2018

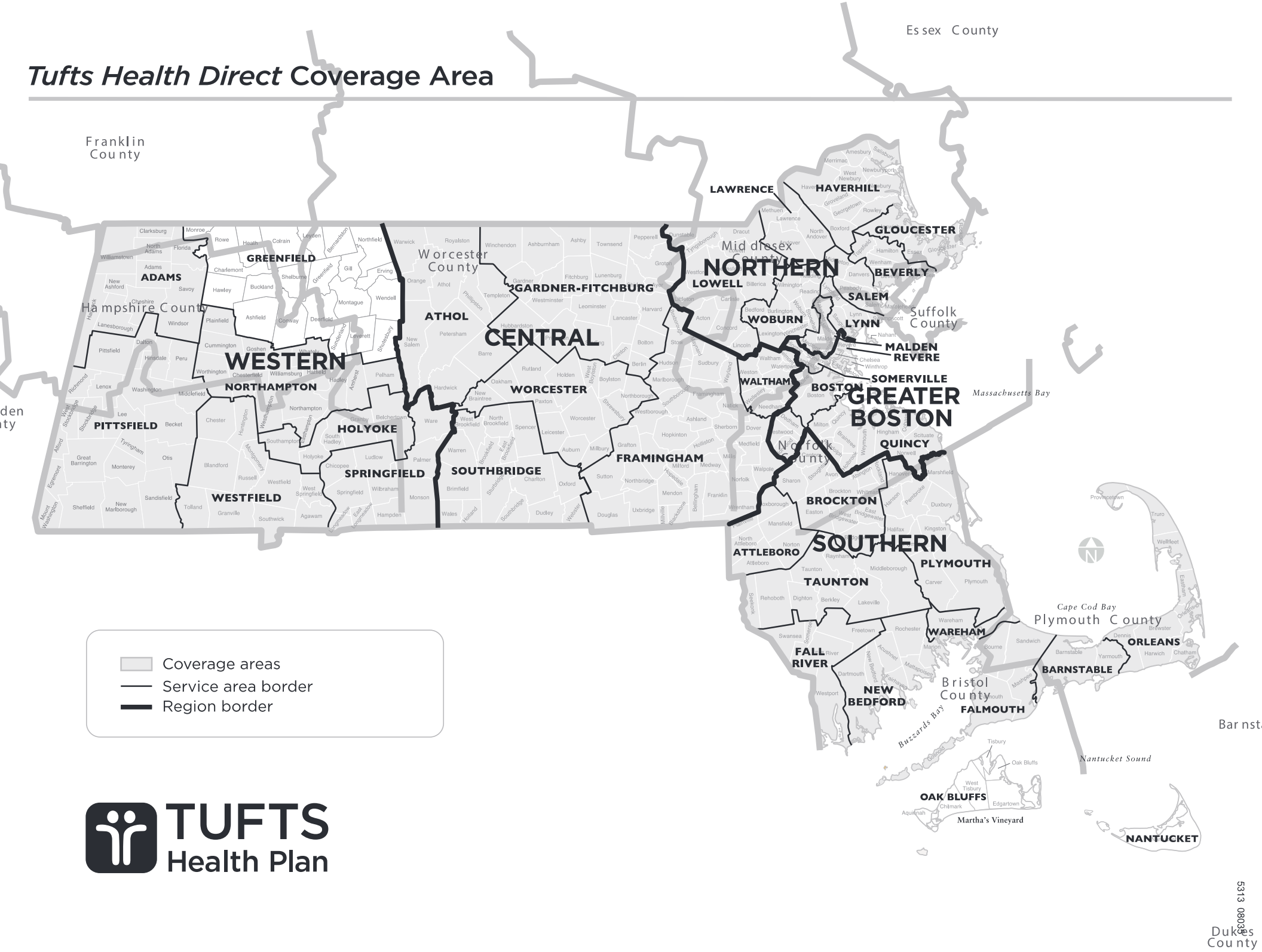
Tufts Health Direct

Member Handbook

This health plan meets **Minimum Creditable Coverage standards** and will satisfy the individual mandate that you have health insurance. Please see page 5 for additional information.

Effective Date: January 1, 2018
Issue Date: January 1, 2018

Tufts Health Direct Coverage Area



TUFTS Health Plan

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Welcome!

This handbook is full of information about how your health plan works. If you want to know how to get care when you need it, what services are covered or who to talk to when you have a question, you'll find the answers here.

This page includes important information to keep handy.

Contact us:

888.257.1985, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays
TTY: 888.391.5535 (for people with partial or total hearing loss)
Web: tuftshealthplan.com
Mail: Tufts Health Plan, P.O. Box 9194, Watertown, MA 02471-9194

We have bilingual staff available and we offer translation services in 200 languages. All translation services are free to members.

Call us:

- **If you move or change your phone number**
  Don't risk losing your health benefits because we can't find you. If you move, you must call the Health Connector and us to tell us your new address and phone number. You should also put the last names of all *Tufts Health Direct* Members in your household on your mailbox. The post office may not deliver mail from the Health Connector or us to someone whose name is not listed on the mailbox.

  If you move, call the Health Connector's customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m., and Tufts Health Plan at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, to update your contact information.

- **To find out if other household members are eligible for an affordable health plan**
  If other people in your home may be eligible for an affordable health plan, we can help! Call us at **888.257.1985**. They can also call the Health Connector's customer service center at 877.623.6765 (TTY: 877.623.7773), Monday through Friday, from 8 a.m. to 6 p.m.
- **If you want to change your Primary Care Provider (PCP)**
  You can switch your PCP for any reason by calling us at **888.257.1985** or by visiting us at tuftshealthplan.com.

IN AN EMERGENCY, GET CARE RIGHT AWAY:

Take immediate action if you believe that you are in a life-threatening Emergency situation.

- For medical or Behavioral Health (mental health and/or substance abuse) Emergencies, call 911 or go to the nearest Emergency room right away. For Behavioral Health Emergencies, you may also call the local Emergency Services Program (ESP) Provider in your area. Please call us at **888.257.1985** or visit us at tuftshealthplan.com for a complete list of emergency rooms and ESPs in Massachusetts, or call the statewide ESP directory at 877.382.1609 to find the closest ESP provider to you. You can also find this list in our online Provider Directory using our Find a Doctor, Hospital or Pharmacy tool, or call us at **888.257.1985** to ask for a copy of Provider information.
- Bring your *Tufts Health Direct* Member ID Card with you.
- Tell your PCP and if applicable, your Behavioral Health Provider within 48 hours of an Emergency to get any necessary follow-up care.

You don't need Prior Authorization for any Emergency care, including ambulance transportation.

risk permanent damage to your health, call your PCP or Behavioral Health Provider. Your PCP or Behavioral Health Provider can usually address these health problems.

You can contact any of your Providers' offices 24 hours a Day, seven Days a week.

Make an appointment if your Provider asks you to come in. If you request an Urgent Care appointment, your Provider must see you within 48 hours.

You may also visit an In-network Urgent Care Center (UCC) for your Urgent Care needs. For more information, see page 10.

Member Services hours:

If you want to talk to a Member Services representative who can answer your questions, call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

24/7 NurseLine:

For general health information and support, call our 24/7 NurseLine at 888-MY-RN-LINE (888.697.6546) (TTY: 800.942.1859), 24 hours a Day, seven Days a week.

Visit us on the web!

Visit us at tuftshealthplan.com to:

- Find a PCP, Specialist, or health center near you in our *Tufts Health Direct* Network
- Find a Behavioral Health Provider near you in our *Tufts Health Direct* Network
- Sign up for *Tufts Health Member Connect*, and:
  - Change your address or phone number
  - Choose or change your PCP
  - Use the secure messaging center to send us information and questions
  - Get answers to your questions
- Download the forms to get your *Tufts Health*
  to make you better or keep you healthy (Utilization Review)
  - How you can file a Grievance or an Appeal
  - How you have the right to request an External Review if we deny an Appeal, as well as your other rights and responsibilities
  - How we may collect, use, protect, and release information about you and your health (your Protected Health Information) according to our privacy policy
- Learn much more!

A great health plan at a great price

Keep this handbook — it has all the information you need to make the most of your membership.

If you have any questions, please call us at **888.257.1985**. Members with partial or total hearing loss should call our TTY line at 888.391.5535 for assistance.

For no-cost translation in English, call **888.257.1985**.

Arabic 888-257-1985 للحصول على المساعدة المجانية باللغة العربية اتصل بنا على

Chinese 若需免費的中文版本，請撥打**888.257.1985**。

French Pour demander une traduction gratuite en français, composez le **888.257.1985**.

German Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die folgende Telefonnummer an: **888.257.1985**.

