr>
<tr>
<td>Besivance</td>
<td>Ciprofloxacin eye drops, Vigamox, Zymar</td>
</tr>
<tr>
<td>Buspar</td>
<td>buspirone</td>
</tr>
<tr>
<td>Bystolic</td>
<td>Atenolol, carvedilol, metoprolol</td>
</tr>
</tbody>
</table>
## Appendix C - Non-Covered Drugs with Suggested Alternatives, continued

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Suggested Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calen</td>
<td>verapamil</td>
</tr>
<tr>
<td>Calen SR</td>
<td>Verapamil extended-release</td>
</tr>
<tr>
<td>Cambia</td>
<td>Diclofenac potassium tablets</td>
</tr>
<tr>
<td>Caphosol</td>
<td>saliva substitute (OTC, not covered)</td>
</tr>
<tr>
<td>Cardizem</td>
<td>diltiazem</td>
</tr>
<tr>
<td>Cardizem CD/LA</td>
<td>Diltiazem extended-release</td>
</tr>
<tr>
<td>Cardura</td>
<td>doxazosin</td>
</tr>
<tr>
<td>Cataflam</td>
<td>Diclofenac potassium</td>
</tr>
<tr>
<td>Catapres</td>
<td>clonidine</td>
</tr>
<tr>
<td>Catapres TTS</td>
<td>Clonidine transdermal</td>
</tr>
<tr>
<td>Chenodal</td>
<td>ursodiol</td>
</tr>
<tr>
<td>Cleanse and Treat</td>
<td>benzyol peroxide wash &amp; salicylic acid pads (OTC, not covered)</td>
</tr>
<tr>
<td>Clinoril</td>
<td>sulindac</td>
</tr>
<tr>
<td>Clobex spray</td>
<td>clobetasol lotion</td>
</tr>
<tr>
<td>Colestid</td>
<td>Colestipol</td>
</tr>
<tr>
<td>Corgard</td>
<td>nadolol</td>
</tr>
<tr>
<td>Coreg</td>
<td>carvedilol</td>
</tr>
<tr>
<td>Daypro</td>
<td>oxaprozin</td>
</tr>
<tr>
<td>Darvocet-N 100</td>
<td>Propoxyphene napsylate/acetaminophen</td>
</tr>
<tr>
<td>Darvon</td>
<td>Propoxyphene</td>
</tr>
<tr>
<td>Damadex</td>
<td>Torsemide</td>
</tr>
<tr>
<td>Demerol</td>
<td>Meperidine</td>
</tr>
<tr>
<td>Deprizine suspension</td>
<td>Ranitidine solution</td>
</tr>
<tr>
<td>Desonate</td>
<td>desonide cream/lotion</td>
</tr>
<tr>
<td>Dexedrine</td>
<td>dextroamphetamine</td>
</tr>
<tr>
<td>Dexedrine Spansule</td>
<td>Dextroamphetamine extended-release</td>
</tr>
<tr>
<td>Dexilant</td>
<td>Prilosec OTC, omeprazole, lansoprazole, pantoprazole</td>
</tr>
<tr>
<td>Dicopanol suspension</td>
<td>Diphenhydramine liquid</td>
</tr>
<tr>
<td>Dilacor XR</td>
<td>Diltiazem extended-release</td>
</tr>
<tr>
<td>Dilaudid</td>
<td>hydromorphone</td>
</tr>
<tr>
<td>Duragesic</td>
<td>Fentanyl patch</td>
</tr>
<tr>
<td>Durasal</td>
<td>Salicylic acid liquid/patch</td>
</tr>
<tr>
<td>Durezol</td>
<td>diclofenac eye drops, prenisolone acetate</td>
</tr>
<tr>
<td>Dyazide</td>
<td>Triamterene/hydrochlorothiazide capsules</td>
</tr>
<tr>
<td>Dynacin</td>
<td>minocycline capsules</td>
</tr>
<tr>
<td>EC Naprosyn</td>
<td>enteric-coated naproxen</td>
</tr>
<tr>
<td>Edluar</td>
<td>zolpidem tartrate tablets</td>