Greek Για δωρεάν μετάφραση στα ελληνικά, καλέστε στο **888.257.1985**.

Haitian Creole Pou tradiksyon gratis nan Kreyòl Ayisyen, rele **888.257.1985**.

Italian Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero **888.257.1985**.

Japanese 日本語の無料翻訳については **888.257.1985**に電話してください。

Khmer (Cambodian) [illegible]

888.257.1985

Korean 한국어로 무료 통역을 원하시면, **888.257.1985**로 전화하십시오.

Laotian [illegible]
888.257.1985.

Navajo Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **888.257.1985**.

Persian برای ترجمه به فارسی به شماره تلفن **888.257.1985** تماس بگیرید.

Polish Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer **888.257.1985**.

Portuguese Para tradução grátis para português, ligue para o número **888.257.1985**.

Russian Для получения услуг бесплатного перевода на русский язык позвоните по номеру **888.257.1985**.

Spanish Para servicio de traducción gratuito en español, llame al **888.257.1985**.

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  — Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  — Qualified interpreters
  — Information written in other languages

If you need these services, contact Tufts Health Plan at 888.257.1985.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan
Attention: Civil Rights Coordinator, Legal Dept.
705 Mount Auburn St.
Watertown, MA 02472
Phone: 888.880.8699 ext. 48000, (TTY 711 or 800.439.2370)
Fax: 617.972.9048
Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

Table of contents

Welcome

You deserve great care. We want you to get the most out of your *Tufts Health Direct* membership.

To bring you the best value in health care, we work with a high-quality Network of doctors, Hospitals and other Providers across Massachusetts. We serve *Tufts Health Direct* Members in all or parts of the following counties: Barnstable, Berkshire, Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester. For a complete listing of our Providers or to see a map of our Service Area, please visit tuftshealthplan.com.

To help you understand what you need to know about your health plan, we have capitalized important words and terms throughout this *Member Handbook*. You can find definitions for each in the Glossary starting on page 55.

This plan is offered by Tufts Health Public Plans, Inc. Tufts Health Public Plans, Inc. is licensed as a health maintenance organization in Massachusetts but does business under the name Tufts Health Plan.

Translation and other formats

Call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays, if you:

- Have questions
- Need this document orally translated
- Need someone to read this or other printed information to you
- Want to learn more about any of our benefits or Covered Services

We have bilingual staff available. And we offer translation services in 200 languages. All translation services are free to Members.

may send you, make up your Evidence of Coverage.

These documents are a contract between you and Tufts Health Plan. By signing and completing an enrollment application, and by choosing *Tufts Health Direct* as your health plan, you applied for coverage from Tufts Health Plan. You also agreed to all the terms and conditions of *Tufts Health Direct* that we set forth, and to the terms and conditions in this handbook.

This handbook explains your rights, benefits and responsibilities as a *Tufts Health Direct* Member.

It also explains our responsibilities to you. If there are any major plan changes, we'll mail you a letter 60 days before the changes go into effect.

Only an approved officer of Tufts Health Plan can change this *Member Handbook* and only in writing. No other actions, including any exceptions we make on a case-by-case basis, change this *Member Handbook*.

Minimum creditable coverage and mandatory health insurance requirement

Massachusetts law requires that Massachusetts residents, 18 years old and older, must have health coverage that meets the minimum creditable coverage standards that the Health Connector sets, unless waived by the Health Connector for affordability or individual hardship. For more information, call the Health Connector at 877.623.6765 (TTY:877.623.7773) or visit the Health Connector's website at MAhealthconnector.org.

This health plan meets minimum creditable coverage standards as part of the

REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

Cost sharing

Premiums

Individuals and groups may have to pay a Premium for *Tufts Health Direct* coverage. A Premium is a monthly bill you pay for your *Tufts Health Direct* benefits. If you are part of a group, you pay your employer, who pays your Premium. You must send your Premium by the due date stated on the bill every month for your health benefits to continue. Please follow the payment directions on your bill when paying your Premiums.

If you have questions about your Premium, please call the number listed on your bill. Please note, we will send an annual notice with the Premium that must be paid.

If an individual or group is late (delinquent) in paying required Premiums, we, at our sole discretion, may stop payment of Claims and/or Prior Authorization of services until we get the full Premium payment.

Federal Premium Tax Credit and ConnectorCare plans

You might be eligible for a Federal Premium Tax Credit if your household income is up to 400% of the Federal Poverty Level (FPL). The Department of Health and Human Services sets the FPL. If you are eligible for a tax credit, then the United States government will pay part of your *Tufts Health Direct* Premiums directly to Tufts Health Plan, or alternatively, you can claim the credit when you file your tax return for the year.

You might also be eligible for a lower-cost ConnectorCare plan if your household income

federal and state governments pay some or all of the member responsibility amount through Cost-sharing Reduction (CSR) payments to Tufts Health Plan. In the event these CSR payments are reduced or terminated, Tufts Health Plan reserves the right to increase the premium for some or all Tufts Health Direct plans mid-benefit year.

The Health Connector can help you find out if you are eligible for a ConnectorCare plan and/or Federal Premium Tax Credit and, if so, how much.

Co-payments

Co-payments are set dollar amounts that are due when you get care or a service, or when billed by a Provider. You're responsible for paying all of the Co-payments listed in your Plan Level's "Benefit and Cost-sharing Summary" starting on page 61. Preventive services don't have any Co-payments. But you will need to pay a Co-payment for most Covered Services, such as doctors' visits, pharmacy services, advanced imaging (MRIs, PET, CT scans), emergency room visits and care you get in the Hospital. If you don't pay the Co-payment at the time of your visit, you'll still owe the money to the Provider. The Provider may use a legal method to collect the money from you. We are not responsible for paying the Provider the Co-payment that you owe.

American Indians and Alaskan Natives do not need to pay Co-payments or Co-insurance for services received through the Indian Health Service. American Indians and Alaskan Natives who make less than 300% of the FPL never pay Co-payments and Co-insurance regardless of where a service is received.

Deductibles

Your *Tufts Health Direct* plan may have an annual Deductible. The Deductible is the

"Benefit and Cost-sharing Summary" for information specific to your Plan Level.

- Individual Deductible: the amount an individual Member pays each year for certain Covered Services before we as your health plan begin to pay for those services
- Family Deductible:
  - The family Deductible applies to all members of a family.
  - Any amount a family Member pays is applied to the family Deductible.
  - Once the family Deductible has been met during a Benefit Year, all Members in a family will have met their Deductibles for the rest of that Benefit Year.
  - Note: The family Deductible is embedded, meaning the individual Deductible still applies to members of the family. Once the family meets the family Deductible, then the entire family is considered to have met the Deductible.

Not all services apply toward a Deductible. There are services that require a Co-payment and/or Co-insurance, those with no charge and those that are subject to a Deductible.

Notes:
The following are not included in the Deductible:

- Co-payments, Co-insurance, Premiums and any payments you make for noncovered services
- Payments you made for Covered Services you got before the start of a Benefit Year are not counted toward your Deductible in the current Benefit Year.
  At the start of each new Benefit Year, your Deductible accumulation will begin at zero, and you will start building again toward your Deductible for the new Benefit Year.
- The amount credited toward a Member's Deductible is based on our allowed amount on the date of service.

Co-insurance

insurance, the Co-insurance percentages are listed in your "Benefit and Cost-sharing Summary."

Note: Co-insurance you paid for Covered Services you got before the start of a Benefit Year is not counted toward your Out-of-pocket Maximum for your current Benefit Year. At the start of each new Benefit Year, your accumulation will begin at zero and you will start building again to your annual Out-of-pocket Maximum for the new Benefit Year.

Out-of-pocket Maximum

Your *Tufts Health Direct* plan has an Out-of-pocket Maximum. This is the maximum amount of cost sharing you have to pay in a Benefit Year for Covered Services.

The Out-of-pocket Maximum is made up of Deductibles, Co-payments and Co-insurance.

However, it does not include:

- Premiums
- Any amount you pay to an Out-of-network Provider in excess of the allowed amount for Covered Services paid by the plan to that Out-of-network Provider
- Costs for noncovered services

Once you meet your Out-of-pocket Maximum, you no longer pay Deductibles, Co-payments or Co-insurance for the rest of that Benefit Year.

- Individual Out-of-pocket Maximum: the maximum amount of cost sharing an individual has to pay in a Benefit Year for Covered Services
- Family Out-of-pocket Maximum:
  - Any amount a family Member pays is applied toward the family Out-of-pocket Maximum.
  - Once the family Out-of-pocket Maximum has been met during a Benefit Year, all Members in a family will have met their Out-of-pocket Maximum for the rest of that Benefit Year.

Note: Deductibles, Co-payments and Co-insurance you paid before the start of a Benefit Year are not counted toward your Out-of-pocket Maximum for your current Benefit Year. At the start of each new Benefit Year, your accumulation will begin at zero and you will start building again toward your annual Out-of-pocket Maximum for the new Benefit Year.

Benefit Year

The Benefit Year is the consecutive 12-month period during which:

- Health plan benefits are purchased and administered.
- Deductibles, Co-payments, Co-insurance and Out-of-pocket Maximums are calculated.
- Most benefit limits apply.

Note: In some cases, described in the following paragraphs, your first Benefit Year will not be a full 12 months.

For individual Subscribers:

- If you enrolled during an annual open enrollment period, your Benefit Year begins on your Effective Coverage Date and continues until December 31.
- If you enrolled (due to a qualifying event) at any other time of the year, your first Benefit Year begins on your Effective Coverage Date and continues until December 31. (This means your first Benefit Year is not a full 12 months.) See page 18 for more information.

For Subscribers enrolled through a group contract: Your Benefit Year begins on the group effective date (always the first of a calendar month) and continues for 12 months from that date. (For example, if the group effective date is April 1, your Benefit Year runs from April 1 to March 31.)

If you are a new employee who became a Subscriber after the group effective date, your Benefit Year ends the same date the Benefit Year ends for all Subscribers in your group.

Getting the care you need

Your Member ID Card

Always carry your *Tufts Health Direct* Member ID Card with you. It has important information about you and your benefits that Providers and pharmacists need. Each person in your family with *Tufts Health Direct* will get a *Tufts Health Direct* Member ID Card.

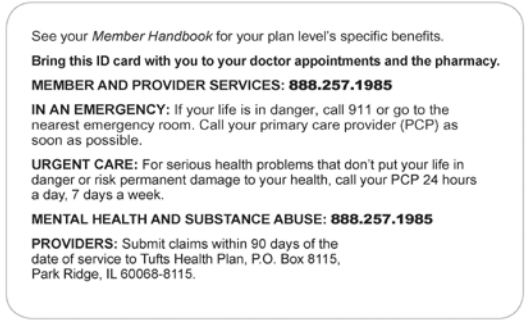

TUFTS Health Plan

Tufts Health Direct
A focused-network plan for individuals and small groups
Tufts Health Public Plans, Inc.

Member ID #: NXXXXXXXXXX
Member: SUSAN A SAMPLE
Cost sharing: OV: $XX/$XX
Preventive: $0
ER: $XXX
RX: $XX.XX/$X.XX/$X.XX
RX mail: $XX/$X.XX/$XX.XX
Plan level: CONNECTORCARE PLAN TYPE II
This space is for PCP Referral.

CVS/caremark customer service: 800.577.5339
RXBIN: 004336 RXPCN: ADV
RXGRP: RX1144

Member services:
888.257.1985 (TTY: 888.391.5535)
tuftshealthplan.com


See your *Member Handbook* for your plan level's specific benefits.

Bring this ID card with you to your doctor appointments and the pharmacy.

MEMBER AND PROVIDER SERVICES: 888.257.1985

IN AN EMERGENCY: If your life is in danger, call 911 or go to the nearest emergency room. Call your primary care provider (PCP) as soon as possible.

URGENT CARE: For serious health problems that don't put your life in danger or risk permanent damage to your health, call your PCP 24 hours a day, 7 days a week.

MENTAL HEALTH AND SUBSTANCE ABUSE: 888.257.1985

PROVIDERS: Submit claims within 90 days of the date of service to Tufts Health Plan, P.O. Box 8115, Park Ridge, IL 60068-8115.

Emergency care

For medical and Behavioral Health (mental health and/or substance use) Emergencies, call 911 or go to the nearest emergency room right away. Please call us at **888.257.1985** or use the Find a Doctor, Hospital, or Pharmacy tool

emergency-related ambulance transportation. A Provider will examine and treat your Emergency health needs before sending you home or moving you to another Hospital, if necessary. Continued services with an Out-of-network Provider after the Emergency condition has been treated or stabilized may not be covered if we determine, in coordination with your Providers, that it is safe to transport you to a Network facility, and it is appropriate and cost-effective to transport you.

Tell us, your Primary Care Provider (PCP) and, if applicable, your Behavioral Health Provider what happened within 48 hours of an Emergency to get any needed follow-up care. If the emergency department where you were seen notifies us or your PCP, then you don't need to tell us.

Examples of medical Emergencies:

- Chest pain
- Bleeding that won't stop
- Broken bones
- Seizures or convulsions
- Dizziness or fainting
- Poisoning or drug overdose
- Serious accidents
- Sudden confusion
- Severe burns
- Severe headaches
- Shortness of breath
- Vomiting that won't stop

Examples of Behavioral Health (mental health and/or substance use) Emergencies:

- Violent feelings toward yourself or others
- Hallucinations

Urgent Care

Call your PCP or Behavioral Health Provider if you need Urgent Care. You can contact any of your Providers' offices 24 hours a Day, seven Days a week. Provider offices have covering Providers who work after hours. If your PCP or Behavioral Health Provider sees you, call 911 or go to the nearest emergency room.

In some areas, there are Urgent Care centers (UCC) you may go to that are *Tufts Health Direct* Providers. When going to a UCC, you should also try to contact your PCP. You must visit a UCC in our Network to be covered for services. To find UCCs in our Provider Network, go to tuftshealthplan.com and use our Find a Doctor, Hospital, or Pharmacy tool. If you obtain services at an out-of-network UCC or at a UCC in an out-of-network hospital, you will not be covered. Note: Emergency services are covered at both Network and out-of-network hospitals.

Getting Hospital services

If you need Hospital services for something that isn't an Emergency, please ask your Provider to help you get these services. If you need Hospital services for an Emergency, don't wait. Call 911 or go to the nearest emergency room right away.

Getting care after office hours

Talk to your PCP to find out how to get care after normal business hours. Some PCPs have longer office hours. If you need Urgent Care after regular business hours, call your PCP's office. PCPs have covering Providers who work after hours. A covering Provider is a Provider who can help you when your PCP is not available. If you have any problems seeing your PCP or any other Provider, please call us at **888.257.1985**.

You can also get free health support from our 24/7 NurseLine to help you stay healthy 24 hours a Day, seven Days a week. Call 888-MY-RN-LINE (888.697.6546) (TTY: 800.942.1859) anytime. You can get help in many languages. The 24/7 NurseLine staff do not give medical advice and do not replace your PCP.

Urgent Care, call your PCP's office and follow your Provider's directions. For other routine health care issues, call your PCP. For routine behavioral health issues, call your Behavioral Health Provider. If you're outside of *Tufts Health Direct*'s Service Area, including out of the country, we'll only cover Emergency care and Urgent Care. Continued services after the Emergency or Urgent condition has been treated or stabilized may not be covered if we determine, in coordination with your providers, that it is safe to transport you back into the Service Area, and it is appropriate and cost-effective to transport you back into the Service Area.

We won't cover:

- Tests or treatment that your PCP asked for but that you decided to get outside of the Service Area
- Routine or follow-up care that can wait until you return to the Service Area, such as physical exams, flu shots, stitch removal and Behavioral Health (mental health and/or substance use) counseling
- Care that you knew you were going to get before you left the Service Area, such as elective surgery

When you get care outside of *Tufts Health Direct*'s Service Area, the Provider might ask you to pay for that care at the time of service.

If you're asked to pay for Emergency care or Urgent care that you get outside of our Service Area, you should show your *Tufts Health Direct* Member ID Card. The Provider shouldn't ask you to pay. If you do pay for any of these services, you may ask us to pay you back. You will be responsible for paying the applicable In-network cost share under your plan. A Member 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. In addition to your in-network cost share, you may be responsible for any bill received from the Provider for

Your *Tufts Health Direct* Providers

Getting information about *Tufts Health Direct* Providers

For the most up-to-date information about Providers (doctors and other professionals who contract with us to provide health care), visit us at tuftshealthplan.com and use the Find a Doctor, Hospital, or Pharmacy tool to find a *Tufts Health Direct* In-network Provider. To request a hard copy of the Provider Directory, to request information from our online Provider Directory or to get information about a Provider, call our Member Services Team at **888.257.1985**.

Our online Find a Doctor, Hospital, or Pharmacy tool lists the following types of *Tufts Health Direct* Providers:

- Primary care sites
- Primary Care Providers (PCPs)
- Hospitals
- Specialty Providers
- Behavioral Health (mental health and/or substance use) Providers

In our online Provider Directory, you can find important information like a Provider's address, phone number, hours of operation, handicap accessibility and languages spoken.