</tr>
<tr>
<td>Effexor XR</td>
<td>Venlafaxine extended-release capsules</td>
</tr>
<tr>
<td>Epiduo</td>
<td>Differin 0.1% gel, benzyol peroxide 2.5% gel</td>
</tr>
<tr>
<td>Exalgo</td>
<td>Hydromorphone tablets</td>
</tr>
<tr>
<td>Extina</td>
<td>ketoconazole cream or shampoo</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Suggested Alternatives</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Factive</td>
<td>ciprofloxacin, ofloxacin, Avelox</td>
</tr>
<tr>
<td>Fanapt</td>
<td>Risperidone, Seroquel, Zyprexa</td>
</tr>
<tr>
<td>Fanatrex</td>
<td>Neurontin solution</td>
</tr>
<tr>
<td>Feldene</td>
<td>piroxicam</td>
</tr>
<tr>
<td>Fenoglide</td>
<td>fenofibrate</td>
</tr>
<tr>
<td>Fentora</td>
<td>fentanyl citrate lollipop</td>
</tr>
<tr>
<td>Fexmid</td>
<td>cyclobenzaprine</td>
</tr>
<tr>
<td>Fibricon</td>
<td>fenofibrate</td>
</tr>
<tr>
<td>Fioricet</td>
<td>Bualbital/acetaminophen/caffeine</td>
</tr>
<tr>
<td>Fiorinal</td>
<td>Bualbital/ aspirin/caffeine</td>
</tr>
<tr>
<td>Flagyl 375 mg,</td>
<td>metronidazole tablets</td>
</tr>
<tr>
<td>Flagyl ER</td>
<td></td>
</tr>
<tr>
<td>Flector</td>
<td>diclofenac tablets</td>
</tr>
<tr>
<td>Flexeril</td>
<td>cyclobenzaprine</td>
</tr>
<tr>
<td>Flonase</td>
<td>flunisolide nasal spray, fluticasone nasal spray, Nasonex</td>
</tr>
<tr>
<td>Focalin</td>
<td>dexamethasphenidate</td>
</tr>
<tr>
<td>Fortamet</td>
<td>metformin extended-release</td>
</tr>
<tr>
<td>Fosamax</td>
<td>alendronate</td>
</tr>
<tr>
<td>Fosamax Plau D</td>
<td>alendronate + Vitamin D (Vitamin D is OTC, not covered)</td>
</tr>
<tr>
<td>Genotropin</td>
<td>Norditropin, Norditropin Nordiflex</td>
</tr>
<tr>
<td>Glumetza</td>
<td>metformin ER</td>
</tr>
<tr>
<td>Glycolax</td>
<td>Miralax (OTC, not covered)</td>
</tr>
<tr>
<td>Halcion</td>
<td>triazolam</td>
</tr>
<tr>
<td>Humatrope</td>
<td>Norditropin, Norditropin Nordiflex, Norditropin Flexpro</td>
</tr>
<tr>
<td>Hydro 35/Hydro 40</td>
<td>urea lotion, urea cream</td>
</tr>
<tr>
<td>Hyzaar</td>
<td>Losartan/hydrochlorothiazide</td>
</tr>
<tr>
<td>Inderal LA</td>
<td>Propranolol extended-release</td>
</tr>
<tr>
<td>Indocin SR</td>
<td>indomethacin</td>
</tr>
<tr>
<td>Inova</td>
<td>benzoyle peroxide wash, Stridex (OTC, not covered)</td>
</tr>
<tr>
<td>Invega</td>
<td>risperidone, Seroquel, Zyprexa</td>
</tr>
<tr>
<td>Invega Sustenna</td>
<td>Risperdal Consta, risperidone</td>
</tr>
<tr>
<td>Keppra XR</td>
<td>Keppra, levetiracetam</td>
</tr>
<tr>
<td>Kerafoam</td>
<td>urea lotion/cream</td>
</tr>
<tr>
<td>Kerala Nailstik</td>
<td>urea nail gel, Kerala nail gel</td>
</tr>
<tr>
<td>Kerlone</td>
<td>betazolol</td>
</tr>
<tr>
<td>Kerol</td>
<td>urea cream/lotion</td>
</tr>
<tr>
<td>Kerol AD</td>
<td>urea emulsion/lotion</td>
</tr>
<tr>
<td>Kerol ZX</td>
<td>urea liquid/lotion</td>
</tr>
<tr>
<td>Klonopin</td>
<td>clonazepam</td>
</tr>
<tr>
<td>Lasix</td>
<td>furosemide</td>
</tr>
</tbody>
</table>
## Appendix C - Non-Covered Drugs with Suggested Alternatives, continued

<table>
<thead>
<tr>
<th>Brand names</th>
<th>Suggested alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levaquin</td>
<td>ciprofloxacin, ofloxacin, Avelox</td>
</tr>
<tr>
<td>Lialda</td>
<td>Apriso, Asacol</td>
</tr>
<tr>
<td>Librax</td>
<td>Chlordiazepoxide/clidinium</td>
</tr>
<tr>
<td>Lidamantine HC Medicated Pads</td>
<td>lidocaine-HC cream or lotion</td>
</tr>
<tr>
<td>Lipofen</td>
<td>fenofibrate</td>
</tr>
<tr>
<td>Livalo</td>
<td>Simvastatin</td>
</tr>
<tr>
<td>Lofibra</td>
<td>Fenofibrate</td>
</tr>
<tr>
<td>Lopid</td>
<td>gemfibrozil</td>
</tr>
<tr>
<td>Lopressor</td>
<td>metoprolol</td>
</tr>
<tr>
<td>Lopressor HCT</td>
<td>Metoprolol/hydrochlorothiazide</td>
</tr>
<tr>
<td>Lotensin</td>
<td>benazepril</td>
</tr>
<tr>
<td>Lotensin HCT</td>
<td>benazepril/hydrochlorothiazide</td>
</tr>
<tr>
<td>Lotrel</td>
<td>Amiodipine/benazepril</td>
</tr>
<tr>
<td>Lovaza</td>
<td>omega-3 fish oil (OTC, not covered)</td>
</tr>
<tr>
<td>Luvox CR</td>
<td>fluvoxamine tablets</td>
</tr>
<tr>
<td>Movik</td>
<td>trandolapril</td>
</tr>
<tr>
<td>Maxzide</td>
<td>Triamterene/hydrochlorothiazide tablets</td>
</tr>
<tr>
<td>Megace ES</td>
<td>megestrol acetate oral suspension 40 mg/ml</td>
</tr>
<tr>
<td>Matadate ER</td>
<td>Methylphenidate extended-release 10 mg</td>
</tr>
<tr>
<td>Methylin Oral Solution</td>
<td>Methylphenidate oral solution</td>
</tr>
<tr>
<td>Metozolv</td>
<td>Metoclopramide oral solution</td>
</tr>
<tr>
<td>Mevacor</td>
<td>ovastatin</td>
</tr>
<tr>
<td>Micardis</td>
<td>Losartan, Benicar, Diovan</td>
</tr>
<tr>
<td>Micardis HCT</td>
<td>Losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT, Hyzaar</td>
</tr>
<tr>
<td>Minocin</td>
<td>minocycline capsules</td>
</tr>
<tr>
<td>Minipress</td>
<td>prazosin</td>
</tr>
<tr>
<td>Mobic</td>
<td>meloxicam</td>
</tr>
<tr>
<td>Monodox</td>
<td>doxycycline monohydrate</td>
</tr>
<tr>
<td>Motrin</td>
<td>ibuprofen</td>
</tr>
<tr>
<td>Moxatag</td>
<td>amoxicillin 500 mg, amoxicillin 875 mg</td>
</tr>
<tr>
<td>MS Contin</td>
<td>Morphine sulfate extended-release</td>
</tr>
<tr>
<td>Naprelan</td>
<td>naproxen sodium extended-release</td>
</tr>
<tr>
<td>Naprelan CR DosePak</td>
<td>naproxen sodium extended-release tablets</td>
</tr>
<tr>
<td>Naprosyn</td>
<td>naproxen</td>
</tr>
<tr>
<td>Brand names</td>