Our online Provider Directory also lists all *Tufts Health Direct* pharmacies, facilities, ancillary Providers, hospital emergency services and Durable Medical Equipment suppliers. You can find this information at tuftshealthplan.com.

Your PCP

As a *Tufts Health Direct* Member, you must

choose a *Tufts Health Direct* PCP and to find out where the PCP's office is located, please use the Find a Doctor, Hospital or Pharmacy tool at tuftshealthplan.com or call us at **888.257.1985**.

You can call your PCP's office 24 hours a Day, seven Days a week. If your PCP is not available, your PCP's office will direct you to somebody else who can help you. If you have problems contacting your PCP, or if you have any questions, please call our Member Services Team at **888.257.1985**.

Here's what your PCP can do for you:

- Give you regular checkups and health screenings, including Behavioral Health (mental health and/or substance use) screenings
- Make sure you get the health care you need
- Arrange necessary tests, laboratory procedures or hospital visits
- Keep your medical records
- Recommend Specialists, when necessary
- Provide information on Covered Services that need Prior Authorization before you get treatment
- Write prescriptions, when necessary
- Help you get Behavioral Health (mental health and/or substance use) services, when necessary

PCP assignment

We'll choose a PCP for you near to where you live and tell you your PCP's name within 15 Days of becoming a new *Tufts Health Direct* Member. It is important that you have a PCP in order to take full advantage of all your benefits. If you do not wish to use the PCP that has been selected for you, you may choose a different PCP in the *Tufts Health Direct* Network by calling us at **888.257.1985** or visiting tuftshealthplan.com.

Specialists

Sometimes you may need to visit a Specialist. To find a *Tufts Health Direct* Specialist, talk to your PCP. You can also call us at **888.257.1985** or visit tuftshealthplan.com to search for a Specialist. You should discuss your need for a Specialist with your PCP first and then call the Specialist to make an appointment.

If the Specialist your PCP wants to send you to is a Non-preferred In-network Provider, your PCP will need to ask us for Prior Authorization before you see this Specialist. By using the Find a Doctor, Hospital or Pharmacy tool at tuftshealthplan.com, you can check to see which Providers need Prior Authorization, or call **888.257.1985** to get this information. Remember, if we don't receive a Prior Authorization request and give written approval for you to see a Non-preferred In-network Provider, we won't cover the services. If you still choose to get the services, you'll be responsible for payment.

If you choose to get services outside of our Network, we won't cover the services. If you still choose to get the services anyway, the Specialist will bill you, and you will be responsible for paying the full cost of the care.

For more information about which services need Prior Authorization, please see your Plan Level's "Benefit and Cost-sharing Summary" section in this *Member Handbook*.

Referrals for specialty services

Some *Tufts Health Direct* Members may need their PCP to give them a Referral for certain specialty services. A Referral is a notification from your PCP to us that you can get care from a different Provider. The Referral helps your PCP better guide the care and services you get from the Providers you see. These services may include:

- Professional services, like a visit to a Specialist
- Outpatient hospital visits

Second opinions

Tufts Health Direct Members can get a second opinion from a different In-network Provider about a medical or behavioral health condition, or proposed treatment and care plan. You don't need Prior Authorization to get a second opinion from an In-network Provider about a medical or behavioral health issue or concern. Even if no second opinion is available in the Network, there is no benefit for a second opinion out of the Network. You can see the most up-to-date list of our In-network Providers at tuftshealthplan.com. Please call us at **888.257.1985** for help or for more information about picking a Provider to see for the second opinion.

Prior Authorization

Your Primary Care Provider (PCP) will work with your other Providers to make sure you get the care you need. For certain services, your PCP or Behavioral Health Provider will need to ask us for Prior Authorization before sending you to get those services. Please see your Plan Level's "Benefit and Cost-sharing Summary" section in this *Member Handbook* for the most up-to-date list of services that require Prior Authorization consistent with Tufts Health Plan's Medical Necessity Guidelines in effect at the time the services or supplies are provided. This information is also available to you at tuftshealthplan.com or by calling the Member Services Team.

Your PCP knows when and how to ask us for Prior Authorization if it is required. When your PCP asks, we'll decide if the service is Medically Necessary and if we have a qualified In-network Provider who can provide the service.

If the service is Medically Necessary and we don't have an In-network Provider who can treat your health condition, we may approve and cover services from an Out-of-network Provider. Prior Authorization for out-of-network services has been obtained. If Prior Authorization is not granted before you see an Out-of-network provider, coverage will be denied, and you will be responsible for payment.

Your PCP or Behavioral Health Specialist must ask us for and get Prior Authorization before you can see an Out-of-network Provider under these circumstances. You may ask your PCP or Behavioral Health Specialist to ask for the Prior Authorization.

You may be authorized to see an Out-of-network Provider in the following circumstances:

- When a participating In-network Provider is unavailable because of location
- When a delay in seeing a participating In-network Provider, other than a Member-related delay, would result in interrupted access to Medically Necessary services
- If there isn't a participating In-network Provider with the qualifications and expertise that you need to get and stay better

Many services don't need Prior Authorization, including: Emergency health care, In-network Family-planning Services, the first 12 Behavioral Health (mental health only) outpatient therapy visits with an In-network Provider each Benefit Year, and some In-network specialty visits. Substance use outpatient therapy visits, Level III community-based detoxification and Level IV detoxification do not require Prior Authorization. You can get Emergency care services from any Emergency care Provider. You can get Family-planning Services and the first 12 outpatient Behavioral Health (mental health only) therapy visits from any *Tufts Health Direct* In-network Provider. You do not need Prior Authorization for care provided by an In-network obstetrician, gynecologist, certified nurse midwife or family practitioner for an annual preventive gynecologic health examination, any follow-up care, maternity care, or treatment for an acute or emergency gynecological condition. And you

limitations or cost sharing to Behavioral Health services that we do not apply to medical services.

If you become a Tufts Health Plan Member by changing from another health plan, and a Provider who does not contract with us is treating you, we'll review that treatment and may let that Provider keep treating you. For more information, please see the "Continuity of Care" section on page 15. Remember, you must get Prior Authorization from us to see that Out-of-network Provider during and after the transition period.

Standard Prior Authorizations

We'll make an initial decision about a Prior Authorization within two business days of getting all necessary information. "Necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation, consults, second opinion, labs, and imaging and/or previous therapies. We'll let your Provider requesting the service know within 24 hours of our decision. We'll let you know in writing within one business day if we deny the Authorization request and within two business days if we approve Authorization.

Remember: If we don't approve you seeing a Provider or having a procedure that requires Prior Authorization, we won't pay for those visits or services.

Concurrent review

When you are a Hospital patient or are getting treatment for a condition that requires Authorization, we will review your situation to ensure that the right care is given in the right place. This is called a concurrent review. We make concurrent review decisions within one business day of getting all the necessary information from your Provider. "Necessary information" includes, but is not limited to, the information. And we'll mail to you and fax to your Provider a confirmation within one business day after that.

The notification will include:

- The number of extended Days or the next review date
- The new total number of Days or services we've approved
- The date of admission or start of services

If we deny a longer stay or more services, we'll let your Provider know within one business day. And we'll mail you and fax your Provider confirmation of this Adverse Determination within one business day. You can keep getting the service at no cost to you until we notify you of our concurrent review decision.

You or your Provider may Appeal the decision before you are discharged. For information on the Expedited Internal Appeal process, please see page 46.

Prior Authorization approvals and denials

If we approve coverage for a service, we will clearly tell you and your Provider, if you identify one, which services we agree to cover. The Provider providing the service must have an Authorization letter from us before giving you care in order to be reimbursed. If you need more care than we approved, your Provider will ask us to approve more services. If we approve the request for more services, we'll send you and your Provider an Authorization letter.

If we don't approve any of the services requested, we'll send you, your Provider and your Authorized Representative a denial or Adverse Determination letter. We'll also send a notice if we decide to reduce, delay or stop covering services that we have previously approved.

The Adverse Determination letter we send will

- Reference and include applicable clinical practice guidelines and review criteria
- Tell you how to ask for an Appeal, including an Expedited Internal Appeal

If you disagree with any of these decisions, you can request a Standard Internal Appeal. For details on requesting a Standard Internal Appeal, please see the section "How to resolve concerns" starting on page 43.

Reconsideration of an Adverse Determination

If we have denied Authorization for services, the Provider treating you can ask us to reconsider our decision. The reconsideration process will occur within one business day after we get the request. A clinical peer reviewer will conduct the reconsideration and talk to your Provider.