<td>Suggested alternatives</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nasacort AQ</td>
<td>flunisolide nasal spray, fluticasone nasal spray, Nasonex</td>
</tr>
<tr>
<td>Neobenz Micro/Kit</td>
<td>benzoyl peroxide</td>
</tr>
<tr>
<td>Neobenz Micro SD</td>
<td>benzoyl peroxide</td>
</tr>
<tr>
<td>Neutrasal</td>
<td>Saliva substitute (OTC, not covered)</td>
</tr>
<tr>
<td>Nexium</td>
<td>Prilosec OTC (OTC, not covered), omeprazole, pantoprazole</td>
</tr>
<tr>
<td></td>
<td>PLEASE NOTE: Nexium suspension is covered for Members 12 years of age or younger.</td>
</tr>
<tr>
<td>Niravam</td>
<td>alprazolam</td>
</tr>
<tr>
<td>Norco</td>
<td>Hydrocodone/acetaminophen</td>
</tr>
<tr>
<td>Norpramin</td>
<td>desipramine</td>
</tr>
<tr>
<td>Norvasc</td>
<td>amiodipine</td>
</tr>
<tr>
<td>Noxafil</td>
<td>fluconazole</td>
</tr>
<tr>
<td>Nucynta</td>
<td>Oxycondone, tramadol</td>
</tr>
<tr>
<td>Nutropin</td>
<td>Norditropin, Norditropin Nordiflex, Norditropin Flexpro</td>
</tr>
<tr>
<td>Nutropin AQ</td>
<td>Norditropin, Norditropin Nordiflex, Norditropin Flexpro</td>
</tr>
<tr>
<td>Nutropin AQ Nuspin</td>
<td>Norditropin, Norditropin Nordiflex, Norditropin Flexpro</td>
</tr>
<tr>
<td>Olux-E</td>
<td>Olux foam, clobetasol 0.05% foam</td>
</tr>
<tr>
<td>Olux-Olux E</td>
<td>Olux foam, clobetasol 0.05% foam</td>
</tr>
<tr>
<td>Omnaris</td>
<td>azelastine nasal spray, Astepro, Astelin</td>
</tr>
<tr>
<td>Omnitrope</td>
<td>Norditropin, Norditropin Nordiflex, Norditropin Flexpro</td>
</tr>
<tr>
<td>Opana</td>
<td>Oxymorphine, hydromorphone tablets, oxycodone tablets</td>
</tr>
<tr>
<td>Opana ER</td>
<td>oxycodone ER</td>
</tr>
<tr>
<td>Oracea</td>
<td>doxycycline</td>
</tr>
<tr>
<td>Oravig</td>
<td>fluconazole</td>
</tr>
<tr>
<td>Orbivan</td>
<td>Butalbital/acetaminophen/caffeine</td>
</tr>
<tr>
<td>Pacnex</td>
<td>benzoyl peroxide cleanser</td>
</tr>
<tr>
<td>Pacnex MX</td>
<td>benzoyl peroxide</td>
</tr>
<tr>
<td>Pamelor</td>
<td>nortriptyline</td>
</tr>
<tr>
<td>Pamate</td>
<td>tranylcypromine</td>
</tr>
<tr>
<td>Pataday</td>
<td>Zaditor (OTC, not covered), Patanol</td>
</tr>
<tr>
<td>Patanase</td>
<td>Azelastine, nasal spray, Astepro, nasal spray Astelin</td>
</tr>
<tr>
<td>Paxil</td>
<td>paroxetine</td>
</tr>
<tr>
<td>Paxil CR</td>
<td>Paroxetine extended-release</td>
</tr>
<tr>
<td>Pepcid (except suspension)</td>
<td>cimetidine, famotidine, nizatidine, ranitidine</td>
</tr>
<tr>
<td>Peranex HC</td>
<td>lidocaine-hydrocortisone-aloe kit</td>
</tr>
<tr>
<td>Peranex HC medicated pads</td>
<td>Lidocaine HC rectal kit</td>
</tr>
<tr>
<td>Percocet</td>
<td>Oxycodone/acetaminophen</td>
</tr>
<tr>
<td>Percodan</td>
<td>Endodan</td>