If we don't change our decision, you, your Provider or your Authorized Representative may use the Appeal process described starting on page 43. You don't have to ask us to reconsider an Adverse Determination before requesting a Standard Internal Appeal or Expedited Internal Appeal.

Continuity of Care

We support Continuity of Care for new and current Members.

New Members

If you are a new *Tufts Health Direct* Member, we'll help you transition any covered care you are currently getting to an In-network Provider as smoothly as possible. To ensure Continuity of Care, we may be able to cover some health services, including Behavioral Health (mental health and/or substance use) services, from a Provider who isn't part of our Network, including from a Nurse Practitioner, for a limited period of time. For example, we will

- Ongoing care for up to 30 Days from your date of enrollment if the Provider is your PCP

In specific circumstances, we offer longer Continuity of Care after Prior Authorization is obtained. For example, we will cover:

- Care you get from your current OB/GYN if you are at least three months pregnant (meaning you are starting your fourth month, based on your expected due date). You can keep seeing your current OB/GYN until you have the baby and a follow-up checkup within the first six weeks after delivery.
- Care from your Provider if you are terminally ill and in active treatment

Current Members

If your PCP or another Provider is disenrolled from our *Tufts Health Direct* Network for reasons not related to quality of care or Fraud, or if they are no longer in practice, we'll make every effort to tell you at least 30 Days before the disenrollment. To ensure Continuity of Care, we may be able to cover some health services, including Behavioral Health services, from a Provider who isn't part of our Network, including from a Nurse Practitioner.

For example, we will cover:

- Care you get from your current OB/GYN if you are at least three months pregnant (meaning you are starting your fourth month, based on your expected due date). You can keep seeing your current OB/GYN until you have the baby and a follow-up checkup within the first six weeks after delivery
- Ongoing covered treatment or management of chronic or acute conditions (like dialysis, home health, chemotherapy and radiation) for up to 90 Days from the date of disenrollment of your Provider, including previously approved services or Covered Services
- Ongoing care for up to 30 Days from the

network Provider for the time periods set forth in this section.

Conditions for coverage of Continuity of Care

Services provided by a disenrolled Provider or an Out-of- network Provider as described in this "Continuity of Care" section are covered *only* when you or your Provider obtains Prior Authorization from us for the continued services, when the services would otherwise be covered under this *Member Handbook*, and when the Provider agrees to:

- Accept payment from us at the rates we pay In-network Providers
- Accept such payment as payment in full and not charge you any more than you would have paid in cost sharing if the Provider was an In-network Provider
- Comply with our quality standards
- Provide us with necessary medical information related to the care provided
- Comply with our policies and procedures, including for Prior Authorization and providing Covered Services pursuant to a treatment plan we approve, if any

Eligibility, enrollment, renewal and disenrollment

Eligibility

The Health Connector determines eligibility for *Tufts Health Direct* Subscribers and their Dependents. Subscribers and their Dependents must meet these requirements to be enrolled in *Tufts Health Direct* through the Health Connector or directly with us. Eligible individuals include Massachusetts residents who live in our Service Area.

Please contact the Health Connector for more long as you keep meeting the eligibility requirements and your Premium is paid. When we get notice of your enrollment from the Health Connector, we will send you a Member ID Card and more information about your plan.

Acceptance into our plan is never based on your:

- Income
- Physical or mental condition
- Age
- Occupation
- Claims experience
- Duration of coverage
- Medical condition
- Gender
- Sexual orientation
- Religion
- Physical or mental disability
- Ethnicity or race
- Previous status as a Member
- Pre-existing conditions
- Actual or expected health condition

We do not use the results of genetic testing in making decisions about enrollment, eligibility, renewal, payment or coverage of Health Care Services. Also, we do not consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making these decisions.

Once you are enrolled in our plan, we will pay for Covered Services that are given to you on or after your Effective Coverage Date. (There are no Waiting Periods or Pre-existing Condition Limitations or exclusions.) We will not pay for any services you got before your Effective Coverage Date with our plan.

Dependent eligibility

The following individuals are eligible for enrollment as a Dependent of the Subscriber:

- A legally married spouse of a Subscriber
- A divorced spouse of a Subscriber is eligible to remain covered in accordance with Massachusetts law.

to enroll in the plan if the group provides for such eligibility.

- Children who are recognized under a qualified medical child-support order as having the right to enroll for coverage under the plan
- A natural child of the Subscriber or of the Subscriber's spouse who is eligible for coverage, is eligible for coverage as a Dependent up to the Dependent's 26th birthday
- A stepchild of the Subscriber or of the Subscriber's spouse who is eligible for coverage, is eligible for coverage as a Dependent up to the Dependent's 26th birthday
- An adopted child of the Subscriber or of the Subscriber's spouse who is eligible for coverage, is eligible for coverage as a Dependent up to the Dependent's 26th birthday
    - The date of placement in the home for the purpose of adoption is the effective date of the child's coverage; or, if the child has been living in the home as a foster child for whom the beneficiary has received foster care payments, the effective date is the date of the filing of the petition to adopt.
- A person who is under the legal guardianship of a Subscriber is eligible for coverage as a Dependent up to the Dependent's 26th birthday.
    - Documentation must be provided that includes a court document signed by a judge indicating the child's name, the appointed legal guardian(s), the temporary or permanent designation, the effective date, and, if temporary legal guardianship, the termination date.
- A child of a Dependent of the Subscriber is eligible for coverage as a Dependent up to the child's 26th birthday. However, when the parent of such child is no longer a Dependent of the Subscriber, the child shall no longer be a Dependent.
- A disabled adult child of a Subscriber or the Subscriber's spouse is eligible for coverage entered before the effective date of the group contract. This coverage requires no further Premium other than the normal cost of covering a current spouse. The former spouse remains eligible for this coverage only until one of the following happens:
    - The Subscriber is no longer required by the judgment to provide health insurance for the former spouse.
    - The Subscriber or former spouse remarries. However, if the Subscriber remarries, and the judgment so provides, the former spouse may keep coverage under the plan in accordance with Massachusetts law.
    - The Subscriber disenrolls from the plan.

Newborn and adoptive children — eligibility, enrollment, and coverage

A newborn infant of a Member is eligible for coverage under the plan from the moment of birth as required by Massachusetts law.

- The Subscriber must properly enroll the newborn in the plan within 60 Days of the newborn's birth for the newborn to be covered from birth. Otherwise, the Subscriber must wait until the next open enrollment period to enroll the child.
- The Subscriber must enroll an adoptive child within 60 Days after the date of filing a petition to adopt the child, or the date the child is placed with the Subscriber for the purpose of adoption. Otherwise, the Subscriber must wait until the next open enrollment period to enroll an adoptive child.
- If payment of a specific premium is required to provide coverage for a child, the policy or contract may require that both the notification of birth of a newly born child or of filing of a petition to adopt a foster child or of placement of a child for purposes of adoption and the payment of the required premium be furnished to the insurer.
- If the Subscriber does not enroll a newborn within 30 Days of the newborn's birth, the plan will only cover the costs of routine

manage the child's care from the time of birth or adoption.
- The Subscriber must contact the Health Connector for further information about enrollment of a newborn or an adoptive child.

Employee eligibility

An employee is eligible to enroll in *Tufts Health Direct* through an employer group if they:
- Reside or work within the *Tufts Health Direct* Service Area
- Are employed by a qualified contributing or non-contributing Massachusetts employer
- Meet all employer eligibility requirements

Change in eligibility status

It is your responsibility to tell the Health Connector of all changes that may affect your or your Dependents' eligibility under your plan or the amount of Premium you pay for coverage under your plan. Notification must occur **within 60 Days** of the event. These include the following:
- You have a baby or adopt a child
- One of your Dependents marries
- You have an address change
- You move out of our Service Area
- You have a job or income change
- You have a change in marital status
- Death of a Member
- You or a Dependent no longer meets the plan's eligibility requirements

Note: Changes in Dependents covered by the plan may result in a change to the Premium that an individual or group must pay. Changes could also affect the amount of federal or state subsidies or tax credits you can get.

We and the Health Connector need your current address and phone number so we can send you important information about benefits and services. To report eligibility, address or phone number changes, please call:
- The Health Connector customer service center at 877.623.6765

No waiting period or pre-existing condition limitations

There are no waiting periods or pre-existing condition limitations in our plan. All Covered Services are available to you as of your Effective Coverage Date, unless you are an inpatient on your Effective Coverage Date, and you have not notified us that you are an inpatient.