</tr>
<tr>
<td>polyethylene glycol 3350 oral powder</td>
<td>Miralax (OTC, not covered)</td>
</tr>
<tr>
<td>Brand names</td>
<td>Suggested alternatives</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Pravachol</td>
<td>pravastatin</td>
</tr>
<tr>
<td>Pravacid</td>
<td>lansoprazole, omeprazole, Prilosec OTC (OTC, not covered)</td>
</tr>
<tr>
<td>Pravacid Solutab</td>
<td>lansoprazole, omeprazole, Prilosec OTC (OTC, not covered)</td>
</tr>
<tr>
<td></td>
<td>PLEASE NOTE: Pravacid Solutab is covered for Members 12 years of age or younger.</td>
</tr>
<tr>
<td>Prilosec</td>
<td>Prilosec OTC (OTC, not covered), omeprazole, pantoprazole</td>
</tr>
<tr>
<td>Prinivil</td>
<td>lisinopril</td>
</tr>
<tr>
<td>Prinzide</td>
<td>lisinopril/hydrochlorothiazide</td>
</tr>
<tr>
<td>Procardia</td>
<td>nifedipine</td>
</tr>
<tr>
<td>Proscar</td>
<td>Nifedipine extended-release</td>
</tr>
<tr>
<td>Protonix</td>
<td>Prilosec OTC (OTC, not covered), omeprazole, pantoprazole</td>
</tr>
<tr>
<td></td>
<td>PLEASE NOTE: Protonix suspension is covered for Members 12 years of age or younger.</td>
</tr>
<tr>
<td>Prozac</td>
<td>fluoxetine</td>
</tr>
<tr>
<td>Prozac Weekly</td>
<td>Fluoxetine delayed-release</td>
</tr>
<tr>
<td>Questran</td>
<td>cholestyramine</td>
</tr>
<tr>
<td>Rapaflo</td>
<td>doxazosin, tamsulosin, Uroxatral</td>
</tr>
<tr>
<td>Remeron Remeron Soltab</td>
<td>mirtazapine</td>
</tr>
<tr>
<td>Restoril</td>
<td>temazepam</td>
</tr>
<tr>
<td>Rhinocort Aqua</td>
<td>flunisolide nasal spray, fluticasone nasal spray, Nasonex</td>
</tr>
<tr>
<td>Ritalin</td>
<td>methylphenidate</td>
</tr>
<tr>
<td>Ritalin-SR</td>
<td>Methylphenidate extended-release</td>
</tr>
<tr>
<td>Rosula cleanser</td>
<td>Prascion, Sulfatol</td>
</tr>
<tr>
<td>Roxicodone</td>
<td>Oxycodone HCl</td>
</tr>
<tr>
<td>Rybix ODT</td>
<td>tramadol</td>
</tr>
<tr>
<td>Saizen</td>
<td>Norditropin, Norditropin Nordiflex, Norditropin Flexpro</td>
</tr>
<tr>
<td>Salkera Foam</td>
<td>salicyclic acid cream or lotion</td>
</tr>
<tr>
<td>Salvax 6% Foam</td>
<td>salicyclic acid cream or lotion</td>
</tr>
<tr>
<td>Salvax Duo Plus Combo Pack</td>
<td>salicyclic acid lotion + urea lotion</td>
</tr>
<tr>
<td>Saphris</td>
<td>Risperidone, Seroquel, Zyprexa</td>
</tr>
<tr>
<td>Sector</td>
<td>acebutolol</td>
</tr>
<tr>
<td>Skelaxin</td>
<td>metaxalone</td>
</tr>
<tr>
<td>Solodyne metaxalone</td>
<td>minocycline tablets</td>
</tr>
<tr>
<td>Soma 250 mg</td>
<td>carisoprodol tablets</td>
</tr>
<tr>
<td>Sonata</td>
<td>zaleplon</td>
</tr>
<tr>
<td>Brand names</td>
<td>Suggested alternatives</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sumaxin</td>
<td>sulfacetamide sodium 10%, sulfur 5% Med Pads</td>
</tr>
<tr>
<td>Taclonex</td>
<td>betamethasone dipropionate/calcipotriene ointment</td>
</tr>
<tr>
<td>Taclonex Scalp</td>
<td>betamethasone dipropionate + calcipotriene solution</td>
</tr>
<tr>
<td>Tarka</td>
<td>Trandolapril/verapamil extended-release</td>
</tr>
<tr>
<td>Tekturna HCT</td>
<td>lisinopril/hydrochlorothiazide, enalapril/hydrochlorothiazide, losartan/hydrochlorothiazide, Benicar HCT, Diovan HCT</td>
</tr>
<tr>
<td>Tenex</td>
<td>Guanfacine</td>
</tr>
<tr>
<td>Tenormin</td>
<td>Atenolol</td>
</tr>
<tr>
<td>Tenoretic</td>
<td>Atenolol/hydrochlorothiazide</td>
</tr>
<tr>
<td>Tersi Foam</td>
<td>selenium sulfide shampoo</td>
</tr>
<tr>
<td>Teveten</td>
<td>Losartan, Benicar or Diovan</td>
</tr>
<tr>
<td>Teveten HCT</td>
<td>Losartan/hydrochlorothiazide, Benicar HCT or Diovan</td>
</tr>
<tr>
<td>Tev-Tropin</td>
<td>Norditropin, Norditropin Nordiflex, norditropin flexpro</td>
</tr>
<tr>
<td>Tiazac</td>
<td>Diltiazem extended-release</td>
</tr>
<tr>
<td>Tofranil</td>
<td>Imipramine</td>
</tr>
<tr>
<td>Toprol XL</td>
<td>Metoprolol succinate extended-release</td>
</tr>
<tr>
<td>Toviaz</td>
<td>oxybutynin ER, trosipium, Enablex, Vesicare</td>
</tr>
<tr>
<td>Trandate</td>
<td>labetolol</td>
</tr>
<tr>
<td>Tranxene T-Tab</td>
<td>clorazepate</td>
</tr>
<tr>
<td>Triaz Foaming Cloths</td>
<td>benzoyl peroxide cleanser or pads</td>
</tr>
<tr>
<td>Tricor</td>
<td>fenofibrate</td>
</tr>
<tr>
<td>Triglide</td>
<td>fenofibrate</td>
</tr>
<tr>
<td>Trilipix</td>
<td>fenofibrate</td>
</tr>
<tr>
<td>Trilipix</td>
<td>fenofibrate</td>
</tr>
<tr>
<td>Trioxin</td>
<td>antipyrine/benzocaine otic, OtiRX</td>
</tr>
<tr>
<td>Twynsta</td>
<td>Amlodipine &amp; ARB, Azor, Exforge</td>
</tr>
<tr>
<td>Tylenol with Codeine NO.3</td>
<td>Acetaminophen with codeine NO.3</td>
</tr>
<tr>
<td>Tylox</td>
<td>Oxycondone/acetaminophen</td>
</tr>
<tr>
<td>Ultracet</td>
<td>Tramadol/acetaminophen</td>
</tr>
<tr>
<td>Ultram</td>
<td>tramadol</td>
</tr>
<tr>
<td>Ultram ER</td>
<td>tramadol</td>
</tr>
<tr>
<td>Umecta PD</td>
<td>urea lotion</td>
</tr>
<tr>
<td>Uniretic</td>
<td>moexipril/hydrochlorothiazide</td>
</tr>
<tr>
<td>Univasc</td>
<td>moexipril</td>
</tr>
<tr>
<td>Uramaxin</td>
<td>urea cream, gel or lotion</td>
</tr>
<tr>
<td>Uramaxin 20% Foam</td>
<td>urea cream, or lotion</td>
</tr>
<tr>
<td>Uramaxin 45% Cream</td>
<td>urea cream</td>
</tr>
<tr>
<td>urea nail stick 50%</td>
<td>urea nail gel 50%</td>
</tr>
<tr>
<td>Valium</td>
<td>diazepam</td>
</tr>
<tr>
<td>Vaseretic</td>
<td>enalapril/hydrochlorothiazide</td>
</tr>
<tr>
<td>Vasotec</td>
<td>enalapril</td>
</tr>
<tr>
<td>Brand names</td>