Effective Coverage Date

The Effective Coverage Date is the date you become a Member of *Tufts Health Direct* and are eligible to get Covered Services from *Tufts Health Direct* Providers. The Health Connector sets Effective Coverage Dates for new individual Subscribers and Dependents, in accordance with state and federal law. Please contact the Health Connector for more information. Your coverage will start at 12:01 a.m. on the first Day of the month your enrollment in *Tufts Health Direct* begins. Individuals who do not meet the requirements to enroll outside of the annual open enrollment period may seek an enrollment waiver. A waiver permits enrollment outside the open enrollment period. Contact the Health Connector or the MA Office of Patient Protection for more information about enrollment waivers.

For Subscribers enrolled through a group contract: You will have a group effective date (always the first of a calendar month). If your group does not meet the participation rules, you may have to apply as individuals during open enrollment or with a qualifying event.

Renewing your coverage

Individual/family *Tufts Health Direct* Subscribers

We do not have to renew the Health Benefit Plan of an eligible person if he or she:

- Has not paid the required Premiums
- Has committed Fraud or misrepresented whether he or she qualifies for the plan, or misrepresented information needed to determine eligibility for a health plan or for specific health benefits
- Has failed to comply with our provisions, the member contract, or the Subscriber agreement, including but not limited to an individual, employee, or Dependent moving outside our Service Area
- Fails, at the time of renewal, to meet eligibility rules, provided that we collect enough information to make such a determination and make such information available to the Health Connector, when appropriate, upon request
- Has failed to comply with our reasonable request for information in an application for coverage

Group Plan participants

Employer groups renew membership 12 months after their Effective Coverage Date and every 12 months thereafter. Employee coverage renews 12 months after the employer group's Effective Coverage Date, regardless of the employee's Effective Coverage Date. Monthly Premiums are based on the employer group's Effective Coverage Date.

If a participating employer changes any of the following items, we or the Health Connector must revalidate the company at the time of the group's renewal. The Health Connector may ask for documentation to validate the information provided by the participating employer at renewal.

We or the Health Connector may not renew an employer's plan if the employer does not meet the eligibility or participation requirements at the time of renewal, or if the employer:

- Has not paid its Premiums
- Failed to comply with our or the Health Connector's reasonable request for information needed to verify the application for coverage
- Is not actively engaged in business
- Failed to satisfy the definition of an Eligible Small Business

Plan nonrenewal

We must provide at least 60 Days' prior notice to an eligible individual or Eligible Small Business of our intention not to renew their health benefit plan. We will include the specific reason(s) for the nonrenewal in accordance with our filed criteria. We must provide at least 90 Days' prior notice to affected eligible individuals or Eligible Small Businesses of our intention to stop offering a particular type of health plan.

Disenrollment

If you're disenrolled from *Tufts Health Direct*, we will provide coverage for covered services for you through 11:59 p.m. on the last Day of the month your enrollment ends.

Your enrollment in our plan can be ended if:

- You are an individual or group Member who has not paid the required Premium for 60 Days from the first Day of the coverage month for which the Premium was due (individuals enrolled in subsidized coverage will have 90 Days from the first day of the coverage month for which the Premium was due).
- You commit an act of physical or verbal abuse unrelated to your physical or mental condition, which poses a threat to any Provider, any other Member, or to the plan or a plan employee.
- You commit an act of intentional misrepresentation or Fraud related to coverage, obtaining Health Care Services or payment for such services (for example, obtaining or trying to obtain benefits under this *Member Handbook* for a person who is not a Member, or misrepresenting your

contributions, or that the group is not actively engaged in business.
- You fail to meet the Health Connector's or our eligibility requirements, such as moving out of the Service Area
- An individual or a group chooses to end coverage by notifying us or the Health Connector

Note: We will never request to end services for a Member due to a negative change in his or her health, or because of the Member's use of medical services, diminished mental capacity or uncooperative behavior resulting from his or her special needs.

Effective date of termination

We or the Health Connector will notify you of the date your coverage under the plan ends. If we or the Health Connector terminates your coverage because you did not pay your Premiums, the Health Connector will notify you at least 30 Days before termination. The time frames for termination depend on how you pay your Premiums:

- If you are an individual enrolled in unsubsidized coverage or a Member in a small group and you have not paid your Premium in two months, we or the Health Connector will terminate your coverage on the Day after the payment due date. Your coverage end date is the last Day of the month for which you made full payment. Your termination is retroactive. For example, if you made your last payment for coverage on January 1, but did not pay your Premium for February or March, we or the Health Connector would terminate your coverage on April 1, effective January 31.
- If you are an individual enrolled in a ConnectorCare plan or are getting a Federal Premium Tax Credit and you have not paid your Premium for three months, the Health Connector will terminate your coverage on the Day after the payment due date. Your coverage end date is the last Day of the first month for which you owed but did not

Benefits after termination

We will not pay for services, supplies, or drugs* you get after your coverage ends, even if:

- You were receiving inpatient or outpatient care before your coverage ended
- You had a medical condition (known or unknown), such as pregnancy, that requires medical care after your coverage ends

* Requests for reimbursement for drugs must be submitted within one year from the date of service.

Health plan changes

We or the Health Connector will give you information about the yearly *Tufts Health Direct* open enrollment period. All current *Tufts Health Direct* Members can change plans for any reason during the open enrollment period.

Outside of the open enrollment period, all Members can change their health plan enrollment or coverage type (individual to family) for the following reasons (called "qualifying events"):

- Marriage
- Divorce, legal separation or annulment
- Birth, adoption or placement for adoption of a child
- Dependent spouse required to cover a child by court order
- Death of a spouse or Dependent
- Covered Dependent reaches the age limit for coverage, making him or her ineligible for coverage
- You, your spouse or eligible Dependent moves outside of your health plan's Service Area.
- You, your spouse or eligible Dependent begins or returns from an unpaid leave of absence.
- You, your spouse or eligible Dependent has a change in job status (for example: change from full-time to part-time employment or leaving employment) that affects eligibility for benefit coverage under the employer's plan or a plan of your spouse's or eligible Dependent's employer

may enroll in or change from one plan to another one time per month.
- You, your spouse or eligible Dependent is newly determined eligible for a Federal Premium Tax Credit or there is a change in eligibility for a ConnectorCare plan.
- Other exceptional circumstances. Please refer to the Health Connector for a complete list.

The qualifying event must be reported to the Health Connector within 60 Days of the event. Changes to health plan enrollment or coverage type will be effective as of the qualifying event date.

Continuing coverage for group Members

Continuation of group coverage under federal law (COBRA)

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), group Members may be eligible to keep coverage under the group contract if:
- You were enrolled in a group that has 20 or more eligible employees
- You experience a qualifying event that would cause you to lose coverage under your group
- You elect coverage as provided under COBRA

Below is a brief summary of COBRA continuation coverage:
- **Qualifying events**: Qualifying events that may entitle you to COBRA continued coverage are as follows:
  - Termination of the Subscriber's employment (for reasons other than gross misconduct)
  - Reduction in the Subscriber's work hours
  - The Subscriber's divorce or legal separation
  - The Subscriber's death

  18 – 36 months depending on the qualifying event.

  COBRA coverage will end at the end of the maximum period of coverage. However, coverage may end earlier if:
  - The Premium is not paid on time
  - Your group ceases to maintain any group plan
  - The group terminates its group contract with us or the Health Connector (in which case your coverage may continue under another health plan)
  - For other reasons such as the end of disability, or becoming eligible for or obtaining other coverage
- **Cost of coverage:** In most cases, you are responsible for payment of 102% of the cost of coverage.
- **Continued coverage for disabled Subscribers**: At the time of the Subscriber's termination of employment or reduction in work hours (or within 60 Days of the qualifying event under federal law), if a Subscriber or his or her eligible Dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued group coverage will be available for up to 29 months from the date of the qualifying event. The Premium cost for the extra 11 months may be up to 150% of the Premium rate.
- **Enrollment**: To enroll, you must complete an election form and return it to your group. The form must be returned within 60 Days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to keep coverage in this plan under a group contract.

For more information about COBRA, contact your group or the Health Connector.

Continuation of group coverage under

- You experience a qualifying event that would cause you to lose coverage under your group
- You elect coverage as provided by Massachusetts law

Below is a brief summary of Massachusetts continuation coverage:

- **Qualifying events**: Qualifying events that may entitle you to keep coverage under Massachusetts law are as follows:
  - Termination of the Subscriber's employment (for reasons other than gross misconduct)
  - Reduction in the Subscriber's work hours
  - The Subscriber's divorce or legal separation
  - Death of the Subscriber
  - The Subscriber's entitlement to Medicare
  - Loss of status as an eligible Dependent
- **Period of continued coverage:** In most cases, continuation coverage is effective on the date following the Day group coverage ends. In most cases, it ends 18 or 36 months from the date of the qualifying event, depending on the type of qualifying event.
- **Cost of coverage:** In most cases, you are responsible for payment of 102% of the group Premium.
- **Enrollment:** To enroll, you must complete an election form and return it to your group. The form must be returned within 60 Days from your date of termination of group coverage or your notification (by your group) of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. This means you will not be allowed to keep coverage in this plan under a group contract.