<td>Suggested alternatives</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Vectical</td>
<td>calcipotriene, Dovonex cream</td>
</tr>
<tr>
<td>Veramyst</td>
<td>fluticasone propionate nasal spray, flunisolide nasal spray, Nasonex</td>
</tr>
<tr>
<td>Verdeso</td>
<td>desonide cream/lotion</td>
</tr>
<tr>
<td>Veregen</td>
<td>Imiquimod podofilox, Aldara, Condylox</td>
</tr>
<tr>
<td>Verelan/PM</td>
<td>Veapamil extended-release</td>
</tr>
<tr>
<td>Vicodin</td>
<td>Hydrocodone/acetaminophen</td>
</tr>
<tr>
<td>Vicodin ES</td>
<td>Hydrocodone/acetaminophen ES</td>
</tr>
<tr>
<td>Vicoprofen</td>
<td>hydrocodone/ibuprofen</td>
</tr>
<tr>
<td>Vimovo</td>
<td>Naproxen &amp; omeprazole</td>
</tr>
<tr>
<td>Vistarin</td>
<td>Hydroxyzine pamoate</td>
</tr>
<tr>
<td>Voltaren</td>
<td>Diclofenac sodium</td>
</tr>
<tr>
<td>Voltaren XR</td>
<td>Diclofenac sodium delayed-release</td>
</tr>
<tr>
<td>Vusion</td>
<td>miconazole nitrate &amp; zinc oxide (OTC, not covered)</td>
</tr>
<tr>
<td>Wellbutrin</td>
<td>bupropion</td>
</tr>
<tr>
<td>Wellbutrin SR/XL</td>
<td>Bupropion sr, bupropion extended-release</td>
</tr>
<tr>
<td>Xanax</td>
<td>alprazolam</td>
</tr>
<tr>
<td>Xanax XR</td>
<td>alprazolam extended-release</td>
</tr>
<tr>
<td>Xolegel</td>
<td>ketoconazole cream</td>
</tr>
<tr>
<td>Zamicet</td>
<td>hydrocodone bitartrate/APAP, Hycet oral solution</td>
</tr>
<tr>
<td>Zaroxolyn</td>
<td>metolazone</td>
</tr>
<tr>
<td>Zebeta</td>
<td>bisoprolol</td>
</tr>
<tr>
<td>Zegerid</td>
<td>Prilosec OTC (OTC, not covered), omeprazole, pantoprazole</td>
</tr>
<tr>
<td>Zelapar</td>
<td>selegiline tablets</td>
</tr>
<tr>
<td>Zestoretic</td>
<td>lisinopril/hydrochlorothiazide</td>
</tr>
<tr>
<td>Zestril</td>
<td>lisinopril</td>
</tr>
<tr>
<td>Ziac</td>
<td>Bisoprolol/hydrochlorothiazide</td>
</tr>
<tr>
<td>Ziana</td>
<td>tretinoin gel and clindamycin gel</td>
</tr>
<tr>
<td>Zinotic</td>
<td>Pramotic, Zolene HC</td>
</tr>
<tr>
<td>Zinotic ES</td>
<td>chloroxylenol/pramoxine HCl, OtiRX</td>
</tr>
<tr>
<td>Zipsor</td>
<td>diclofenac tablets</td>
</tr>
<tr>
<td>Zithranol-RR</td>
<td>Drithocreme HP</td>
</tr>
<tr>
<td>Zocor</td>
<td>simvastatin</td>
</tr>
<tr>
<td>Zoderm Redi-Pads</td>
<td>benzoyl peroxide</td>
</tr>
<tr>
<td>Zofran/Zofran ODT</td>
<td>Ondansetron, ondansetron ODT</td>
</tr>
<tr>
<td>Zoloft</td>
<td>Sertraline</td>
</tr>
<tr>
<td>Zuplenz</td>
<td>Ondansetron, ondansetron ODT</td>
</tr>
<tr>
<td>Zyflo CR</td>
<td>Singulair, Accolate</td>
</tr>
<tr>
<td>Zymaxid</td>
<td>Ciprofloxacin drops, ofloxacin</td>
</tr>
<tr>
<td>Zypram Rectal Kit</td>
<td>Analpram HC, hydrocortisone/pramoxine cream</td>
</tr>
</tbody>
</table>