For more information about Massachusetts continuation coverage, contact your group or the Health Connector.

Coverage under an individual contract: If

Covered Services

We cover Medically Necessary Covered Services listed in this handbook that are provided by In-network Providers (except Emergency services, which you can get anywhere). If a service or service category is not specifically listed as covered, then it is not covered under this agreement. (See the section "Services not covered" on page 35)

The following "Services we cover" section lists services we cover for *Tufts Health Direct* Members.

In addition, the Covered Services for each of the Plan Levels are listed in the section "Benefit and Cost-sharing Summary" starting on page 61. Check the summary for your Plan Level and for a list of services covered and Prior Authorization requirements for *Tufts Health Direct* Members. If you have any questions, call us at **888.257.1985**, Monday through Friday, from 8 a.m. to 5 p.m. We can give you more information about any of these Covered Services.

Covered Services are only covered if they are Medically Necessary. Medically Necessary services are services that we determine are consistent with generally accepted principles of medical practice. This means that they're the least intensive and most cost-effective available, and are:

- The most appropriate available supply or service for you based on potential benefits and harm to you
- Known to be effective in improving health outcomes based on scientific evidence, professional standards and expert opinion

In addition to any limitations in the "Benefit and Cost-sharing Summary," we may limit or require Prior Authorization for Covered Services on the basis of Medical Necessity.

Services we cover

Outpatient medical care

Abortion services

We cover abortion services you get from a *Tufts Health Direct* Provider. We must give Prior Authorization, requested by your PCP, for an abortion from a provider who does not participate in *Tufts Health Direct*'s Network.

Anesthesia

We cover Medically Necessary anesthesia services. If you need anesthesia, we provide coverage on a nondiscriminatory basis for Covered Services. This means you have the same coverage whether the service was given to you by an In-network Certified Nurse Anesthetist or by another In-network Provider. The Covered Services provided must be services the Provider is legally authorized to practice.

Cleft palate/cleft lip

We cover medical, dental, oral and facial surgery for Members 18 years and younger with a cleft palate and/or cleft lip. This includes surgical management and follow-up care by oral and plastic surgeons, as well as orthodontic treatment and management, preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, Speech Therapy, audiology, and nutrition services, if prescribed by the treating physician or surgeon and the physician or surgeon certifies that the services are Medically Necessary.

Community health center visits and office visits

We cover community health center and office visits to *Tufts Health Direct* Providers for Primary Care or for specialty services. We must give Prior Authorization for office visits to all Out-of-network Providers. Call us at

Hearing Aids

We cover Medically Necessary hearing aids for Members age 21 and younger. This includes the cost of one hearing aid per hearing-impaired ear for up to $2,000 each, every 36 months.

Outpatient surgery

We cover surgical procedures performed in an In-network outpatient surgical center or Hospital operating room. Some procedures require Prior Authorization.

Laboratory services

We cover In-network laboratory services (such as blood tests, urinalyses, Pap smears and throat cultures) that your Provider orders to diagnose, treat, and prevent disease, and to maintain your health, such as:

- Diagnostic laboratory tests, such as glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin tests, and lipid profiles to diagnose and treat diabetes
- Human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to set up bone marrow transplant donor suitability. This includes testing for A, B, or DR antigens, or any combination, in accordance with Massachusetts Department of Public Health guidelines.

Certain laboratory tests may require prior authorization, such as genetic testing and others.

Radiology services

We cover radiology services, such as:

- X-rays
- Mammography
- MRIs
- PET and CT scans

Some of these — MRIs, MRAs, CT scans, outpatient nuclear cardiology and PET — require Prior Authorization. Please see the

licensed Hospital setting with Prior Authorization. Prior Authorization is not required for Emergency care.

Reconstructive surgery and procedures

We cover Medically Necessary reconstructive surgery and procedures. These are covered only when the services are required to relieve pain or to improve or restore bodily function that is impaired as a result of:

- A birth defect
- Accidental injury
- Disease
- A covered surgical procedure

We also cover the following post-mastectomy services:

- Reconstruction of the breast affected by the mastectomy
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of all stages of mastectomy (such as lymphedema)

Removal of breast implants is covered only when:

- There is a medical complication related to an implant (such as a breast implant rupture) or
- There is documented evidence of autoimmune disease.

We do not cover cosmetic procedures, except for post-mastectomy coverage as specifically described in this section.

Covered medications and pharmacy

Pharmacy program

We aim to provide high-quality, cost-effective options for drug therapy. We work with your Providers and pharmacists to make sure we

Note: Requests for reimbursement for drugs must be submitted within one year of the date of service.

Prior Authorization drug 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. Our *Preferred Drug List* states whether a drug requires Prior Authorization.

If we don't approve the request for Prior Authorization, you or your Authorized Representative can appeal the decision. For more information, please see the section "How to resolve concerns" starting on page 43. If you want more information about our pharmacy program, visit tuftshealthplan.com or call us at **888.257.1985**.

Preferred Drug List (*PDL*)

We use a *PDL* as our list of covered drugs. The *PDL* applies only to drugs you get at retail, mail-order and specialty pharmacies. The *PDL* doesn't apply to drugs you get if you're in the Hospital. For the most current *PDL* information, please visit tuftshealthplan.com or call us at **888.257.1985**.

Step-therapy 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.

Quantity limits

To make sure the drugs you take are safe and

Specialty pharmacy program

We have designated specialty pharmacies that specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for Members. Some medications must be obtained at a specialty pharmacy. Medications may be added to this program from time to time. Designated specialty pharmacies can dispense up to a 30-day supply of medication at one time, and the supply is delivered directly to the Member's home via mail. This is NOT part of the mail-order pharmacy benefit. Extended day supplies and Co-payment savings do not apply to these designated specialty drugs.

Generic drugs

Generic drugs have the same active ingredients and work the same as brand-name drugs. When generic drugs are available, we won't cover the brand-name drug without giving Prior Authorization. If you and your Provider feel that a generic drug is not right for your health condition and that the brand-name drug is Medically Necessary, your Provider can ask for Prior Authorization. One of our clinicians will then review the request.

New-to-market drugs

We review new drugs for safety and effectiveness before we add them to our *PDL*. A Provider who feels a new-to-market drug is Medically Necessary for you before we've reviewed it can submit a request for approval. One of our clinicians will review this request. If we approve the request, we'll cover the drug according to our clinical guidelines. If we don't approve it, you or your Authorized Representative can Appeal the decision.

Covered prescription drugs and supplies

In addition to the covered prescription drugs and supplies listed in the *PDL*, we cover:

- medical literature or by the Massachusetts Commissioner of Insurance.
- Oral and injectable drug therapies used in the treatment of covered infertility services only when you have been approved for covered infertility treatment (see the section "Infertility services" on page 30)
- Compounded medications, if at least one active ingredient requires a prescription by law and is FDA-approved. Compounding kits that are not FDA-approved and include prescription ingredients that are readily available may not be covered. To confirm whether the specific medication or kit is covered under this plan, please call the Member Services Team.

Included in the *PDL* are:

- Hormone replacement therapy (HRT) for perimenopausal and postmenopausal women
- Oral and other forms of prescription drug contraceptives (birth control drugs)
- Hypodermic syringes or needles when Medically Necessary
- Insulin, insulin pens, insulin needles and syringes, and lancets; blood glucose, urine glucose and ketone monitoring strips; and oral diabetes medications only when your Provider has given you a prescription that meets all legal requirements
- Prescription smoking cessation agents

Noncovered drugs with suggested alternatives

While Tufts Health Plan covers a majority of drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. 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.

Exclusions

- Immunization agents administered or dispensed at a pharmacy, except for the influenza virus vaccine when administered by a pharmacist between August 1 and April 30 at a participating pharmacy to Members who are at least 18 years old*
- Medical supplies*
- Mifepristone (Mifeprex)*
- Prescription and over-the-counter homeopathic medications
- Drugs that by law do not require a prescription (unless listed as covered in the "Covered medications and pharmacy" section)
- Vitamins and dietary supplements (except prescription prenatal vitamins, vitamins as required by the Affordable Care Act, fluoride for children and supplements for the treatment of mitochondrial disease)
- Topical and oral fluorides for adults
- Medications for the treatment of idiopathic short stature
- 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 section.
- Prescriptions written by Providers who do not participate in the *Tufts Health Direct* Network, except in cases of authorized referral or Emergency care
- Prescriptions filled at pharmacies other than Tufts Health Plan designated pharmacies, except for Emergency care
- 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.
- Prescription medications when packaged with non-prescription products

Covered Behavioral Health (mental health and/or substance use) services

Outpatient Behavioral Health (mental health and/or substance use) services

These services may require Prior Authorization. When treatment is for substance use disorder Outpatient services, Level III community-based detoxification and Level IV detoxification services, we do not require Prior Authorization for In-network providers. Please see our Medical Necessity Guidelines at tuftshealthplan.com/ medicalnecessityguidelines.

We cover Medically Necessary Behavioral Health services provided in a face-to-face encounter in:

- An In-network licensed Hospital
- A mental health or substance use clinic licensed by the Massachusetts Department of Public Health
- A public community mental health center
- A professional office
- Home-based services by a licensed professional acting within the scope of his or her license

Biologically-based and nonbiologically based outpatient services are provided without annual, lifetime or visit/unit/ day limits. Outpatient Behavioral Health services include:

- Individual, group and family counseling
- Medication visits
- Community crisis counseling
- Family and case consultation
- Diagnostic evaluation
- Psychological testing
- Narcotic treatment services
- Electroconvulsive therapy

For each Benefit Year, we cover 12 Behavioral Health outpatient therapy visits without Prior Authorization; additional visits require Prior Authorization. Outpatient therapy visits for

less intensive than inpatient services. Intermediate services do not have any annual, lifetime or visit/unit/day limits. Examples include:

- Day treatment programs
- Partial hospital programs
- Intensive outpatient programs
- Crisis stabilization
- In-home therapy services, such as family stabilization team services
- Acute residential treatment, such as community-based acute treatment (this is not a substance-use specific service)
- Clinically managed detoxification services
- Level III community-based detoxification services

These services may require Prior Authorization. When treatment is for substance use disorder, we do not require Prior Authorization for In-network Providers. Please see our Medical Necessity Guidelines at tuftshealthplan.com.

Other related services

We also cover:

- Medication management services
- Neuropsychological assessment and psychological testing. Prior Authorization is required.

Inpatient Behavioral Health (mental health and/or substance use) services

We cover Medically Necessary 24-hour clinical intervention services for Behavioral Health diagnoses delivered in:

- A licensed In-network Hospital
- A facility under the direction and supervision of the Department of Mental Health
- A private mental health hospital licensed by the Department of Mental Health
- A substance use facility licensed by the Massachusetts Department of Public Health

We cover an inpatient treatment if Medically Necessary. Biologically-based and services to diagnose and treat mental disorders. This includes:

- Biologically-based mental disorders, such as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance use disorders, autism, and other psychotic disorders or biologically-based mental disorders
- Autism spectrum disorder (ASD) services: We provide coverage for ASD in accordance with Massachusetts law without annual, lifetime or visit/unit/day limits.
  - ASD includes any of the pervasive developmental disorders (as defined by the most recent edition of the DSM), such as autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.
  - Diagnosis of ASD includes: Medically Necessary assessments, evaluations (such as neuropsychological evaluations), genetic testing or other tests to diagnose whether a Member has an ASD.
  - Treatment for ASD includes: habilitative or rehabilitative care (such as applied behavioral analysis*), pharmacy care (under the pharmacy benefit), psychiatric care (direct or consultative services provided by a licensed psychiatrist), psychological care (direct or consultative services provided by a licensed psychologist), and therapeutic care (services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers). Benefit limits applicable to the rehabilitation therapies benefit do not apply to therapeutic care services provided to Members with ASD. Services must be rendered by In-network autism services Providers (Providers who treat ASDs). These include board-certified behavior analysts,** psychiatrists, psychologists

human behavior. This includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

** Defined as a behavioral analyst credentialed by the behavior analyst certification board as a board-certified behavior analyst.

- Rape-related mental or emotional disorders

to victims of rape or victims of an assault with intent to commit rape
- All other nonbiologically based mental disorders

Mental health parity law

Tufts Health Plan complies with Massachusetts and federal laws on mental health parity. This means that, among other things, Co-payments, Co-insurance, Deductibles, and/or unit of service limits (e.g., hospital days, outpatient visits) are not greater for Behavioral Health or substance use disorders than those required for medical/surgical services, and office visit Co-payments are not greater than those required for Primary Care visits.

Home health care

We cover certain home health services provided by a home health agency in your home, as long as your home isn't a Hospital or skilled nursing or rehabilitation institution. The services also must be Medically Necessary as part of a Provider-approved home health services plan. Prior Authorization is required if the request is to receive daily visits or the visits exceed six months of service. You must be home bound to receive home health care services. Covered services include:
- Durable Medical Equipment (DME)
- Part-time or intermittent skilled nursing care
- Physical, Occupational and Speech Therapies
- Part-time or intermittent home health aide

Year at a Skilled Nursing Facility. Prior Authorization is required.

Inpatient Rehabilitation Hospital

We cover daily Medically Necessary rehabilitative services provided in an inpatient setting for a maximum of 60 Days per Member per Benefit Year at an inpatient Rehabilitation Hospital. Prior Authorization is required.

Short-term outpatient rehabilitation and habilitative services (Physical, Occupational and Speech Therapies)

Physical and Occupational Therapies

We provide Physical and Occupational Therapy coverage with Prior Authorization.

Therapies are covered for evaluation and restorative short-term treatments that you need to attain your highest level of independent functioning. Care is provided in the timeliest manner possible and when we determine that the therapy will result in significant, sustained and measurable improvement of your condition. We may require Prior Authorization for rehabilitation and habilitative therapy services after the initial evaluation. Rehabilitative Physical and Occupational Therapy are covered only if Medically Necessary for up to 60 visits combined per member per Benefit Year. Habilitative Physical and Occupational Therapy are covered only if Medically Necessary for up to 60 visits combined per member per Benefit Year. Limit does not apply when these services are furnished to treat autism spectrum disorders.

Speech, hearing and language disorders

We cover the diagnosis and treatment of speech, hearing and language disorders when you get services from
a registered, licensed speech-language pathologist, audiologist, or therapist as part of

Other benefits

Chiropractic care

We cover spinal manipulation, therapeutic exercise and attended electrical muscle stimulation for Members for 20 visits per Benefit Year.

Clinical trials

We cover limited services for Members enrolled in a qualified clinical trial of a treatment. Coverage will be under the terms and conditions provided for under Massachusetts and federal law. We cover the following services:

- Services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the plan
- Patient care services provided as part of a qualified clinical trial for the treatment of cancer or another life-threatening disease or condition (Prior Approval by an authorized reviewer may be required)

To the extent required by Massachusetts and federal law, patient care services provided as part of a qualified clinical trial conducted to prevent, detect, or treat cancer, or another life-threatening disease or condition, 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.

Diabetes treatment

We cover the following services for Members with diabetes if they are Medically Necessary to diagnose or treat insulin-dependent, insulin-using, non-insulin-dependent, or gestational diabetes:

- Diabetes outpatient self-management training and educational services. This includes medical nutrition therapy. An In-network Provider who is a certified diabetes Provider must provide these services.
- Diabetes lab tests, such as glycosylated hemoglobin (or HbA1c) tests, urinary protein/microalbumin and lipid profiles
- Insulin pumps and insulin pump supplies (may need Prior Authorization when exceeding $1,000), insulin needles and syringes, diabetic test strips and lancets, blood glucose monitors for home use, voice synthesizers (with Prior Authorization), and visual magnifying aids when Medically Necessary for home use for the legally blind
- Therapeutic and molded shoes and shoe inserts for severe diabetic foot disease. An In-network Podiatrist or other qualified doctor must prescribe shoes/shoe inserts, and an In-network Podiatrist, orthotist, prosthetist or pedorthist must furnish them.
- Prescribed oral diabetes medications that influence blood sugar levels; insulin, insulin needles and syringes, insulin pens and lancets; and blood glucose, urine glucose and ketone monitoring strips. Our *Preferred Drug List* shows covered medications and diabetes supplies.

Durable Medical Equipment (DME)

We cover certain DME. Coverage includes, but is not limited to, the rental or purchase of medical equipment, some replacement parts, and repairs. Prior Authorization is required if the total cost is over $1,000.

Early intervention services

We cover, with Prior Authorization, early intervention services provided by an In-network Provider who is a certified early intervention specialist. These services must be part of an early intervention program meeting the standards of the Department of Public Health. This benefit is only for Members from birth through the age of 3 who meet set criteria. There are no charges, Co-payments, Deductibles or Co-insurance for these services. Benefit limits applicable to rehabilitation therapies do not apply to early intervention services. Early intervention services include the following: