Filing at a Glance

Companies:	Tufts Associated Health Maintenance Organization, Inc. Tufts Insurance Company
Product Name:	RI 2014 Rate Review Process - TAHMO & TIC LG
State:	Rhode Island
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.002A Large Group Only - PPO
Filing Type:	Rate
Date Submitted:	05/15/2013
SERFF Tr Num:	THPC-129022561
SERFF Status:	Assigned
State Tr Num:	
State Status:	Open-Pending Actuary Review
Co Tr Num:	2013-RI-130
Implementation Date Requested:	01/01/2014
Author(s):	Paul Hatch, Haiyun Guo, Colin Woodworth, Michael Kulikowski, Jen Stevenson, Emily Mulligan
Reviewer(s):	Patrick Tigue (primary), Charles DeWeese, Herbert Olson, Maria Casale, Bela Gorman
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: *Rhode Island* **First Filing Company:** *Tufts Associated Health Maintenance Organization, Inc., ...*

TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*
Product Name: *RI 2014 Rate Review Process - TAHMO & TIC LG*
Project Name/Number: *RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*

General Information

Project Name: RI 2013 Rate Review Process - TAHMO & TIC LG
Status of Filing in Domicile: Authorized

Project Number: 2013-RI-130
Date Approved in Domicile:

Requested Filing Mode: Review & Approval
Domicile Status Comments:

Explanation for Combination/Other:
Market Type: Group

Submission Type: New Submission
Group Market Size: Large

Group Market Type: Employer
Overall Rate Impact:

Filing Status Changed: 05/15/2013

State Status Changed: 05/15/2013
Deemer Date:

Created By: Paul Hatch
Submitted By: Jen Stevenson

Corresponding Filing Tracking Number: 2013-RI-130

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Attached are the Tufts Associated Health Maintenance Organization Inc. (TAHMO) and Tufts Insurance Company (TIC) Large Group Rate Review Process filings for 1/1/13. For any questions about this submission, please contact Jen Stevenson, Analytic Manager, at 617-972-9400, ext. 3748.

Company and Contact

Filing Contact Information

Jen Stevenson, Analytic Manager
705 Mt. Auburn Street
Watertown, MA 02472

jen_stevenson@tufts-health.com
617-972-9400 [Phone] 3748 [Ext]
617-972-9078 [FAX]

Filing Company Information

Tufts Associated Health Maintenance Organization, Inc.
705 Mount Auburn Street
Watertown, MA 02472-1508
(617) 972-9400 ext. [Phone]

CoCode: 95688
Group Code:
Group Name:
FEIN Number: 04-2674079

State of Domicile: Massachusetts
Company Type:
State ID Number:

Tufts Insurance Company
705 Mount Auburn Street
Watertown, MA 02472-1508
(617) 972-9400 ext. [Phone]

CoCode: 60117
Group Code:
Group Name:
FEIN Number: 04-3319729

State of Domicile: Massachusetts
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $80.00

State: *Rhode Island* ***First Filing Company:*** *Tufts Associated Health Maintenance Organization, Inc., ...*

TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*

Product Name: *RI 2014 Rate Review Process - TAHMO & TIC LG*

Project Name/Number: *RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*

Retaliatory? No

Fee Explanation:

Per Company: Yes

Company	Amount	Date Processed	Transaction #
Tufts Insurance Company	$40.00	05/15/2013	70315943
Tufts Associated Health Maintenance Organization, Inc.	$40.00	05/15/2013	70315944

Rate Information

Rate data applies to filing.

Filing Method: SERFF
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision: 01/01/2013
Filing Method of Last Filing: SERFF

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Tufts Associated Health Maintenance Organization, Inc.	Increase	9.500%	9.500%	$1,177,155	46	$12,397,135	9.600%	9.100%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	2,184					81		
Policy Holders:	44					2		

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Tufts Insurance Company	Increase	10.100%	10.100%	$4,119,499	47	$40,704,228	10.200%	9.700%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:		6,569				356		
Policy Holders:		42				5		

State: Rhode Island **First Filing Company:** Tufts Associated Health Maintenance Organization, Inc., ...

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO
Product Name: RI 2014 Rate Review Process - TAHMO & TIC LG
Project Name/Number: RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130

Rate Review Detail

COMPANY:

Company Name:	Tufts Associated Health Maintenance Organization, Inc.
HHS Issuer Id:	90010
Product Names:	Tufts Health Plan (TAHMO) HMO
Trend Factors:	The projected overall combined Medical and Rx trend is 6.2%. Please see the details in the OHIC template.

FORMS:

New Policy Forms:	For HMO - EC-RIHMO-001
Affected Forms:	n/a
Other Affected Forms:	n/a

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Annual
Member Months:	22,302
Benefit Change:	None
Percent Change Requested:	Min: 9.1 Max: 9.6 Avg: 9.5

PRIOR RATE:

Total Earned Premium:	12,397,135.00
Total Incurred Claims:	10,855,788.00
Annual $:	Min: 323.47 Max: 510.52 Avg: 402.46

REQUESTED RATE:

Projected Earned Premium:	13,574,289.00
Projected Incurred Claims:	11,624,379.00
Annual $:	Min: 354.24 Max: 559.32 Avg: 440.68

State: *Rhode Island* ***First Filing Company:*** *Tufts Associated Health Maintenance Organization, Inc., ...*

TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*
Product Name: *RI 2014 Rate Review Process - TAHMO & TIC LG*
Project Name/Number: *RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*

COMPANY:

Company Name:	Tufts Insurance Company
HHS Issuer Id:	38712
Product Names:	Standard (non-CareLink) PPO; CareLink PPO
Trend Factors:	The projected overall combined Medical and Rx trend is 6.2%. Please see the details in the OHIC template.

FORMS:

New Policy Forms:	Standard PPO - Form RI-PPO-001; CareLink PPO - Form RI-PPO-002.
Affected Forms:	
Other Affected Forms:	

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Annual
Member Months:	56,285
Benefit Change:	None
Percent Change Requested:	Min: 9.7 Max: 10.2 Avg: 10.1

PRIOR RATE:

Total Earned Premium:	40,704,228.00
Total Incurred Claims:	35,643,436.00
Annual $:	Min: 340.93 Max: 541.68 Avg: 432.21

REQUESTED RATE:

Projected Earned Premium:	44,823,727.00
Projected Incurred Claims:	38,170,663.00
Annual $:	Min: 375.50 Max: 596.85 Avg: 475.95

SERFF Tracking #:	*THPC-129022561*	***State Tracking #:***		***Company Tracking #:***	*2013-RI-130*

State:	*Rhode Island*	***First Filing Company:***	*Tufts Associated Health Maintenance Organization, Inc., ...*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*		
Product Name:	*RI 2014 Rate Review Process - TAHMO & TIC LG*		
Project Name/Number:	*RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		TAHMO HMO EOC	EC-RIHMO-001 Ed. 7-2012	New		7-2012 RI HMO EOC - Clean Version.pdf,
2		TIC Standard PPO Certficate	RI-PPO-001 Ed. 7-2012	New		7-2012 RI TIC Standard PPO Cert - Clean Version.pdf,
3		TIC CareLink PPO Certficate	RI-PPO-002 Ed. 7-2012	New		7-2012 RI TIC CareLink PPO Cert - Clean Version.pdf,

REVISED Rhode Island HMO Evidence of Coverage (EOC) for
Tufts Associated Health Maintenance Organization, Inc. (TAHMO)

REVISED CLEAN COPY

(submitted to Rhode Island Dept. of Business Regulation – 2-22-13)

TUFTS Health Plan

Health Maintenance Organization

Rhode Island
[[Premium] [Value] [Basic] Benefit]

Evidence of Coverage

Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508

Tufts Health Plan Address And Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, Massachusetts 02472-1508

Hours:
Hours: Monday through Thursday 8:00 a.m.-7:00 p.m.
Friday 8:00 a.m - 5:00 p.m.

IMPORTANT PHONE NUMBERS:

Emergency Care

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

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

Liability Recovery

Call the Liability and Recovery Department at 1-888-880-8699, x. 1098 for questions about coordination of benefits and workers compensation. For example, call that Department with questions about how *Tufts Health Plan* coordinates coverage with other health care coverage you may have. This 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.

You may have questions about subrogation. If so, call a Member Specialist at 1-800-682-8059. You may not be sure about which department to call with your questions. If so, call Member Services.

Member Services Department

Call our Member Services Department at 1-800-682-8059 for: general questions; assistance in choosing a *Primary Care Provider (PCP);* benefit questions; and information regarding eligibility for enrollment and billing.

[Mental Health Services

You may need information regarding mental health professionals in your area. If so, call the Mental Health Department at 1-800-208-9565.]

Services for Hearing Impaired Members

You may be hearing impaired. If so, these 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.

Rhode Island Relay

1-800-745-5555

IMPORTANT ADDRESSES:

Appeals and Grievances Department

You may need to call us about a concern or appeal. If so, call a Specialist at 1-800-682-8059. To submit your appeal or grievance in writing, send your letter to:

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

Web site

You may want more information about *Tufts Health Plan* or to learn about the self-service options available to you. If so, 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.

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

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ នៃតំរោងថែរក្សាសុខភាពរបស់ Tufts ។

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

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

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

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການຫຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts , ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

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

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

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

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

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

1-800-682-8059

Telecommunications Device for the Deaf (TDD)
Call 1-800-868-5850

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. We arrange 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)*. Your *PCP* will manage your care. Your *PCP* is a physician or nurse practitioner in private practice. He or she personally cares for your health needs. If the need arises, your *PCP* will refer you to a specialist in our network.

[IMPORTANT NOTE:

- For *Outpatient* care: You may receive services from your *PCP*, a mental health/substance abuse *Provider*, or an obstetrician/gynecologist ("Ob/Gyn"). If this happens, your *Copayment* may be lower than for services from other *Providers*.
- [For *Inpatient* care or *Day Surgery*: Your *Copayment* may be lower when you receive care at a *Community Hospital* [or at your *Designated Facility]* than when you receive care at a *Tertiary Hospital* (. See Appendix A for definitions of these facilities.]

For more information, see "*Covered Services*" in Chapter 3. **]**

This book will help you find answers to your questions about *Tufts Health Plan* benefits. Italicized words are defined in the Glossary in Appendix A.

Your satisfaction with *Tufts Health Plan* is important to us. If you have any questions, call a Member Specialist. We will be happy to help you.

Tufts Associated Health Maintenance Organization, Inc. is licensed as a health maintenance organization in Massachusetts and Rhode Island. This company 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 on your *Effective Date*.

IMPORTANT NOTE FOR *MEMBERS* IN *GROUP CONTRACTS* ONLY: You may live in Massachusetts or New Hampshire. If so, your benefits under this plan may include benefits required under applicable Massachusetts or New Hampshire law. For more information, call Member Services.

Calls to Member Services

Our Member Services Department is committed to excellent service. Calls to our Member Services Department may be monitored. This is done to assure quality service.

Table of Contents

Table of Contents, continued

Chapter 3 -- *Covered Services,* continued

Table of Contents, continued

Table of Contents, continued

Benefit Overview

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

[COINSURANCE
Except as described in the "Benefit Overview" table below, the *Member* pays [0-35%] of the *Reasonable Charge* for certain *Covered Services*. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.]

COPAYMENTS

- ***Emergency* Care:**
  - Emergency room.....[[$0 - $350] *Copayment* per visit.] [Covered in full.]
  - In *Provider's* office [$0 - $60] *Copayment* per visit [for care received from your *PCP*]. [[$0-$60] *Copayment* per visit for care received from any other *Tufts Health Plan Provider*].] [Covered in full.]

  [Note[s]:
    - [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]
- **[*Urgent Care*** [*Copayment* varies depending on [type of *Provider* (*PCP* or Specialist) and]location in which service is rendered (for example, *Emergency Room,* urgent care center, or physician's office).]
- **[Other] *Covered Services*: [**
  - Office Visit..... [[$0 - $60] *Copayment* per visit [for office visits that are not subject to the *Deductible**].] [Covered in full [for office visits that are subject to the *Deductible**].]
  - [*Inpatient* Services ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]]
  - *Day Surgery*.....[[$0 - $1,500] *Copayment* per admission.] [Covered in full.]] **]**

  [*Note: The *Deductible* will apply for certain types of office visits. Please see "Important Information about your *Deductible*" and the "Benefit Overview" table below for information about when the *Deductible* does and does not apply.]

  [• Lower Office Visit *Copayment* ..... [[$0 - $60] *Copayment* per visit[for office visits that are not subject to the *Deductible**].] [Covered in full [for office visits that are subject to the *Deductible**].]

  [Note: This *Copayment* applies to covered *Outpatient* care provided by your *PCP*, [a mental health/substance abuse *Provider*, or an obstetrician/ gynecologist ("Ob/Gyn"),] [as well as for *Outpatient* [physical, occupational, or speech therapy services,] [spinal manipulation,] [chiropractic medicine;] [acupuncture;] [cardiac rehabilitation services,] [and] routine eye care.]]

  ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Deductible can only be applied to Health Savings Account (HSA) plans.]*

(continued next page)

COPAYMENTS, continued

- Higher Office Visit *Copayment* [[$0 - $75] *Copayment* per visit [for office visits that are not subject to the *Deductible**].] [Covered in full [for office visits that are subject to the *Deductible**].]

  [Note: This *Copayment* applies to all covered *Outpatient* care subject to an Office Visit *Copayment,* except for care obtained from the *Providers* or for the services listed above under Lower Office Visit *Copayment*.]

  [*Note: The *Deductible* will apply for certain types of office visits. See "Important Information about your Deductible" and the "Benefit Overview" table below for information about when the *Deductible* applies.]

  - *[Inpatient* Services at a *Community Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]]
  - *[Inpatient* Services at a *Tertiary Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]]
  - *[Day Surgery* at a *Community Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]]
  - *[Day Surgery* at a *Tertiary Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] **]]**

Note: Certain *Outpatient* services may be listed as "covered in full" in the table below. If so, you may be charged [the *Deductible* (if applicable) and] an Office Visit *Copayment* when these services are provided along with an office visit.

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM]

- [*Copayment* Maximum per *Member*.....[$0 - $6,000] [*0-5 Copayments*]
- *Copayment* Maximum per family .....[$0-$30,000]

Most of the [*Inpatient*] [and] [*Day Surgery*] services listed in the table below are subject to an [*Inpatient*] [and] [*Day Surgery*] *Copayment*. You must pay an [*Inpatient*] [and] [*Day Surgery*] *Copayment* up to your [$0 - $6,000] [0-5 *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per *Contract Year*.

The [$0 - $6,000] [0-5 *Copayment]* [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum is the most money you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a *Contract Year*. The [$0 - $6,000] [0-5 *Copayment*] [*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*] [and] [*Day Surgery*] *Copayments* will be taken in that *Contract 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-five] times the [$0 - $6,000] [0-5 *Copayment*] individual *Copayment* Maximum] [$0-$30,000]. When the family *Copayment* Maximum is reached, all *Members* in that family will have met their individual *Copayment* Maximum for that *Contract Year*.]

[*DEDUCTIBLE*] *This option used for non-Health Savings Account (non-HSA) plans only.*

[Individual *Deductible*..... [$0-$5,000] per *Contract Year*]
[Family *Deductible* .....[$0-$25,000] per *Contract Year*]

[This Family *Deductible* applies for all enrolled *Members* of a family.]

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

[The Family *Deductible* is satisfied in a *Contract Year* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a *Contract Year* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible*.]

[Once the Family *Deductible* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that *Contract Year*.] [Also, please note that any amount paid by the for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year's Deductible*.

[DEDUCTIBLE] ***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Used for Health Savings Account (HSA) plans only. Deductible ranges below will be adjusted to comply with the IRS requirements for the applicable tax year.*

[The *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Services* before payments are made under this *Evidence of Coverage*.]

[The *Deductible* applies to all *Covered Services* except as listed below.]

[The amount of the *Deductible* which applies to you and the enrolled members of your family (if applicable) each [calendar year] [*Contract Year]* is:

[Family Size — *Deductible* Amount

- One Member ..... [$1,200-$3,050] per person.
- Two Members or more ..... [$2,400-$6,150] per family.]

[The minimum *Deductible* dollar amount is adjusted each year to meet Internal Revenue Service requirements.]

[***Note:** If you have two or more covered family members enrolled in the plan, and only one *Member* receives services in a [calendar year] [*Contract Year*], that *Member* must meet the full family *Deductible* ([$2,400-$6,150]) himself or herself before *Tufts Health Plan* will pay for any of his or her care in that year as *Covered Services.]*

FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: USED FOR NON-HEALTH SAVINGS ACCOUNT (NON-HSA) PLANS ONLY.

[Important Information About Your *Deductible*:

- The following are not subject to the *Deductible*:
  - [*Emergency* care];
  - Office visits for preventive care*; office visits for family planning; [office visits to diagnose and treat illness or injury]; [mental health and substance abuse services;] routine ob/gyn exam; routine eye exam; [other vision care [from an optometrist];] *Outpatient* maternity care (pre-natal and post-partum)[**]; [pediatric dental care;] [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education. *including diagnostic tests associated with preventive health care, as described in Chapter 3.
    [**This does not include diagnostic tests such as ultrasounds.]
  - routine cytology exams (Pap Smears);
  - early intervention services for a *Dependent Child;*
  - preventive immunizations;
  - routine mammograms;
  - screening for colon and colorectal cancer;
  - routine prostate and colorectal exams;
  - [Any amounts you pay for prescription drugs. [A separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *Deductible* in a *Contract Year* for *Covered Services*, you pay only the following:
  - Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
  - Emergency room [*Copayment*][*Cost Sharing Amount*];
  - [Inpatient Services *Copayment*.]
  - [Day Surgery *Copayment*.]
  - [[A separate Prescription Drug *Deductible*] [*Coinsurance*] [and] [*Copayments*] for prescription drugs. For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - *Coinsurance*.]

FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: USED FOR HEALTH SAVINGS ACCOUNT (HSA) PLANS ONLY.

[Important Information About Your *Deductible*:

- The following are not subject to the *Deductible*:
  - Office visits for: preventive care*; well-child exams; certain disease and disorder screenings**; routine ob/gyn exam; routine eye exam; and routine *Outpatient* maternity care (pre-natal and post-partum).

    *including diagnostic tests associated with preventive health care, as described under "Preventive Health Care for *Members* through age 19" and "Preventive Health Care for *Members* Age 20 and Older" in Chapter 3[, as well as other preventive services in accordance with the ACA].

    **includes disease and disorder screenings related to the following conditions: cancer; heart and vascular disease; infectious diseases; mental health conditions and substance abuse; metabolic, nutritional, and endocrine conditions; musculoskeletal disorders; obstetric and gynecological conditions; pediatric conditions; and vision and hearing disorders[, as well as other screenings and counseling in accordance with the ACA]. Please contact Member Services for more information.
  - routine cytological exams (Pap Smears);
  - immunizations#;

    # includes the following routine preventive immunizations:
    - For *Children* under age 18: Hepatitis B, DTP (diptheria, tetanus, pertussis), HiB (haemophilus influenza Type B), IPV (inactivated polio virus), meningococcal disease, varicella (chicken pox), pneumococcal influenza, hepatitis A, HPV (for female *Children* age 9 and over), and rotavirus vaccines.
    - For adults: TD (tetanus and diptheria), TDaP (tetanus, diphtheria, and pertussis), HPV (for adult females through age 26), varicella (chicken pox), influenza, hepatitis A, hepatitis B, meningococcal disease, and herpes zoster (shingles) vaccines.
  - routine mammograms;
  - screening for colon or colorectal cancer;
  - routine prostate and colorectal exams;
- Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Any amounts you pay for prescription drugs are subject to the *Deductible*. For more information, see "Prescription Drug Benefit" in Chapter 3.
- Once you meet your *Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayments*; and
  - [*Coinsurance*] [and] [*Copayments*] for prescription drugs. For more information, see "Prescription Drug Benefit" in Chapter 3.

FILING NOTE: USED WITH NON-HEALTH SAVINGS ACCOUNT (NON-HSA) PLANS ONLY.

[OUT-OF-POCKET MAXIMUM]

[*Out-of-Pocket Maximum* (Individual)]

[This *Evidence of Coverage* has an individual *Out-of-Pocket Maximum* of [$0-$5,000] per *Member* per *Contract Year* for all *Covered Services.* [Only [*Copayments*] [,] [Deductibles] [and] [*Coinsurance*] count[s] toward the *Out-of-Pocket Maximum*.] For more information , see the definition of *"Out-of-Pocket Maximum*" in Appendix A.]

[*Out-of-Pocket Maximum* (Family)*]*

[The Family *Out-of-Pocket Maximum* is satisfied in *Contract Year* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Out-of-Pocket Maximum*.]

[The Family *Out-of-Pocket Maximum* is satisfied in a *Contract Year* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximum* a collective amount equaling [$0-$25,000] Family *Out-of-Pocket Maximum.*]

[All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the [$0-$25,000] Family *Out-of-Pocket Maximum*.]

[Once the Family *Out-of-Pocket Maximum* has been met during a *Contract Year*, all enrolled *Members* in a family will thereafter have satisfied their [$0-$5,000] Individual *Out-of-Pocket Maximums* for the remainder of that *Contract Year.*

FILING NOTE – USED FOR HSA PLANS ONLY; OUT-OF-POCKET MAXIMUM RANGES BELOW WILL BE LIMITED TO COMPLY WITH THE IRS LIMITS FOR THE APPLICABLE TAX YEAR.

OUT-OF-POCKET MAXIMUM

[The amount of the *Out-of-Pocket Maximum* for you and the enrolled members of your family (if applicable) each [calendar year] [*Contract Year*] is:

Family Size	*Out-of-Pocket Maximum Amount*
• One Member	[$0- $6,050] per person.
• Two Members or more	[$0- $12,100] per family.]

[The *Out-of-Pocket Maximum* is limited to the maximum dollar amount as defined each year by the Internal Revenue Service. For more information, see the definition of "*Out-of-Pocket Maximum"* in Appendix A.]

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams*"* in the Benefit Overview chart below.

COVERED SERVICE	**YOUR COST**	**PAGE**
***Emergency* Care**		
Treatment in an Emergency Room	[*Deductible* and then] [[$0-$350] *Copayment* per visit. (waived if admitted as an *Inpatient* or for *Day Surgery*)] [Covered in full.] **[Note:** *Observation* services will [not] take an *Emergency* room *[Copayment*][*Cost Sharing Amount*].]	[3-1]
Treatment in a *Provider's* office	[Care from your *PCP*:] [*Deductible* and then] [[$0 - $60] *Copayment* per visit. (waived if admitted as an *Inpatient* or for *Day Surgery*)]] [Covered in full.] [Care provided by any other *Tufts Health Plan Provider*: [*Deductible* and then] [[$0 -$60] *Copayment* per visit. (waived if admitted as an *Inpatient* or for *Day Surgery*)]] [Covered in full.]	[3-1]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient*, we recommend that you or someone acting for you call your *PCP* or *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]		

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care**			
[Acupuncture] **[(PA)] [(BL)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$75] *Copayment* per visit.] [Covered in full.]	[3-2]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care, continued**			
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.41-75, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[3-2]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care, continued**			
[Cardiac rehabilitation] **[(PA)] [(BL)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-2]
[Chiropractic care See "Spinal manipulation"]			
[Chiropractic medicine] **[(BL)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-2]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care, continued**			
Diabetes services and supplies (For detailed information about diabetes supplies coverage, see "Diabetes services and supplies" in Chapter 3.)	[Diabetic test strips: [[*Deductible* and then] [$0 - $75] *Copayment* applies.] [Covered in full.]] Diabetes self-management education: [*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.] Diabetes supplies covered as *Durable Medical Equipment*: [*Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [*Deductible* and then] [[0%-35%] *Coinsurance*] [Covered in full]. For information about your cost for diabetes supplies covered as prescription medication, see "Prescription Drug Benefit" in Chapter 3.	[Diabetic test strips: [[*Deductible* and then] [$0 - $75] *Copayment* applies.] [Covered in full.]] Diabetes self-management education: [*Deductible* and then] [[$0 - $75] *Copayment* per visit.] [Covered in full.] Diabetes supplies covered as *Durable Medical Equipment*: [*Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [*Deductible* and then] [[0%-35%] *Coinsurance*] [Covered in full.] [For information about your cost for diabetes supplies covered as prescription medication, see "Prescription Drug Benefit" in Chapter 3.]	[3-2]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care, continued**			
Early intervention services for a *Dependent Child* ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Deductible can only be applied to Health Savings Account (HSA) plans.*	[*Deductible* and then] Covered in full.	[*Deductible* and then] Covered in full.	[3-3]
Family planning (procedures, services[, and contraceptives]) **[(PA)]** ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Contraceptives and female sterilization services and procedures will be covered in full for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.]*]*	**Office Visit**: [*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.] ***Day Surgery***; [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* [*] per *Day Surgery* admission to a *Community Hospital*.] [Covered in full.] [*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**[Office Visit**: [and then] [[$0 - $75] per visit.] [Covered in full.] **Day Surgery**; [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* [*] per *Day Surgery* admission to a *Tertiary Hospital*.] [Covered in full.] [*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]]	[3-3]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] **[Care Provided By Your *PCP* (or Ob/GYN, if applicable)]**	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
Outpatient* Care (*continued)			
Hemodialysis **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-3]
[House calls to diagnose and treat illness or injury]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-3]
Infertility services **(PA) [(BL)]**	[*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are covered in full.]	[*Deductible* and then] [[$0 - $75] *Copayment* per visit.] [Covered in full.] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are covered in full.]	[3-4]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (*continued*)**			
Maternity Care ***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** Both "routine" and "non-routine" care sections will appear in this outpatient maternity care section for Health Savings Account (HSAs) plans only. Non-Health Savings Account (non-HSA) plans will not differentiate between routine and non-routine care in this benefit.			
[Routine] Maternity care [Note: Providers may collect *Copayments* in a variety of ways for this coverage. (Examples include: at the time of your first visit; at the end of your pregnancy; or in installments). Check with your *Provider*. Also, please note that routine laboratory tests associated with maternity care are covered in full, in accordance with the ACA.]	[[$0 - $60] *Copayment* per visit.] [Covered in full.] [Note: This Office Visit *Copayment* will apply per visit up to 10 visits per pregnancy. After that, these services are covered in full for the remainder of your pregnancy.]	[[$0 - $75] *Copayment* per visit.] [Covered in full.] [Note: This Office Visit *Copayment* will apply per visit up to 10 visits per pregnancy. After that, these services are covered in full for the remainder of your pregnancy.]	[3-4]
[Non-Routine Maternity care]	[*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-4]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
Outpatient* Care (*continued)			
Oral Health Services **(PA)**	**Office Visit**: [*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Emergency Room**: [*Deductible* and then] [[$0 - $350] *Copayment* per visit.] [Covered in full.] ***Inpatient* services**: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] ***Day Surgery*:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* [*] per *Day Surgery* admission to a *Community Hospital*.] [Covered in full.] [*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.] [(subject to *[Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**[Office Visit**: [*Deductible* and then] [[$0 - $75] *Copayment* per visit.] [Covered in full.] **Emergency Room**: [*Deductible* and then] [[$0 - $350] *Copayment* per visit.] [Covered in full.] ***Inpatient* services**: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] ***Day Surgery*:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [$0 - $1,500] *Copayment* [*] per *Day Surgery* admission to a *Tertiary Hospital*.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] [*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.]]	[3-5]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
Outpatient* Care (*continued)			
Outpatient Medical Care			
Allergy injections **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60 *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75 *Copayment* per visit.] [Covered in full.]	[3-6]
Allergy testing and treatment **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]
Chemotherapy	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Outpatient Medical Care, continued			
Diagnostic imaging: **[(PA)]** • General imaging (such as x-rays and ultrasounds); • MRI/MRA, CT/CTA, PET[and nuclear cardiology]. **[(PA)]**	**General Imaging:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60 *Copayment* per visit.] [Covered in full.] [**MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250 *Copayment* per visit.] [Covered in full.]] [**MRI/MRA**: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.] **CT/CTA**: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.] **PET**: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.] [**Nuclear cardiology**: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.]]] [**Note**: Diagnostic imaging [except general imaging] [related to a cancer diagnosis will be covered in full] [will be covered in full when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	**[General Imaging:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$75 *Copayment* per visit.] [Covered in full.]] [**MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250 *Copayment* per visit.] [Covered in full.]] [**MRI/MRA:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.]] **[CT/CTA**: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.]] **[PET:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.]] [**Nuclear cardiology:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$250] *Copayment* per visit.] [Covered in full.]] [**Note**: Diagnostic imaging [except general imaging] [related to a cancer diagnosis will be covered in full] [will be covered in full when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[3-6]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Outpatient Medical Care, continued			
Human leukocyte antigen (HLA) testing or histocompatibility testing **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Outpatient Medical Care, continued			
[Immunizations]	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.]	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$75] *Copayment* per visit.] [Covered in full.]	[3-6]
Laboratory tests **(PA)** **Note:** In accordance with the ACA, laboratory tests performed as part of routine preventive care are covered in full.	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$75] *Copayment* per visit.] [Covered in full.]	[3-6]
Lead screenings	Covered in full.	Covered in full.	[3-6]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Outpatient Medical Care, continued			
Medically Necessary diagnosis and treatment of chronic lyme disease	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]
Nutritional counseling **[(BL)]**	[*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]
Office visits to diagnose and treat illness or injury	[*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]
Outpatient surgery in a *Provider's* office **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]
Radiation therapy	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]
Respiratory therapy or pulmonary rehabilitation services [(**PA**)]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-6]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Outpatient Medical Care, continued			
Smoking cessation counseling services	Covered in full.	Covered in full.	[3-6]

COVERED SERVICE	**YOUR COST**	**PAGE**
Outpatient* Care *(continued)		
[Pediatric dental care for *Members* under age 12] **[(PA)]**	[Covered in full.]	[3-7]

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
Outpatient* Care *(continued)			
Preventive health care - *Members* through age 19 Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an Office Visit *Copayment.*	Covered in full.	Covered in full.	[3-7]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Preventive health care – *Members* age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to an Office Visit *Copayment.*	Covered in full. [[Hearing screenings]: [[$0-$60] *Copayment* per visit.] [Covered in full.] All other preventive health care services: Covered in full.]	Covered in full.	[3-7]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Outpatient Medical Care, continued			
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	[3-6]

COVERED SERVICE	YOUR COST		PAGE
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Preventive Screenings and Diagnostic Procedures & Exams, continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* [*] per *Day Surgery* admission to a *Community Hospital*.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.] Diagnostic mammogram: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.] Diagnostic prostate and colorectal exam: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.] [*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* [*] per *Day Surgery* admission to a *Community Hospital*.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.] Diagnostic mammogram: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.] Diagnostic prostate and colorectal exam: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.]	[3-6]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
Short-term] speech, physical and occupational therapy services **(PA)** [**(BL)**]	[Speech therapy:] [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] *Copayment* per visit.] [Covered in full.] [Physical Therapy:] [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] per visit.] [Covered in full.] [Occupational Therapy:] [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.]	[Speech therapy:] [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$75] *Copayment* per visit.] [Covered in full.] [Physical Therapy:] [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.] [Occupational Therapy:] [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-8]

COVERED SERVICE	**YOUR COST**	**PAGE**
[Spinal manipulation **(BL)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-8]

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
[*Urgent Care* in an urgent care center]	[[$0-$60] Office Visit *Copayment*] [Covered in full].	[[$0-$75] Office Visit *Copayment*][Covered in full].	[3-8]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided By Your *PCP* (or Ob/GYN, if applicable)]	**[Care Provided by Any other *Tufts Health Plan Provider*]**	
***Outpatient* Care (continued)**			
[Vision care services]			
[Routine eye examination **(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full].	[[$0-$75] Office Visit *Copayment*][Covered in full].	[3-8]
[Other] vision care services	**[Care from an optometrist:]**[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] Office Visit *Copayment*] [Covered in full]. **[Care from an ophthalmologist:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] Office Visit *Copayment*] [Covered in full.]]	**[Care from an optometrist:]**[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$75] Office Visit *Copayment*] [Covered in full]. **[Care from an ophthalmologist:** [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0-$60] Office Visit *Copayment*] [Covered in full.]]	[3-8]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided at *Community Hospital*)]	**[Care Provided by *Tertiary Hospital*]**	
Day Surgery			
Day Surgery [Note: Endoscopies and proctosigmoidoscopies are covered under this benefit.] ***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: THE ABOVE NOTE FOR THIS BENEFIT IS ONLY FOR USE WITH HEALTH SAVINGS ACCOUNT (HSA) PLANS.***	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* [*] per *Day Surgery* admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] [*This *Copayment* also applies for Covered *Day Surgery* services at a free-standing surgical center.]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* [*] per *Day Surgery* admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] [*This *Copayment* also applies for Covered *Day Surgery* services at a free-standing surgical center.]	[3-8]
***Inpatient* Care**			
Acute hospital services **(PA)**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*[[and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-8]
Hematopoietic stem cell transplants and human solid organ transplants **(PA) [(BL)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-9]

COVERED SERVICE	**YOUR COST**	**PAGE**
Extended care **(PA)** [**(BL)**]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [Covered in full].	[3-9]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	[Coverage] [Care Provided at *Community Hospital*)]	**[Care Provided by *Tertiary Hospital*]**	
Maternity care	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-9]
Reconstructive surgery and procedures and mastectomy surgeries **(PA)**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-10]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**	**PAGE**
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient* and Intermediate)**		
To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.		
Outpatient services **(PA) [(BL)]**	**[Care provided by your *PCP*:]** • [**Visits 1-30 in a *Contract Year*:** [Individual session - [*Deductible* and then] [[$0-$60] *Copayment* per visit.] [Covered in full.]] [Group session - [*Deductible* and then] [[$0-$60] *Copayment* per visit.] [Covered in full.]] • [**Visits [31-unlimited] in a *Contract Year*:** [*Deductible* and then] [$0-$60] *Copayment* per visit.] [[0%-50%] *Coinsurance]]* [Individual session -] [*Deductible* and then] [[$0-$60] *Copayment* per visit.] [Covered in full.] [Group session -] [*Deductible* and then] [[$0-$60] *Copayment* per visit.] [Covered in full.]] [Care provided by another other *Tufts Health Plan Provider*: • [**Visits 1-30 in a *Contract Year*:** [Individual session - [*Deductible* and then] [[$0-$75] *Copayment* per visit.] [Covered in full.]] [Group session - [*Deductible* and then] [[$0-$75] *Copayment* per visit.] [Covered in full.]] • [**Visits [31-unlimited] in a *Contract Year*:** [*Deductible* and then] [$0-$75] *Copayment* per visit.] [[0%-50%] *Coinsurance]]* [Individual session -] [*Deductible* and then] [[$0-$75] *Copayment* per visit.] [Covered in full.] [Group session -] [*Deductible* and then] [[$0-$75] *Copayment* per visit.] [Covered in full.]]]	[3-11]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services have been omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*		
Inpatient services **(PA)**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-11]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services have been omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*		

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.

(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	PAGE
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient* and Intermediate), continued**		
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services have been omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*		
Intermediate care **(PA)**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-11]
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**		
To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.		
Outpatient services **(PA)** [**(BL)**]	Substance Abuse Treatment Services: **[Care provided by your *PCP*:]** [Individual session -] [*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [Covered in full.] [Group session -] [*Deductible* and then] [[$0-$60] *Copayment* per visit.] [Covered in full.] **[Care provided by another other *Tufts Health Plan Provider*:** [Individual session -] [*Deductible* and then] [[$0-$75] *Copayment* per visit.] [Covered in full.] [Group session -] [*Deductible* and then] [[$0-$75] *Copayment* per visit.] [Covered in full.]]	[3-11]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*		
Inpatient services **(PA)** [**(BL)**]	Detoxification services: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to *Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] Substance Abuse Treatment Services: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to *Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-12]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.

(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

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

COVERED SERVICE	YOUR COST	PAGE
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate), continued**		
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*		
Intermediate care **(PA)** [**(BL)**]	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-12]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*		
Community Residential care **(PA) (BL)**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-12]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*		

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.

(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	PAGE
Other Health Services		
Ambulance services **(PA)** Ground ambulance services All other covered ambulance services	[*Deductible* and then] [Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0 - $50] *Copayment* applies [per trip].] [*Deductible* and then] [Covered in full] [[$0 - $50] *Copayment* applies [per trip].]	[3-12]
[Diabetic monitoring strips]	[[*Deductible* and then] [$0 - $75 *Copayment* applies.] [Covered in full.]	[3-12]
Durable Medical Equipment **(PA)**	[*Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.]	[3-13]
Hearing Aids **[(PA)] (BL)**	[*Deductible* and then] [Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance.*]	[3-14]
Home health care **(PA) (BL)**	*[Deductible* and then] [[0%-35%] *Coinsurance*] [Covered in full].	[3-15]
[Hospice care **(PA)] [(BL)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.]	[3-15]
[Injectable, infused or inhaled medications] **(PA)**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment*.] [Covered in full.]	[3-15]
Medical supplies **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [Covered in full].	[3-16]
New cancer therapies **[(PA)]**	***Outpatient***: [*Deductible* and then] [[$0 - $60] *Copayment* per visit.] [[0%-35%] *Coinsurance*] [Covered in full.] ***Inpatient***: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $1,500] *Copayment]* per admission.] [Covered in full.] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[3-16]
Orthoses and prosthetic devices **[(PA)]**	[*Deductible* and then] [Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[3-16]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan*. Please see "Bills from *Providers*" in Chapter 6 for more information.]	[3-16]
[Private duty nursing **[PA]**]	[[*Deductible* and then] [[0%-35%] *Coinsurance*] [$0 - $75 *Copayment* applies.] [Covered in full.]	[3-16]

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.

(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST	PAGE
Other Health Services, continued		
Scalp hair prostheses or wigs for cancer or leukemia patients **(BL)**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [Covered in full].	[3-16]
Special medical formulas		
Low protein foods **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment*] applies per 30-day supply.] [Covered in full.]	[3-17]
Nonprescription enteral formulas **[(PA)]**	[*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment*.] [Covered in full.]	[3-17]

[Prescription Drug Benefit]	
[**YOUR COST:** [*Deductible* and then] *Copayments*.] [For information about your *Copayments* for covered prescription drugs, see the "Prescription Drug Benefit" section in Chapter 3.]	[3-17]
[Prescription drugs are not covered as part of this plan.]	

(PA) – *Prior authorization* is recommended for these services. See page 3-1 for more information.
(BL) – Benefit Limit applies. See "*Covered Services*" in Chapter 3 for more information.

Benefit Limits

[Acupuncture]

[[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family.] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person.]]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.41-75, this autism spectrum disorders benefit only applies to groups of 51 or more*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per *Contract Year.*]

[Chiropractic medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] per person or [10-unlimited visits] [$300-$5,000] per family.]

Extended Care Services

Covered up to [100-unlimited] days per *Contract Year* in a skilled nursing facility. Covered up to any combination of [60-unlimited] days per *Contract Year* in a rehabilitation hospital or chronic hospital.

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid;
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid.

Infertility Services

Coverage is limited to [$100,000-unlimited] per *Member* per lifetime. [Note: This limit applies to infertility services covered under the "*Outpatient* Care" benefit [and oral and injectable drug therapies used in the treatment of infertility and covered under the "Prescription Drug Benefit."]]

[Mental Health *Outpatient* Services

The maximum benefit payable in each *Contract Year* is [30-unlimited visits]. **]** ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for mental health care services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional counseling
Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.*

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of [$350-unlimited] per *Contract Year*.

[[Short-term] [speech,] [physical] [and] [occupational] therapy]
[[Short term] speech therapy services covered up to [20-unlimited] visits per *Contract Year.*] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*.] [[Short term] occupational therapy services covered up to [20-unlimited] visits per *Contract Year*.] [[Short term] speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year*.]]

[Spinal manipulation]
[The maximum benefit payable in each *Contract Year* is [10-unlimited visits] [$300-$5,000] per person.
Note: Spinal manipulation services are not covered for *Members* age 12 and under.]

[Substance Abuse *Community Residential* Services
The maximum benefit payable in each *Contract Year* is [30-unlimited] days for *Community Residence* services**.]** **[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** *The benefit limits for* substance abuse *services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.*]

[Substance Abuse *Inpatient* Detoxification Services
Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per *Contract Year*, or [30-unlimited] days per *Contract Year*, whichever occurs first.**]** *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services
The maximum benefit payable in each *Contract Year* is [30-unlimited] hours.**]** *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Chapter 1
How Your HMO Plan Works

How the Plan Works

Primary Care Provider

Each *Member* must choose a *Primary Care Provider* (*PCP*) who will provide or authorize care. 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, you should always call your *PCP*. Without authorization from your *PCP*, services may not be covered. You should never wait until your condition becomes an *Emergency* to call.

Covered Services

We will pay for *Covered Services* and supplies when they are *Medically Necessary*. [For most *Covered Services*, you will first have to meet a *Deductible*. For some of these services, you will also pay a *Copayment* after you meet your *Deductible*. 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 care in the *Tufts Health Plan Service Area*. (The *Service Area*, is defined in Appendix A It 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 rare events, a service cannot be provided by a *Tufts Health Plan Provider* in either the Standard or Extended *Service Area*, .In those instances, call a Member Specialist for assistance. You can also visit our Web site at **www.tuftshealthplan.com**.

Provider network

We offer *Members* access to an extensive network of physicians, hospitals, and other *Providers* throughout the *Service Area*. We work to ensure the continued availability of our *Providers*, However, our network of *Providers* may change during the year.

This can happen for many reasons. Those reasons include: a *Provider's* retirement; moving out of the *Service Area*; or failure to continue to meet our credentialing standards. , This can also happen if *Tufts Health Plan* and the *Provider* are unable to reach agreement on a contract. This is because Providers are independent contractors; they do not work for us.

For questions about the availability of a *Provider*, call a Member Specialist.

Coverage

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

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

- deliveries within one month of the due date. This includes postpartum care and care provided to the newborn *Child*; and
- long-term conditions that need ongoing care.

[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*.]

[Continuity of Care, continued

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

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* for up to 30 days from your *Effective Date*.
- the *Provider* is your *PCP*. In this instance, you may continue to see your *PCP* for up to 30 days from your *Effective Date*;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* through your first postpartum visit;
- you are terminally ill. In this instance, you may continue to see your *Provider* as long as necessary.

Conditions for coverage of continued treatment
Tufts 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*.]

Emergency 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. 911 services may not be available in your area. In this event, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.
- You do <u>not</u> 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;* your *PCP* can provide or arrange for any follow-up care that you may need.
- You may receive *Emergency Covered Services* from a non-*Tufts Health Plan Provider*. If this happens, we will pay up to the *Reasonable Charge*. You pay the applicable [*Copayment*][*Cost Sharing Amount*].

Emergency and *Urgent Care,* continued

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 or the emergency room.
- You do not need approval from your *PCP* before receiving *Emergency* care.

Important Notes:
- You may be admitted as an *Inpatient* after receiving *Emergency* or *Urgent Care Covered Services*. If this happens, you or someone acting for you should call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care. (Notification from the attending *Provider* meets this requirement.)
- You may receive *Urgent Care* outside of the *Service Area*, .If this happens, we recommend that you or someone acting for you should contact your *PCP*. You need to do this to arrange for any necessary follow-up care.
- *Emergency* or *Urgent Care* services are covered, whenever you need it, anywhere in the world. We may not cover continued services after the *Emergency* or *Urgent* condition is treated and stabilized. This may happen if we determine, in coordination with the *Member's Providers*, that: (1) the *Member* is safe for transport back into the *Service Area;* and: (2) that transport is appropriate and cost-effective .
- You may receive care outside the Standard or Extended *Service Area*. If this happens, the *Emergency* or *Urgent Care Provider* may: (1) bill *Tufts Health Plan* directly; or (2) require you to pay at the time of service. If you must pay, we will reimburse you up to the *Reasonable Charge* for this care. You must pay the applicable [*Copayment*][*Cost Sharing Amount*]. See "Bills from *Providers*" in Chapter 6 for more information about how to get reimbursed for this care.

Inpatient Hospital Services
- You may need *Inpatient* services. In most cases, you will be admitted to your *PCP's Tufts Health Plan Hospital*.
- Charges after the discharge hour: You may choose to stay as an *Inpatient* after a *Tufts Health Plan Provider* has: (1) scheduled your discharge; or (2) determined that further *Inpatient* services are no longer *Medically Necessary*. If this happens, we may not pay for any costs incurred after that time.
- You may be admitted to a facility which is not the *Tufts Health Plan Hospital* in your *PCP's Provider Organization*. If your *PCP* determines that transfer is appropriate, you will be transferred to: (1) the *Tufts Health Plan Hospital* in your *PCP's Provider Organization* or; (2) another *Tufts Health Plan Hospital*. Important: We may not pay for *Inpatient* care provided in the facility to which you were first admitted after: (1) your *PCP* decides a transfer is appropriate; and (2) transfer arrangements are made.

Mental Health/Substance Abuse Services

Inpatient and intermediate mental health and substance abuse services

Each *Member* may be assigned to a *Designated Facility* or another *Inpatient* facility. Assignment is based on: (1) each *Member's* age (adult or *Child*); and (2) the *Provider Organization* affiliation of that *Member's PCP*.

- You may live in an area where *Tufts Health Plan's Designated Facilities* are available. In this case, you will be assigned to one. The following will apply:
  - You must call your *Designated Facility* to receive *Inpatient*/intermediate mental health and 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.
  - You may be admitted to a facility which is not your *Designated Facility*,. If the *Designated Facility* decided that transfer is appropriate, you will be transferred to your *Designated Facility* or another *Provide*. This may require authorization by the *Designated Facility*.

    Important Notes:

    - We will not pay for *Inpatient* care provided in the facility to which you were first admitted after: (1) your *Designated Facility* has decided the transfer is appropriate; and (2) transfer arrangements have been made.
    - You may choose to stay as an *Inpatient* after your *Designated Facility:* (1) schedules your discharge; or (2) determines that further *Inpatient* services are no longer *Medically Necessary*. In this case, 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. They will provide you with 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 and substance abuse services. He or she will call *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.

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*. 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*: (1) provides routine health care (This includes routine physical examinations.); (2) arranges for your care with other *Tufts Health Plan Providers*, ; and (3) provides referrals for other health care services. See "*Inpatient* mental health/substance abuse services" and "*Outpatient* mental health/substance abuse services" later in this chapter. Those section have 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*. You may already have a *Provider* who is listed as a *PCP*. In most instances you may choose him or her as your *PCP*. Once you choose a *PCP* in our network, you must inform us of your choice. This is required for you to be eligible for all *Covered Services.*

You may not have a *PCP.* Or, your *PCP* may not be not listed in our *Directory of Health Care Providers*. In either case, call a Member Specialist for help in choosing a *PCP*.

[Note:

- 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.]

Contacting your new *PCP*

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

- Contact your new *PCP* as soon as you join. Identify yourself as a new *Tufts Health Plan Member*, to him or her;
- 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

Your *PCP* may not be able to take your call right away. Always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return you call.

You may need medical services after hours. Contact your *PCP* or a *Covering Provider*. A *Provider* is available 24 hours a day, 7 days a week. For *Inpatient* mental health or substance abuse services after hours, call 1-800-208-9565.

> Note: You may experience a medical emergency. If this happens, you do not have to contact your *PCP* or a *Covering Provider*; instead, proceed to the nearest emergency medical facility for treatment (see "*Emergency* and *Urgent Care*" above for more information).

Changing your *PCP*

You may change your *PCP.* 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 an *Inpatient* or in a partial hospitalization program, except when approved by *Tufts Health Plan* in limited circumstances.

Canceling appointments

You may need to cancel an appointment with any *Provider*. If so, always give as much notice to the *Provider* as possible (at least 24 hours). Your *Provider's* office may charge for missed appointments that you did not cancel in advance. If this happens, 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). The *PCP* and the specialists already have a working relationship; as a result, this helps to provide quality and continuity of care.

You may need specialty care not available within your *PCP's Provider Organization* This is a rare event. If this happens, your *PCP* will choose a specialist in another *Provider Organization* and make the referral. When selecting a specialist for you, your *PCP* will consider: (1) any long-standing relationships that you have with any *Tufts Health Plan Provider*; and (2) your clinical needs. (A long-standing relationship means that you have recently been seen or been treated repeatedly by that *Tufts HP* specialist.)

Referrals for specialty services, continued

You may require specialty care not available through any *Tufts Health Plan Provider.* This is a rare event. Your *PCP* may refer you, with the prior approval of *or its designee*, to a *Provider* not associated with *Tufts Health Plan*. [*Tufts Health Plan* will pay up to the *Reasonable Charge* for these services. You are responsible for any charges over the *Reasonable Charge* (as well as any applicable *Copayment*).]

Notes:

- You need a referral to a specialist from your *PCP*. You need that before receiving any *Covered Services* from that specialist. If you do not do this, you will be responsible for the cost of those services.
- *Covered Services* provided by non-*Tufts Health Plan Providers* are not paid for unless: (1) approved in advance by your *PCP;* and (2) approved by *Tufts Health Plan* or its designee.
- A specialist refers you to a non-*Tufts Health Plan Provider*. If so, the referral must be approved by your *PCP*. It must also be approved by *Tufts Health Plan* or its designee.
- Referrals for mental health and substance abuse services: You do not need a referral from your *PCP* for care from a *Tufts Health Plan Provider*. However, we recommend that you obtain authorization from a *Tufts Health Plan* Mental Health *Authorized Reviewer* for that care. See "*Inpatient* mental health/substance abuse services" and "*Outpatient* mental health/substance abuse services" later in this chapter.

Referral forms for specialty services

Except as provided below, your *PCP* must complete a referral to refer you to a specialist. Your *PCP* may ask you to give a referral form to the specialist at your appointment. Your *PCP* may refer you for one or more visits and for different types of services. Your *PCP* must approve referrals a specialist makes to other *Providers*. Make sure that your *PCP* makes a referral before you go to any other *Provider*. A *PCP* may approve a standing referral. This referral would be for specialty health care provided by a *Tufts Health Plan Provider*.

When referrals are not required

The following *Covered Services* do not require a referral or prior authorization from your *Primary Care Provider*: You must obtain these services from a *Tufts Health Plan Provider* except:(1) as listed in this chapter; (2) for out of our; or (3) for care.

- *Emergency* Care in an Emergency room or *Provider's* office. (Note: If admitted as an *Inpatient*, you or someone acting for you should call your *PCP* or *Tufts Health Plan* within 48 hours after receiving care.)
- *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.)
- Mammograms, in accordance with guidelines established by the American Cancer Society
- Prostate and colorectal exams.
- [Pregnancy terminations.]
- [Routine eye exams.]
- [Other vision care services from an optometrist.]
- [Care in an urgent care center.]
- [Care in a limited service medical clinic, if available.]
- [Acupuncture.]
- [Spinal manipulation.]
- [Medical treatment performed by an optometrist.]
- [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. This includes 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 paying *Providers* is to encourage preventive care and active illness management. We strive to be sure that our financial reimbursement system: (1) encourages appropriate access to care; (2) 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 that can be both harmful and costly to *Members*.

We review the quality of care provided to our *Members* through our Quality of Health Care Program. 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).

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; 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, tell the office staff that you are a *Tufts Health Plan Member*.

IMPORTANT NOTE: Identify yourself as a *Tufts Health Plan Member*. If you do not, 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, 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. It does this by evaluating whether health care services provided to *Members* are: (1) *Medically Necessary;* and (2) 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 if proposed treatment is *Medically Necessary*. This review happens before that treatment begins. Prospective review is also referred to as "Pre-Service Review".

We engage in **concurrent review**. We do this to:

- monitor the course of treatment as it occurs; and
- to determine when that treatment is no longer *Medically Necessary*.

We use **retrospective review** to evaluate care after it is provided.Sometimes, we use retrospective review to more accurately decide if a *Member's* health care services are appropriate. Retrospective review is also called "Post-Service Review".]

[

TIMEFRAMES FOR TUFTS HEALTH PLAN TO REVIEW YOUR COVERAGE REQUEST:

Type of Review:	Timeframe for Determinations:*
Prospective (Pre-Service).	Urgent: [Within 72 hours of receipt of the request.] [Within 72 hours of receiving all necessary information.] Non-urgent: [Within 15 days of receipt of the request.] [Within 15 business days of receiving all necessary information.]
Concurrent Review.	[Prior to the end of the current certified period.] [Urgent: Within 24 hours of receipt of the request.]
Retrospective (Post-Service).	[Within 30 days of receipt of the request.] [Within 30 business days of receipt of a request for payment with all supporting documentation.]

]

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

Utilization Management, continued

We may deny your request for coverage. If this happens, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal.

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

IMPORTANT NOTE: *Members* can call *Tufts Health Plan* these 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 – 1-800-682-8059

[Specialty case management

Some *Members* with Severe Illnesses or Injuries may warrant case management intervention under our specialty case management program. Under this program, we:

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

We may contact that *Member* and his or her *Tufts Health Plan Provider.* We may do this 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.]

Individual case management (ICM)

In certain circumstances, *Tufts Health Plan* may approve 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 approve coverage for alternative services and supplies that do not otherwise qualify as *Covered Services* for that *Member*. This will occur only if *Tufts Health Plan* determines, in its sole discretion, that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary*;
- the alternative services and supplies are provided directly to the *Member* with the condition;
- the alternative services and supplies are in place of more expensive treatment that qualifies as *Covered Services*;
- the *Member* and *Tufts Health Plan* or its designee agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition. *Tufts Health Plan* or its designee will determine this periodically.

We may approve an ICM plan. If this happens, 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*. We may decide, at any time, that these services and supplies fail to satisfy any of the conditions described above. In this event, we may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.

Chapter 2
Eligibility, Enrollment and Continuing Eligibility

Eligibility

[Eligibility rule

You are [eligible as a *Subscriber* only if you are an employee of a *Group*] [a *Subscriber* only if you are eligible to be a *Subscriber* under your *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 *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 of the *Service Area* is limited to *Emergency* or *Urgent Care* only.
- The 12-month period begins with the first month you do not live in the *Service Area*. **]**

If you live outside the *Service Area*

If you live outside the *Service Area*, you can be covered only if:

- you are a *Child;* or
- you are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced *Spouse* that *Tufts Health Plan* must cover.

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 30 days of the date you or your *Dependent* is first eligible for this coverage.

  Note: You may fail to enroll for this coverage when first eligible. If this happens, 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
  - and you have acquired a *Dependent* through marriage, birth, adoption, or placement for adoption.

In these cases, you or your eligible *Dependent* may enroll 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 within 60 days after either of the following events:

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

Effective Date of coverage

We may accept your application and receive the needed *Premium*. When this happens, coverage starts on the date your *Group* chooses. Enrolled *Dependents'* coverage starts when the *Subscriber's* coverage starts, or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

You or your enrolled *Dependent* may be an *Inpatient* on your *Effective Date*. If this happens, 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* not currently enrolled in *Tufts Health Plan* only:

- during your *Open Enrollment Period* t; 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.

How to add *Dependents*

You may have *Family Coverage*. If so, fill out a membership application form listing the *Dependents*. Give the form to your *Group* during your *Open Enrollment Period*. Or, give your *Group* the form within 30 days after the date of an event listed above, under "When *Dependents* may be added." You may not have *Family Coverage*. In this case, ask your *Group* to change your *Individual Coverage* to *Family Coverage*. Then, follow the procedure above.

Effective Date of *Dependents'* coverage

We may accept your application to add *Dependents*. If this happens, 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;
- in the case of marriage or loss of prior coverage, the date of the qualifying event.

Availability of benefits after enrollment

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

Note: We will only pay for *Covered Services* 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*.

Newborn *Child:* You must notify *Tufts Health Plan* of the birth of a newborn *Child* and pay the required *Premium* within 31 days after the date of birth. Otherwise, that *Child* will not be covered beyond such 31-day period. No coverage is provided for a newborn *Child* who remains hospitalized beyond that 31-day period and has not been enrolled in this plan. 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.

Adoptive Child: You must enroll your *Adoptive Child* within 31 days after the *Child* has been adopted or placed for adoption with you. This is required 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.
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*

When coverage ends
Dependent coverage for a *Child* ends on the *Child's* 26th birthday.

Note: This age limit does not apply to a *Child* who qualifies as a *Disabled Dependent* at any age. .

Coverage after termination
When a *Child* loses coverage under this *Evidence of Coverage,* he or she may be eligible for federal or state continuation. He or she may also be able to enroll in *Individual Coverage*. See Chapter 5 for more information.

Disabled Dependents

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* 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.]

Former *Spouses*

Rule for former *Spouses* for *Group Contract* (Also see Chapter 5)
If you and your *Spouse* divorce, your former *Spouse* may continue coverage as a *Dependent* under your *Family Coverage* in accordance with Rhode Island law if the order for continued coverage is included in the judgment when entered.

Note: Coverage for your divorced *Spouse* ends:

- when either you or your divorced *Spouse* remarry;
- until such time as provided by the judgment for divorce; or
- when your divorced *Spouse* becomes eligible for coverage in a comparable plan through his or her own employment.

How to continue coverage for former *Spouses*

Follow these steps to continue coverage for a former *Spouse*:

- Call a Member Specialist within 30 days after the divorce decree is issued. Do this to tell us about your divorce.
- Send us proof* of your divorce when asked.

[*Domestic Partners]*

[You have elected coverage of *Domestic Partners*. In order to enroll a *Domestic Partner*, the *Subscriber* must provide the *Group*:

- proof of common residence for [[0-12] prior consecutive months]. This proof may include a driver's license, canceled rent check, utility bill, lease, or mortgage; and
- a completed and sign enrollment statement certifying that the relationship between the *Subscriber* and the *Domestic Partner* satisfies the criteria described in Appendix A.]

[A *Subscriber* may have only one *Domestic Partner* at a time. If a *Domestic Partner's* coverage ends, the *Subscriber* may not enroll another *Domestic Partner* until the later of:

- [[0-12] consecutive months] following the termination of the former *Domestic Partner's* coverage; or
- the date the relationship between the *Subscriber* and the new *Domestic Partner* satisfies that criteria.]
- [The *Covered Services* available to a *Spouse* are available to a *Domestic Partner*. The *Covered Services* available to a *Child* are available to the child of a *Domestic Partner.]*

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*.

We have forms for you to report these changes. The forms are available from your *Group* or from the Member Services Department.

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 Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available on our Web site at **www.tuftshealthplan.com**. You can also call 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.);
- in the case of *Inpatient* 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]*.

IMPORTANT NOTE: *Prior authorization* is recommended for certain *Covered Services*. We only cover a service listed in this *Evidence of Coverage* if we or our designee determine that the care is *Medically Necessary*. Please contact [Member Services, or, for mental health and substance abuse services] the *Tufts Health Plan* Mental Health Department at 1-800-208-9565 for more information. *Covered Services* for which we suggest *prior authorization* include a "(PA)" notation in the "Benefit Overview" section of this document.

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 services that qualify as *Covered Services*.

Notes:

- For information about your costs for the *Covered Services* listed below (for example, [*Deductibles*,] *Copayments* and *Coinsurance*), see the "Benefit Overview" section earlier in this document.
- Please note that your coverage level under this plan will be different for **preventive services** and **diagnostic services**:
  - **Preventive care services** described in the ACA guidelines, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full. For more information, see "Preventive Screenings" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.
  - You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.
- This chapter lists information about the day, dollar, and visit limits under this plan. are listed in certain *Covered Services*
- [For *Outpatient* care: You may receive services from your *PCP*, [a mental health/substance abuse *Provider*, or an obstetrician/gynecologist ("Ob/Gyn"),]. In

those cases, your *Copayment* may be lower than for services from other *Providers*.]

- [For *Inpatient* care or *Day Surgery*: You may receive care at a *Community Hospital* [or at your *Designated Facility]*. Your Copayments at those facilities may be lower than when you receive care at a *Tertiary Hospital*. (See Appendix A for definitions of these facilities.).]

Emergency care

- *Emergency* room (no *PCP* referral required);
- In *Provider's* office (no *PCP* referral required).

Notes :

- The Emergency Room [*Copayment*] [*Cost Sharing Amount*] is waived if the Emergency room visit results in immediate hospitalization [or *Day Surgery]*.
- You may receive *Emergency Covered Services* from a non-*Tufts Health Plan Provider*. In this case, we will pay up to the *Reasonable Charge*. You pay the applicable [*Copayment*][*Cost Sharing Amount*].
- [You may register in an Emergency room but leave that facility without receiving care. If this happens, an Emergency Room [*Copayment*][*Cost Sharing Amount*] may apply.]
- [You may receive *Day Surgery* services. If this happens, a [*Deductible* and] *Day Surgery Copayment* may apply.]

Outpatient care

[Acupuncture services]
[Note[s]: [The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family.] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0- 50] visits per person.] [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15
(*Prior authorization* is recommended for these services. See page 3-1 for more information.)
Coverage is provided, in accordance with Rhode Island law, for the diagnosis and treatment of autism spectrum disorders for *Children* under age 15. 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*:

- applied behavioral analysis services (ABA)*, supervised by a *Board-Certified Behavior Analyst (BCBA)* who is a licensed health care clinician. [These services are covered up to [$32,000-unlimited] per [calendar year] [*Contract Year*].] For more information about these services, call the *Tufts Health Plan* Mental Health Department at 1-800-208-9565.
- Therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, or physical therapists), covered under your "[Short-term] speech, physical and occupational therapy services" benefit, described later in this chapter.

*For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modification, using behavioral stimuli and consequences, to product socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.]
FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.41-75, this benefit only applies to groups of 51 or more*

[Cardiac rehabilitation services [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]

Outpatient treatment of documented 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[s]:

- [We do not cover the program phase that maintains rehabilitated cardiovascular health.]
- **[Covered up to [10-unlimited] visits per *Contract Year.*]**

[Chiropractic care

See "Spinal manipulation."]

[Chiropractic medicine]

[Coverage is provided for *Medically Necessary* visits for the purpose of chiropractic treatment or diagnosis, regardless of the place of service.

Members are covered for up to three of the following modalities per visit: application of hot or cold pack; mechanical traction; electrical stimulation; ultrasound; myofascial release; diathermy.]

Diabetes services and supplies

In accordance with Rhode Island General Law § 27-41-44, coverage is provided for the following services and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, or gestational diabetes, when *Medically Necessary* and prescribed by a *Provider*:

- blood glucose monitors and blood glucose monitors for the legally blind (covered as "Durable Medical Equipment: - see page XX);
- test strips for glucose monitors and/or visual reading [(covered under your "Prescription Drug Benefit" – see page XX)] [covered as "Other Health Services" – see page XX);
- insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar [(covered under your "Prescription Drug Benefit" – see page XX)]; [(covered as "Other Health Services – see page XX)];
- insulin pumps and related supplies and insulin infusion devices (covered as "Medical Supplies" – see page XX);
- therapeutic/molded shoes for the prevention of amputation (covered as "Durable Medical Equipment" - see page XX); and
- diabetes self-management education, including medical nutrition therapy.

Upon the approval of the United States Food and Drug Administration, new or improved diabetes equipment and supplies will be covered when *Medically Necessary* and prescribed by a *Provider*.

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Coverage for test strips, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar will be provided as part of the "Diabetes services and supplies" listed above for plans that **include** prescription drug coverage. For plans that **exclude** prescription drug coverage, those items will be covered under the "Prescription Drug Benefit" found later in this chapter.]*

Early intervention services for a *Dependent Child* [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]

Services provided by early intervention programs that meet the standards established by the Rhode Island Department of Human Services. Early intervention services include, but are not limited to:

- evaluation and case management;
- occupational therapy;
- nursing care;
- physical therapy;
- speech and language therapy;
- nutrition;
- service plan development and review; and
- assistive technology services and devices.

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

Family planning

[Coverage is provided for *Outpatient* contraceptive services This includes consultations, examinations, procedures and medical services These services must be related to the use of all contraceptive methods approved by the United State Food and Drug Administration.]

- [Procedures: [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]
  - [sterilization]; [and]
  - [pregnancy terminations[, when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest (*PCP* referral is not required.).]]]
- [Services:
  - medical examinations;
  - consultations;
  - 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 approved by the United States Food and Drug Administration.][*]

[*Note: We cover certain contraceptives under a Prescription Drug Benefit. Those contraceptives include oral contraceptives and diaphragms. If those contraceptives are covered under that Benefit, they are not covered here.]

[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: *Contraceptives and female sterilization procedures and services will be covered in full for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.]*

Hemodialysis [(*Prior authorization* is recommended for these services. See page 3-1 for more information)]

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

[**House calls to diagnose and treat illness or injury]**

[A licensed physician must provide this care.]

Outpatient care - continued

Infertility services

In accordance with Rhode Island General Law § 27-41-33, coverage is provided for *Medically Necessary* diagnosis and treatment of infertility. We only cover these services for a woman who is:

- between the ages of 25 and 42;
- married, in accordance with the laws of the state in which she resides;
- unable to conceive or sustain a pregnancy during a period of one year; and
- a presumably healthy individual.

Notes:

- Oral and injectable drug therapies may be used to treat infertility. These therapiesare considered *Covered Services* for *Members* covered by a Prescription Drug Benefit. Your plan may include prescription drug coverage. If so, see the "Prescription Drug Benefit" section in this chapter for information about drug therapy benefit levels.
- These infertility services are covered at the benefit level shown in the "Benefit Overview" section at the front of this *Evidence of Coverage*. Also, these services are subject to the maximum benefit listed in the "Benefit Limits" section . Your plan may include prescription drug coverage. If so, those drug therapies are also subject to that maximum benefit.

Maternity Care [- Routine and Non-Routine Care] (no *PCP* referral required)

FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: Bracketed text in this benefit will only be used for Health Savings Account (HSA) plans.

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

Note: In accordance with the ACA, routine prenatal tests are covered in full.

<u>*Outpatient* care - continued</u>

Oral health services

- *Emergency* care

  X-rays and *Emergency* oral surgery in a *Provider's* office or emergency room. This care must be done 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

  <u>Important Note</u>: *Prior authorization* is recommended for all Non-*Emergency* oral health services performed in an *Inpatient* or *Day Surgery* setting.

  - [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. For these services (see 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 (An example of this is hemophilia.), AND
    - the *Member* requires these services in order to maintain his/her health (Also, the services cannot be cosmetic or *Experimental*.).

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

<u>Note</u>: Non-*Emergency* oral health services are not covered when performed in an office setting.]

Outpatient care - continued

Oral health services, continued **[**

IF you require these services…	THEN you are covered for:
Surgical removal of impacted or unerupted teeth when embedded in bone.	Hospital, *Provider*, and surgical charges.
Extraction of seven or more permanent teeth during one visit.	Hospital, *Provider*, and surgical charges.
Surgical treatment of skeletal jaw deformities.	Hospital, *Provider*, and surgical charges.
Surgical repair related to Temporomandibular Joint Disorder.	Hospital, *Provider*, and surgical charges.

Note: *Prior authorization* is recommended for these services. See page 3-1 for more information.

- Coverage for hospital charges **only** may be provided. This is the case when a *Member* requires treatment in an *Inpatient* or *Day Surgery* setting for oral health services not described in this benefit. The *Member* must meet the following criteria. Otherwise, hospital services will not be covered:
  - the *Member* cannot safely and effectively receive oral health services in an office setting. This must be due to a specific and serious nondental organic impairment (An example of this is hemophilia.), AND
  - the *Member* requires these services in order to maintain their health (Also, the services cannot be cosmetic or *Experimental*.).]

***Outpatient* medical care**

- allergy testing (including antigens) and treatment, and allergy injections [(is recommended for these services. See page 3-1 for more information.)];
- chemotherapy;
- diagnostic imaging This includes:
  - general imaging (Examples are x-rays and ultrasounds.) [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]; and
  - MRI/MRA, CT/CTA and PET tests[and nuclear cardiology].
    [**Important Note:** Prior approval by an *Authorized Reviewer* applies to MRI/MRA, CT/CTA, and PET tests[and nuclear cardiology].]
- 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 [(*Prior authorization* is recommended for these services. See page 3-1 for more information.prior approval by an *Authorized Reviewer* applies)]. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. Includes costs of testing for A, B or DR antigens. [Limited to one testing per lifetime.]

***Outpatient* care - continued**

***Outpatient* medical care,** continued

- immunizations;
- laboratory tests These include, but are not limited to: blood tests; urinalysis; throat cultures; glysolated hemoglobin (A1c) tests; genetic testing; and urinary protein/microalbumin and lipid profiles. **Important:** *Prior authorization* is recommended for some laboratory tests. An example of this is genetic testing. Also, please note that laboratory tests associated with routine preventive care are covered in full.
- lead screenings, lead screening related services, and diagnostic evaluations for lead poisoning in accordance with Rhode Island law;
- *Medically Necessary* diagnostic testing and, to the extent not covered under a Prescription Drug Benefit, long-term antibiotic treatment of chronic Lyme disease. Treatments for Lyme disease otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, *Experimental or Investigative;*
- 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 is required.).
- *Outpatient* surgery in a *Provider's* office; [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]
- radiation therapy;
- respiratory therapy or pulmonary rehabilitation services [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)];
- smoking cessation counseling sessions, including individual, group, and telephonic smoking cessation counseling services that:
  - are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
  - meet the requirements of the Rhode Island Office of the Health Insurance Commissioner Regulation 14.

[Note: Coverage is also provided for prescription and over-the-counter smoking cessation agents. For more information, see the "What is Covered" provision within the "Prescription Drug Benefit" section later in this chapter.]

O*utpatient* care - continued

[Pediatric dental care for *Members* under age 12 [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]

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

Important: You must choose a dentist for your *Dependent Child*. Do this from the preferred dental provider directory. No referral is required from your *Child's PCP*. For more information , call Delta Dental [of Massachusetts]. You can reach them at [617-886-1234 or 800-872-0500].]

Preventive health care for *Members* through age 19

Coverage is provided for pediatric preventive care for a *Child* from birth to age 19, in accordance with the guidelines established by the American Academy of Pediatrics and as required by Rhode Island General Laws Section § 27-38.1.

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to an Office Visit *Copayment.*

Preventive health care for *Members* age 20 and older

- routine physical examinations. These include appropriate immunizations and lab tests as recommended by a *Tufts Health Plan Provider*;
- routine annual gynecological exam This includes any follow-up obstetric or gynecological care we decide is *Medically Necessary* based on that exam (No *PCP* referral required.); and
- hearing examinations and screenings.

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to an Office Visit *Copayment.*

Outpatient **care - continued**

Preventive Screenings and Diagnostic Procedures & Exams

IMPORTANT NOTE: Your coverage level under this plan will be different for these **preventive screenings** (covered in full) versus **diagnostic services** (subject to *Member Cost Sharing)*. For more information, see "Preventive Screenings" and "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

Coverage is provided for the following Preventive Screenings (with no *PCP* referrals required):

Note: These routine screenings and exams are covered in full under this plan. For more information, see "Preventive Screenings"" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

- Preventive screenings for colon and colorectal cancer.

  Examples include colonoscopy and sigmoidoscopy screenings.

- Routine annual cytology (Pap Smear) examinations.

  Coverage for routine pap smears is provided in accordance with guidelines established by the American Cancer Society. This includes coverage for one annual screening for women age 18 and older.

- Routine mammograms, in accordance with guidelines established by the American Cancer Society.
- Routine prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines.

Coverage is provided for the following Diagnostic Procedures & Exams:

Note: These diagnostic procedures and exams may be subject to *Member Cost Sharing* under this plan. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

- Diagnostic colon or colorectal procedures. (*Prior authorization* is recommended for these services. See page 3-1 for more information.)

  Examples include diagnostic colonoscopy, endoscopy and proctosigmoidoscopy procedures.

- Diagnostic cytology (Pap Smear) examinations.

  Coverage for diagnostic pap smears is provided in accordance with guidelines established by the American Cancer Society.

- Diagnostic mammograms, in accordance with guidelines established by the American Cancer Society.
- Diagnostic prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines.

<u>*Outpatient* care - continued</u>

[Short term] speech, physical and occupational therapy services

(*Prior authorization* is recommended for these services. See page 3-1 for more information.)

These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or sickness. [For these services to be covered, *Tufts Health Plan* we must decide that the *Member's* condition is subject to significant improvement within a period of [0-90] days from the initial treatment. That improvement needs to be a direct result of these therapies.]

Massage therapy may be covered as a treatment modality. This is the case when done 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 This may include our prior authorization guidelines.

<u>[Note: [Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year*.]</u> [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year*.]]

[Spinal manipulation]

[Manual manipulation of the spine (No *PCP* referral is required.).]

<u>[(Note: Covered up to [10-unlimited visits] [$300-$5,000] per *Contract Year*.] [Spinal manipulation services are not covered for *Members* age 12 and under.)]</u>

[*Urgent Care* in an urgent care center]

Vision care services

- <u>[Routine eye examination</u>: Coverage is provided for one routine eye examination [every zero-twenty four] months] [per *Contract Year*] [every other *Contract Year*].

  <u>Note:</u> You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network. Otherwise, these services are not covered. Go to **<u>www.tuftshealthplan.com.</u>** Or, contact Member Services for more information. Except as described below, you must obtain [a referral from your *PCP* for] services from a *Tufts HP Provider*.] Otherwise, services to treat a medical condition of the eye are not covered,

- <u>Other vision care services:</u>]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

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.
- You must be shown on the facility's census as an *Outpatient*.

[Note: Endoscopies and proctosigmoidoscopies are covered under this benefit.]

FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: NOTE IN THIS BENEFIT ONLY TO BE USED FOR HEALTH SAVINGS ACCOUNT (HSA) PLANS.

***Inpatient* Care**

Acute hospital services [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]

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

***** *Prior authorization* is recommended for these services.

Hematopoietic stem cell transplants and human solid organ transplants

(*Prior authorization* is recommended for these services. See page 3-1 for more information.)

- 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*. However, we will do this 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 related 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. *Prior authorization* is recommended for additional donor search expenses for unrelated donors.
- We cover a *Member's* human leukocyte antigen (HLA) testing. See "*Outpatient* medical care" for more information.
- [A lifetime maximum benefit of [$0-$10,000] applies per *Member* for transportation, accommodations, and special expense costs related to covered transplants. The services must be provided by a *Tufts Health Plan Provider*. Authorization by *Tufts Health Plan* applies.]

Extended care

(*Prior authorization* is recommended for these services. See page 3-1 for more information.)
In an extended care facility (These include *skilled* nursing facilities, rehabilitation hospitals, and chronic hospitals.) for:

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

Maternity Care (No *PCP* referral required.)

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

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

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

Any decision to shorten these minimum coverages shall be made by the attending health care provider. (This may be the attending obstetrician, pediatrician, family practitioner, general practitioner, or certified nurse midwife attending the mother and newborn *Child.*) in consultation with the mother.

Notes:

- [In case of an early discharge,] *Covered Services* will include one home visit by a registered nurse, *Provider*, or certified nurse midwife. It includes 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*. This is regardless of whether or not there is an early discharge. (This means: (1) a hospital discharge less than 48 hours following a vaginal delivery; (2) or 96 hours following a caesarean delivery).]

Inpatient **care – continued**

Reconstructive surgery and procedures and mastectomy surgeries

Coverage is provided for the cost of:

- services required to relieve pain or to restore a bodily function impaired as a result of: a congenital defect; a birth abnormality; a traumatic injury; or a covered surgical procedure (*Prior authorization* is recommended for these services. See page 3-1 for more information.);
- the following services in connection with mastectomy:
  - surgical procedures known as a mastectomy;
  - axilary node dissection;
  - 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).

  Inpatient care in hospital for mastectomies is covered for:

  - a minimum of 48 hours following a surgical procedure known as a mastectomy; and
  - a minimum of 24 hours following an axilary node dissection.

  Any decision to shorten this minimum coverage shall be made by the attending *Provider* in consultation with and upon agreement by the *Member.* [If the *Member* agrees to an early discharge,] coverage shall also include a minimum of one home visit conducted by a *Provider* or registered nurse.

* Breast prostheses are covered as described under “Prosthetic Devices” in this chapter.

Removal of a breast implant. This is covered when:

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

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

Note: Cosmetic surgery is not covered.

***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**

***Outpatient* mental health care services**

Services to diagnose and treat *Mental Disorders*. This includes individual, group, and family therapies.

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

Notes:

- *Prior authorization* is recommended for *Outpatient* mental health care services. See "*Outpatient* mental health/substance abuse services" in Chapter 1.
- **[*Outpatient* mental health care services. These are covered up to [30-unlimited] visits per *Contract Year*.]** ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*
- ***Prior authorization* is recommended for psychological testing and neuropsychological assessment services.**

***Inpatient* and intermediate mental health care services**

[(These services must be provided in advance by your *Designated Facility*, if you have one. See "*Inpatient* and intermediate mental health/substance abuse services" in Chapter 1.)]

- *Inpatient* mental health services for *Mental Disorders* in a general hospital, a mental health hospital, or a substance abuse facility.
- Intermediate mental health care services. These services are more intensive than traditional *Outpatient* mental health care services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate mental health care services are:
  - [level III community-based detoxification;]
  - intensive *Outpatient* programs; and
  - [acute residential treatment (longer term residential treatment is not covered);]
  - [crisis stabilization;]
  - day treatment / partial hospital programs*;

Note: No visit limit applies to *Inpatient* or intermediate mental health care services.

***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**

(Note: Treatment for the abuse of tobacco or caffeine is not covered under these substance abuse services benefits.)

***Outpatient* substance abuse services**

Outpatient substance abuse treatment services.

Notes:

- *Prior authorization* is recommended for ***Outpatient* substance abuse treatment services. See "*Outpatient* mental health/substance abuse services" in Chapter 1.**
- **[*Outpatient* substance abuse treatment services are [30-unlimited] hours per *Contract Year*.]** ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*
- ***Outpatient* medication visits are covered as "Office visits to diagnose and treat illness or injury", as described earlier in this chapter.**

***Inpatient* and intermediate substance abuse services**

- *Inpatient* substance abuse detoxification and treatment services in a general hospital, substance abuse facility, or *Community Residence*.
- Intermediate substance abuse services. These services are more intensive than traditional *Outpatient* substance abuse services. They are less intensive than 24-hour hospitalization. Some examples of covered intermediate substance abuse services are day treatment/partial hospital programs and intensive *Outpatient* programs.
- Substance abuse treatment in a *Community Residential* care setting.

[Note: No visit limit applies to *Inpatient* substance abuse treatment or intermediate substance abuse services. *Inpatient* detoxification services are limited to [5-unlimited] detoxification occurrences per *Contract Year*, or [30-unlimited] days per *Contract Year*, whichever occurs first. *Community Residential* care services are covered up to [30-unlimited] days per *Contract Year*.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services are omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Other Health Services

Ambulance services

- Ground, sea and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance services (An example is Medflight,). (*Prior authorization* is recommended for these services. See page 3-1 for more information.)
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities. [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)].
- Non-emergency ambulance transportation. This is covered for *Medically Necessary* care when the *Member's* medical condition prevents safe transportation by any other means. *Prior authorization* is recommended for these services. See page 3-1 for more information.

Important Note[s]:

- You may be treated by Emergency Medical Technicians (EMTs) or other ambulance staff. At that time, you may refuse to be transported to the hospital or other medical facility In this case, you will be responsible for the costs of this treatment.
- [The maximum benefit payable in each [calendar year] [*Contract Year*] for covered sea, helicopter, and airplane ambulance transportation service (An example is Medflight.) is [$3,000-unlimited]. This limit does not apply to the ground ambulance services we cover.]

[Diabetic Monitoring Strips

The following diabetic monitoring strips for home use. These strips must be ordered by a *Provider* in writing to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes:

- blood glucose monitoring strips;
- urine glucose strips;
- ketone strips.]

Other Health Services - continued

Durable Medical Equipment

Equipment must meet the following definition of "*Durable Medical Equipment*":

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

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

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

Tufts Health Plan may decide that equipment is: (1) non-medical in nature; and (2) used primarily for non-medical purposes. (This may occur even though that equipment has some limited medical use.) In this case, the equipment will not be considered *Durable Medical Equipment* and. It will not be covered under this benefit.

(Note: *Prior authorization* is recommended for certain *Durable Medical Equipment*. See page 3-1 for more information.)

Important Note: You may need to pay towards the cost of the *Durable Medical Equipment* we cover. Your *Durable Medical Equipment* benefit may be subject to [a *Deductible,*] [or] *Coinsurance.* See the "Benefit Overview" section.

These are examples of covered and non-covered items. They are for illustration only. Call a Member Specialist to see if we cover a certain piece of equipment.

- **Examples of covered items. (This list is not all-inclusive.):**
  - contact lenses or eyeglass lenses (One pair per prescription change are covered.) to replace the natural lens of the eye or following cataract surgery. [Note: Eyeglass frames are covered up to a maximum of $69 per *Contract Year*. They must be provided in association with these lenses.];
  - gradient stockings (Up to three pairs are covered per calendar year);
  - [insulin pumps;]
  - oral appliances for the treatment of sleep apnea;
  - prosthetic devices, except for arms, legs, or breasts*;

    * Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Orthoses and prosthetic devices" benefit.

(continued on next page)

Other Health Services - continued

***Durable Medical Equipment*, continued**

Examples of covered items (continued):

- [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: See "Scalp hair prostheses or wigs for cancer or leukemia patients.");]
- [power/motorized wheelchairs;]
- therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease.

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.

- **Examples of non-covered items (This list is not all-inclusive.):**
  - 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;
  - fixtures to real property. Examples are ceiling lifts, elevators, ramps, stair lifts, or stair climbers;
  - exercise equipment and saunas;
  - orthoses and prosthetic devices (see "Orthoses and prosthetic devices" for information about these *Covered Services*);
  - 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 (Examples are Tempur-Pedic® and Posturepedic® mattresses.). are not covered. This is the case even if used in conjunction with a hospital bed;
  - breast prostheses and prosthetic arms and legs. For more information, see "Prosthetic Devices" [;and
  - scooters].

Hearing Aids [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]

Coverage is provided for:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid;
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid.

Other Health Services - continued

Home health care (*Prior authorization* is recommended for these services. See page 3-1 for more information.)

This is a *Medically Necessary* program to: (1) reduce the length of a hospital stay or; (2) delay or eliminate an otherwise *Medically Necessary* hospital admission. Coverage includes:

- home visits by a *Tufts Health Plan Provider*;
- *skilled* [intermittent] nursing care and physical therapy;
- [*Medically Necessary* private duty nursing care. A certified home health care agency needs to provide this care.];
- speech therapy;
- occupational therapy;
- medical/psychiatric social work;
- nutritional consultation;
- prescription drugs and medication;
- medical and surgical supplies (Examples include dressings, bandages and casts.);
- laboratory tests, x-rays, and E.K.G. and E.E.G. evaluations;
- the use of *Durable Medical Equipment*, and
- the services of a part-time home health aide.

Note: Home health care services for speech, physical and occupational therapies may follow an injury or illness. If this occurs, the services are only covered to the extent provided to restore function lost or impaired. This is described under "Short term speech, physical and occupational therapy services." However, those home health care services are [not] subject to: (1) the [0-90]-day period for significant improvement requirement [or; (2) the visit limit[s]] listed under "Short term speech, physical and occupational therapy services."

[**Hospice care services** (*Prior authorization* is recommended for these services. See page 3-1 for more information.**)**

We will cover the following services for *Members* who are terminally ill (This means 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 (This includes bereavement counseling services for the *Member's* family. This applies for up to one year after 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.]

[Note: Covered up to [0-unlimited] visits per [calendar year] [*Contract Year*] for any combination of home visits and *Inpatient* facility visits.]

Other Health Services – continued

[Injectable, infused or inhaled medications]

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

Notes:

- *Prior authorization* is recommended for certain medications. Quantity limitations may apply for certain medications. See page 3-1 for more information.
- There are designated home infusion *Providers* for a select number of specialized pharmacy products and drug administration services. These *Providers* offer clinical management of drug therapies, nursing support, and care coordination to *Members* with acute and chronic conditions. Medications offered by these *Providers* include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency, and enzyme replacement therapy. Call Member Services or see our Web site for more information on these medications and *Providers.*
- Coverage includes the components required to administer these medications This includes, but is not limited to, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.
- Medications 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. Also, see our Web site at **www.tuftshealthplan.com**.]

Medical supplies

Tufts Health Plan covers the cost of certain types of medical supplies. The supplies must come from an authorized vendor. These supplies include:

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

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. [
- *Prior authorization* is recommended for these services. See page 3-1 for more information.]

New cancer therapies

Coverage is provided for new cancer therapies (both *Inpatient* and *Outpatient*) still under investigation as required by Rhode Island General Laws Section § 27-41-41. (*Prior authorization* is recommended for these services. See page 3-1 for more information.)

Other Health Services – continued

Orthoses and prosthetic devices

We cover the cost of orthoses and prosthetic devices (This includes repairs.), as required by Rhode Island law. This includes coverage of breast prostheses as required by federal law. Coverage is provided for the most appropriate model that adequately meets the *Member's* needs. His or her treating *Provider* decides this. (*Prior authorization* is recommended for these services. *)]

[*Important Note: Breast prostheses provided in connection with a mastectomy are not subject to any *prior authorization*. See page 3-1 for more information.

[Prescription infant formulas]

[Infant formulas are covered when *Medically Necessary.* The formulas must be prescribed for infants and children up to age 2.

Contact Member Services for more information.]

[Private duty nursing]

[We cover private duty nursing. This must be *Medically Necessary*, . Also, it needs to be ordered by a physician and performed by a certified home health care agency. Private duty nursing services are covered when the patient requires continuous skilled nursing observation and intervention.]

[Note: *Prior authorization* is recommended for these services. See page 3-1 for more information.]

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. (See "Durable Medical Equipment" in this chapter.)

[Note: Covered up to a maximum benefit of [$350-unlimited] per *Contract Year*.]

Special medical formulas

Includes nonprescription enteral formulas and low protein foods. A needs to prescribe the formula or food for these:

Low protein foods [(*Prior authorization* is recommended for these services. See page 3-1 for more information.)]

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

Nonprescription enteral formulas (*Prior authorization* is recommended for these services. See page 3-1 for more information.)

Coverage is provided for home use for treatment of malabsorption caused by: Crohn's disease; ulcerative colitis; gastroesophageal reflux,; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids.

Other Health Services - continued

[Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. These topics are included i here. They explain your prescription drug coverage:

- How Prescription Drugs Are Covered;
- Prescription Drug Coverage Table;
- Programs;
- What is Covered;
- What is Not Covered;
- *Tufts Health Plan* Pharmacy Management;
- Filling Your Prescription.

How Prescription Drugs Are Covered

Prescription drugs may be considered *Covered Services*. This occurs only if they comply with the "*Tufts Health Plan* Pharmacy Management Programs" section 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*. This is not required in cases of authorized referral or in *Emergencies*.

[We have a current list of covered drugs. See our Web site at **www.tuftshealthplan.com**. You can also call a Member Specialist.]

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

- [Tier-0 drugs [are covered in full] [have the lowest *Cost Sharing Amount].*
- Tier-1 drugs have [the lowest] [a lower] level *Cost Sharing Amount*; many generic drugs are on Tier-1.
- Tier-2 drugs have [the middle] [a higher] level *Cost Sharing Amount*.
- [Tier-3 drugs have the [higher] [highest] level *Cost Sharing Amount*.]
- [[Tier-4] [Special Designated Pharmacy Program] drugs have the highest *Cost Sharing Amount*.]

[Note: Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law are covered in full. [However, if a generic equivalent is available, non-generic oral contraceptives, diaphragms and hormonal contraceptives are subject to the applicable Tier *Copayment.]]*

FILING NOTE: *As of 8/1/12, contraceptives and sterilization services will be covered in full for all new groups or upon a group's renewal on or after that date for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services..*

PRESCRIPTION DRUG COVERAGE TABLE

INFERTILITY MEDICATIONS

[0-20%] *Coinsurance**]], for up to a 30-day supply [(This is subject to the [prescription drug deductible] below.].

*Notes:

- *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.
- [Coverage for infertility is limited to [$100,000-unlimited] per *Member* per lifetime (This maximum is for *In-Network* and *Out-of-Network Levels* combined.). This limit applies to both: (1) infertility services covered under the "*Outpatient* Care" benefit; and (2) oral and injectable drug therapies used to treat infertility and covered under this "Prescription Drug Benefit."]

ALL OTHER MEDICATIONS

DRUGS OBTAINED AT A RETAIL PHARMACY:

Covered prescription drugs (This includies both acute and maintenance drugs.) [up to a 30-day supply]. You need to obtain these drugs directly from a *Tufts Health Plan* designated retail pharmacy.

[Tier-0 drugs:	**Tier-1 drugs:**	**Tier-2 drugs:**	**[Tier-3 drugs:**
[[[$0-$50] *Copayment,*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$50],] for a 1-30-day supply]	[[[$0-$50] *Copayment]* [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$50],] for a 1-30-day supply]	[[[$0-$75] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$75],] for a 1-30-day supply]	[[[$0-$150] *Copayment*] [[10-60%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 1-30-day supply]
[[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$150] *Copayment]* [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 31-60 day supply]	[[[$0-$300] *Copayment*] [[10-60%] *Coinsurance*]] [, up to a maximum of [$0-$300],] for a 31-60 day supply]
[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 61-90 day supply **]**	[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 61-90 day supply]	[[[$0-$225] *Copayment]* [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$225],] for a 61-90 day supply]	[[[$0-$450] *Copayment]* [[10-60%] *Coinsurance*]] [, up to a maximum of [$0-$450],] for a 61-90 day supply **]**

[Note[s]:

- [You may fill your prescription in a state that allows you to request a brand-name drug even though your physician authorized the generic equivalent. In this case, you will pay the applicable Tier *Cost Sharing Amount.* You will also pay the difference in cost between the brand-name drug and the generic drug.]
- [You always pay the applicable *Cost Sharing Amount*.. This is the case even if the cost of the drug is less than the *Cost Sharing Amount*.] **]**

[Generic Incentive Program: Your *Provider* may prescribe a brand-name drug that has a generic equivalent This can happen in Massachusetts and many other states. In this case, you will receive the generic drug and pay the applicable Tier *Cost Sharing Amount*. Wherever you fill your prescription, your *Provider* may request that you receive a covered brand-name drug only. In this case, you will pay the *Cost Sharing Amount* for the generic drug. You will also need to pay the difference between the cost of the generic drug and the cost of the covered brand-name drug. In many cases, there may be a significant difference in price between the brand-name drug and the generic drug. This may result in a significant difference in what you need to pay.]

[(subject to the [prescription drug deductible] [and] [the *Contract Year* maximum benefit] below.)]
Copayment]

Prescription Drug Benefit – continued

PRESCRIPTION DRUG COVERAGE TABLE - continued

[DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY:

[Most maintenance medications, when mailed to you through a *Tufts Health Plan* designated mail services pharmacy.]

[Tier-0 drugs:	**Tier-1 drugs:**	**Tier-2 drugs:**	**[Tier-3 drugs:**
[[[[$0-$100] *Copayment*] [[10-50%] Coinsurance]] [, up to a maximum of [$0-$100],] for a 1-[30-90]-day supply]	[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$100],] for a 1-[30-90]-day supply]	[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 1-[30-90]-day supply]	[[[$0-$300] *Copayment*] [[10-60%] *Coinsurance*]] [, up to a maximum of [$0-$300],] for a 1-[30-90]-day supply]
[[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$150] *Copayment]* [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 31-60 day supply]	[[[$0-$300] *Copayment*] [[10-60%] *Coinsurance*]] [, up to a maximum of [$0-$300],] for a 31-60 day supply]
[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 61-90 day supply **]**	[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$150],] for a 61-90 day supply]	[[[$0-$225] *Copayment]* [[10-50%] *Coinsurance*]] [, up to a maximum of [$0-$225],] for a 61-90 day supply]	[[[$0-$450] *Copayment]* [[10-60%] *Coinsurance*]] [, up to a maximum of [$0-$450],] for a 61-90 day supply **]**

[(subject to the [prescription drug deductible] [and] [the *Contract Year* maximum benefit] below.)]

Prescription Drug Benefit – continued

PRESCRIPTION DRUG COVERAGE TABLE - continued

[**DRUGS OBTAINED THROUGH THE SPECIAL DESIGNATED PHARMACY PROGRAM ***
A select number of medications are covered These include medications used to treat infertility, multiple sclerosis, hemophilia, hepatitis C, growth hormone deficiency, rheumatoid arthritis, and cancers treated with oral medications. You must obtain the medication from a special designated pharmacy.

[Tier-4 drugs:]
[[[$0-$125] *Copayment*] [[10-70%] *Coinsurance**]],
[,up to a maximum of [$0-$300],]
for up to a 30-day supply

[(subject to the [prescription drug deductible] [and] [the *Contract Year* maximum benefit] below.)]

*Note: *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.

**For more information, see "Tufts Health Plan Pharmacy Management Programs" below.]

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** If implemented, this Special Designated Pharmacy Program will not be limited to mail order.]*

Prescription Drug Benefit – continued

PRESCRIPTION DRUG COVERAGE TABLE - continued

[Prescription drug deductible]

[A [$0-$600] individual prescription drug deductible applies to [prescription drugs on Tiers 2 and 3 for] each *Member* per *Contract Year*. This is the amount you must first pay for covered prescription drugs [obtained at a *Tufts Health Plan* designated retail pharmacy] [obtained through a *Tufts Health Plan* designated mail order pharmacy] [on Tiers 2 and 3] before we will pay for any covered [retail] [mail order] prescription drugs. [Upon initially joining *Tufts Health Plan*, any deductible amount you paid for covered [retail] [mail order] prescription drugs under another health plan during the current *Contract Year* may be used to satisfy your prescription drug deductible for that year.]

[Any deductible amount you pay for covered [retail] [mail order] prescription drugs [on Tiers 2 and 3] under this plan in the last [0-12] months of a *Contract Year* can be used to satisfy your prescription drug deductible during the following *Contract Year*.]

[Any combination of enrolled *Members* of a covered family may satisfy the [$0-$1,800] family prescription drug deductible during a *Contract Year*. In this case, the remainder of the covered *Members* of that family will not need to satisfy an individual prescription drug deductible for the rest of that *Contract Year*.]

[The deductible is calculated based on *Tufts Health Plan's* contracted rate when the Rx is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.]

[**Note:** This prescription drug deductible does **not** apply to [generic drugs, regardless of their tier] [prescription drugs on Tier 1] [prescription and over-the-counter smoking cessation agents].]

[***Deductible***]

[Prescription drugs are subject to the *Deductible*. For more information, see the "Benefit Overview" section.]

Prescription Drug Benefit – continued

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Text in "What is Covered" and "What is Not Covered" provisions in this "Prescription Drug Benefit" will include coverage for oral contraceptives and diaphragms for groups with prescription drug **except** upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C. section 3121[(w)(3)(A) and (B)].]*

What is Covered

We cover the following under this Prescription Drug Benefit:

- Prescribed drugs that by law require a prescription and are not listed under "What is Not Covered": (See "Important Notes" below.).
- [Test strips for glucose monitors and/or visual aid reading, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar levels.]

  *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Coverage for test strips, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar will be provided as part of the "Prescription Drug Benefit" listed above for plans that **include** prescription drug coverage. For plans that **exclude** prescription drug coverage, those items will be covered under the "Diabetes services and supplies" in the "Outpatient Care" section earlier in this chapter.]*
- 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 (e.g., [patches,] rings) that by law require a prescription. See "Family planning" above for information about other covered contraceptive drugs and devices .]
- Fluoride for *Children*.
- Injectables and biological serum included in the list of covered drugs on our Web site. For more information, call Member Services. Aso see our Web site at **www.tuftshealthplan.com**.
- Prefilled sodium chloride for inhalation (This is covered both by prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer 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. These are only covered 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. Also, see our Web site at **www.tuftshealthplan**.]
- Prescription and over-the-counter smoking cessation agents. These must be recommended and prescribed by a *Tufts Health Plan Provider*.

[Note: Certain prescription drug products may be subject to a "*Tufts Health Plan* Pharmacy Management Program" described below.]

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).
- Drugs not listed on the "Tufts Health Plan Prescription Drug List". See the list at **www.tuftshealthplan.com**. Also, you can call Member Services for more information.
- Vitamins and dietary supplements (except prescription prenatal vitamins and 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.
- 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.)], [oral contraceptives, diaphragms and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription].
- 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" above.
- Prescriptions written by *Providers* who do not participate in *Tufts Health Plan*. These drugs are excluded except in cases of authorized referral or *Emergency* care.
- Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.
- 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*.
- [Drugs dispensed in an amount or dosage that exceeds our established quantity limitations.]
- 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 medications becomes available over-the-counter. In this case, the specific medication [is not] [may not be] covered. Also, the entire class of prescription medications may also not be covered. For more information, call Member Services. You can also check our Web site at **www.tuftshealthplan.com**.
- Prescription medications when packaged with non-prescription products.
- [Drugs for the treatment of erectile dysfunction.]
- [Weight-loss drugs.]
- Oral non-sedating antihistamines.

[*Tufts Health Plan* Pharmacy Management Programs]

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

[Quantity Limitations Program]:

[We limit the quantity of selected medications *Members* can receive in a given time period .We do this for cost, safety and/or clinical reasons.]

[Prior Authorization Program:

We restrict the coverage of certain drug products. These are drugs with a narrow indication for usage, may have safety concerns and/or are extremely expensive. We require the prescribing *Provider* to obtain prior approval from us for such drugs.]

Step Therapy PA Program

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

[Special Designated Pharmacy Program:

We have designated special pharmacies to supply a select number of medications. This includes medications to treat 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. They 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. [Medications are delivered directly to the *Member's* home via mail. This is NOT part of the mail order pharmacy benefit.] Extended day supplies and *Copayment* savings to not apply to these special designated drugs. **]**

[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: If implemented, this program will not be limited to mail order.]

[Non-Covered Drugs:

Tufts Health Plan covers over 4,500 drugs. However, a small number of drugs (less than 1%) are not covered. This is because there are safe, effective and more affordable alternatives available. Drugs may not be covered for safety reasons, if they are new on the market, if they become available over-the-counter, or if a generic version of a drug becomes available. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA). They are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. For up-to-date information on these non-covered drugs and their suggested alternatives, please call *Member Services,* or see the web site at www.tuftshealthplan.com.]

Prescription Drug Benefit – continued

[*Tufts Health Plan* Pharmacy Management Programs, continued**]**

[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. This is usually within 6 months of the drug product's availability.]

[IMPORTANT NOTES:

- Your *Provider* may feel it is *Medically Necessary* for you to take medications that are [not on the formulary or] restricted under any of the "*Tufts Health Plan* Pharmacy Management Programs" above. In this case, he or she may submit a request for coverage. We will approve the request if it meets our guidelines for coverage. For more information, call a Member Specialist.
- The *Tufts Health Plan* Web site has a list of covered drugs with their tiers. We may change a drug's tier during the year. [For example, a brand drug's patent may expire. In this case, we may [move] [change the drug's status by either (a) moving] the brand drug from Tier-2 to Tier-3 [or (b) no longer covering the brand drug] when a generic alternative becomes available. Many generic drugs are available on Tier-1.]
- You may have questions about your prescription drug benefit. You may want to know the tier of a particular drug. You might like to know if your medication is part of a Pharmacy Management Program. For these issues, check our Web site at **www.tuftshealthplan.com**. You can also call a Member Specialist at 1-800-682-8059.]

Prescription Drug Benefit – continued

Filling Your Prescription

Where to Fill Prescriptions:

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

- [for the majority of prescriptions,] most of the pharmacies in Massachusetts and Rhode Island. They also include additional pharmacies nationwide[; and]
- [for a select number of drug products, a small number of special designated pharmacy providers. (See "*Tufts Health Plan* Pharmacy Management Programs" above.)] You may have questions about where to fill your prescription. If so, 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. This is not required, though, 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*.
- The cost of your prescription may be less than your *Copayment*. In this case, you only need to pay the actual cost of the prescription.
- If you have any problems using this benefit at a *Tufts Health Plan* designated pharmacy, call the Member Services Department.

Important: Your prescription drug benefit is honored only at *Tufts Health Plan* designated pharmacies. In cases of *Emergency*, call the Member Services .They can explain how to submit your prescription drug claims for reimbursement.

[Filling Prescriptions for Maintenance Medications:

You may need to take a "maintenance" medication. If so, 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. This is done through a *Tufts Health Plan* designated mail services pharmacy.

*These drugs 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; [or]
- 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 from Benefits

Tufts Health Plan 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 the *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 This does not apply to complications related to pregnancy terminations.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

  This exclusion does not apply to:

  - treatment of chronic Lyme disease;
  - new cancer therapies, as described earlier in this chapter [; or
  - off-label uses of prescription drugs for the treatment of cancer, if you have a Prescription Drug Benefit]

  which meet the requirements of Rhode Island law.

  If the A treatment may be *Experimental or Investigative*. In this case, we will not pay for any related treatments provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter.
- Services provided by your relative (by blood or marriage) unless the relative is a *Tufts Health Plan Provider* and the services are authorized by your *PCP*. If you are a *Tufts Health Plan Provider*, you cannot provide or authorize services for yourself or be your own *PCP* for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay. Services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.

Exclusions from Benefits, continued

- 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 see 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[, except as provided under "Pediatric dental care for *Members* under age 12" earlier in this chapter]; 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.
- Cosmetic (This means 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 [unless *Medically Necessary*]; treatment of vitiligo.
- Hair removal, except when *Medically Necessary* to treat an underlying skin condition.
- [Contraceptives] [and] [contraceptive services].
- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcisions performed in any setting other than a hospital, *Day Surgery,* or a *Provider's* office.
- Infertility services for *Members* who do not meet the definition of Infertility as described in the "*Outpatient* Care" section earlier in this chapter; experimental infertility procedures; the costs of surrogacy; reversal of voluntary sterilization; long-term (longer than 90 days) [sperm or] embryo cryopreservation unless the *Member* is in active infertility treatment; costs associated with donor recruitment and compensation; [sterilization;] Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization[; infertility services for male *Members*;] [; 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 authorization* is recommended for these services.]

Exclusions from Benefits, continued

- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the ART service is provided at a *Tufts Health Plan* ART center and the *Member* is the sole recipient of the donor's eggs. (*Prior authorization* is recommended for these services.)
- [Pregnancy terminations[, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest].]
- [Preimplantation genetic testing and related procedures performed on gametes or embryos.]
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- 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 embryos, under "Infertility services" (This is 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;] [chiropractic medicine;] [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 speech, 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. All services, procedures, labs and supplements associated with this type of medicine.
- Any service, supply or procedure performed in a non-conventional setting (This includes, but is not limited to, spas/resorts, therapeutic programs, camps and clinics.)
- Blood, blood donor fees, blood storage fees, or 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 authorization* is recommended for these services.);
    - intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (*Prior authorization* is recommended for these services.).
- Devices and procedures intended to reduce snoring. These include, but are not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

Exclusions from Benefits, continued

- Examinations, evaluations or services for educational purposes or developmental purposes. This includes 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 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 (This includes radial keratotomy.) for conditions which can be corrected by means other than surgery. [Routine eye exams.] Except as described earlier in this chapter, *Tufts HP* will not pay for contact lenses or contact lens fittings.
- Methadone treatment or methadone maintenance related to substance abuse.
- Routine foot care. Examples includes: 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; or other non-orthotic support devices for the feet.

  Note: This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in “Ambulance services” in this chapter;
- Lodging related to receiving any medical service [, except as described under “Hematopoietic stem cell transplants and human organ transplants” earlier in this chapter].
- [Bariatric surgery.]
- [Private duty nursing (block or non-intermittent nursing) [, except as described under “Home health care” earlier in this chapter].]
- [The prescription drug, RU-486, or its therapeutic equivalent.]
- [Telephone consultations.]
- [Supervision of maintenance therapy for chronic disease which is not aggravated by surgery and would not ordinarily require hospitalization; rehabilitation for maintenance purposes.]
- [Sleep studies performed in the home.]
- [Bone marrow blood supply MRIs.]
- [Non-cadaveric small bowel transplants.]

Chapter 4
When Coverage Ends

Reasons coverage ends

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

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

Note: *Children* are not required to maintain primary residence in the *Service Area.* However, care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only.

Benefits after termination

If you are totally disabled when your coverage ends, you may be able to continue your coverage as described in "Extension of Benefits" later in this chapter. Otherwise, we 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 converted plans

Once your coverage ends, you may be eligible to continue your coverage with your *Group*. Or, you may be able to enroll in a converted coverage plan. 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. This is done back to the date you are no longer eligible for coverage.

If you move out of the *Service Area*

If you are a *Subscriber* or *Spouse* and you move out of the *Service Area*, coverage ends on the date you move. *Children* are not required to maintain primary residence in the *Service Area.* However, care outside of the *Service Area* is limited to *Emergency* or *Urgent Care* only. Before you move, tell your *Group* or call a Member Specialist to notify us of your move date. You may have kept a residence in the *Service Area*, but been out of the *Service Area* for more than 90 days. If this happens, coverage ends 90 days after the date you left the *Service Area*.

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

When a *Member* is No Longer Eligible, continued

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. See Chapter 2, "Continuing Eligibility for *Dependents*," for more information.

You choose to drop coverage

Coverage ends if you decide you no longer want coverage and you meet any qualifying event your *Group* requires. To end your coverage, notify your *Group*. You must do this 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

We 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

We may terminate your coverage for misrepresentation or fraud during the first two years of coverage under this plan. If your coverage is terminated for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an individual plan 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 *Provider*; or
- allowing someone else to use your Member ID.

Date of termination

If we terminate your coverage for misrepresentation or fraud, your coverage will end as of a later date chosen by us. During the first two years of coverage, we reserve the right to revoke coverage and deny payment of claims retroactive to your *Effective Date* for any false or misleading information on your application.

Membership Termination for Misrepresentation or Fraud, continued

Payment of claims

We will pay for all *Covered Services* you received between:

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

We may use any *Premium* you paid for a period after your termination date to pay for any *Covered Services* you received after your termination date.

The *Premium* may not be enough to pay for that care. In this case, *Tufts Health Plan*, at its option, may:

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

The *Premium* is may be more than is needed to pay for *Covered Services* you received after your termination date. In this case, we will refund the excess to your *Group*.

Despite the above provisions related to *Member* termination for misrepresentation or fraud:

- the validity of the *Group Contract* will not be contested, except for non-payment of *Premiums*, after the *Group Contract* has been in force for two years from its date of issue; or
- no statement made for the purpose of effecting insurance coverage with respect to a *Member* under this *Group Contract* shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits thereunder after that *Member's* insurance under this *Group Contract* has been in force for a period of two years during his or her lifetime, nor unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to him or her.

Termination of a *Group Contract*

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.

*Note: In accordance with the provisions of the *Group Contract,* the *Group* is entitled to a one-month grace period for the payment of any *Premium* due, except for the first month's *Premium*. During that one-month grace period, the *Group Contract* will continue to stay in force. However, upon termination of the *Group Contract*, the *Group* will be responsible for the payment of Premium, prorated based on the actual date of the termination. That termination date will be at the end of the grace period, unless the *Group* notifies us of an earlier termination date.

Extension of Benefits

If you are totally disabled on the date the *Group Contract* ends, you will continue to receive *Covered Services* for 12 months.

The following conditions apply:

- the *Covered Services* must be:
  - *Medically Necessary*,
  - provided while the total disability lasts, and
  - directly related to the condition that caused the *Member* to be totally disabled on that date; and
- all of the terms, conditions, and limitations of coverage under the *Group's* contract with *Tufts Health Plan* will apply during the extension of benefits.

The extension of benefits will end on the earliest of:

- the date the total disability ends;
- the date you become eligible for coverage under another plan; or
- 12 months after your extended benefits began.

Transfer to Other Employer Group Health Plans

Conditions for transfer

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.

Obtaining a Certificate of Creditable Coverage

Certificates of Creditable Coverage are mailed to each *Subscriber* and/or *Dependent* upon termination. This is done in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting us. Call the Member Services Department at 1-800-682-8059.

Chapter 5
Continuation of *Group Contract* Coverage and Conversion Privilege

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 as 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 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 (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.

FEDERAL COBRA - DURATION OF COVERAGE		
Qualifying Event(s)	**Qualified Beneficiaries**	**Maximum Period of Coverage**
• Termination of *Subscriber's* employment for any reason other than gross misconduct. • Reduction in the *Subscriber's* work hours.	*Subscriber, Spouse*, and *Dependent Children*	18 months*
Subscriber's divorce, legal separation, entitlement to Medicare, or death.	*Spouse* and *Dependent Children*	36 months
Subscriber's or *Spouse's* enrolled *Dependent* ceases to be a *Dependent Child*.	*Dependent Child*	36 months
*__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.

Rhode Island Continuation Coverage

If your employment is terminated because of involuntary layoff or death, or as a result of the workplace ceasing to exist, or the permanent reduction in size of the workforce, the benefits under this *Group Contract* may be continued as provided under Rhode Island General Laws, Chapter 27-19.1. The period of this continuation will be for up to eighteen (18) months from your termination date. The continuation period cannot exceed the shorter of:

- the period that represents the period of your continuous employment preceding termination with your *Group;* or
- the time from your termination date until the date that you or any other covered *Member* under your plan becomes employed by another employer and eligible for benefits under another group plan.

Note: We must receive the applicable *Premium* in order to continue coverage under this provision.

Rhode Island Conversion Privilege

You may be entitled to enroll in a separate health benefit contract ("converted contract") if your coverage under this *Group Contract*:

- has been terminated for any reason other than discontinuance of the *Group Contract* in its entirety or with respect to an insured class; and
- you have been continuously covered under the *Group Contract* (and under any employer contract providing similar benefits which it had replaced) for at least three (3) months immediately prior to termination.

Notes:

- You will not be entitled to coverage under a converted contract if your coverage under the *Group Contract* ended because (1) you failed to pay any required contribution or (2) any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days.
- You must submit written application for the converted contract and pay us the first required contribution no later than thirty-one (31) days after such termination.

For more information about converted contracts, please call Member Services.

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 service, and (1) you ensure that your employer receives advance written or verbal notice of your service; (2) you have five years or less of cumulative service in the uniformed service while with that particular employer' (3) you return to work or apply for reemployment in a timely manner after conclusion of service; and (4) you have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you 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 anyone 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.gove/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 of representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

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

Chapter 6
Member Satisfaction

Member Satisfaction Process

Tufts Health Plan has a multi-level *Member* Satisfaction Process including:

- Internal Inquiry;
- *Member* Grievances Process; and
- Two levels of Internal *Member* Appeals; and
- External Review by an External Appeals Agency designated by the Rhode Island Department of Health.

Mail all grievances and appeals to us at:

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

You can also call us at **1-800-682-8059**.

Internal Inquiry:
Call a *Tufts Health Plan* Member Specialist to discuss concerns you have about your health care coverage. We will make every effort to resolve your concerns. You may choose to file a grievance or appeal. If you do this, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Member Grievance Process
A grievance is a formal complaint about actions taken by *Tufts 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 us as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. You may choose to file a grievance verbally. If you do this, please call a *Tufts Health Plan* Member Specialist. That person 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. Then, send it to the address at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and *Provider* names; and
- any supporting documentation.

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

Administrative Grievances

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

Administrative Grievance Timeline

- You may file your grievance verbally or in writing. If you do this, we will notify you by mail. We will do notify you, within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That notification will provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- We will review your grievance and will send you a letter regarding the outcome. As allowed by law, we will send that 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. This would be done by 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. You may have concerns about your medical care. If so, you should discuss them directly with your *Provider*. You may not be satisfied with your *Provider's* response or want to address your concerns directly with your *Provider*. If so, you may contact Member Services to file a clinical grievance.

You may file your grievance verbally or in writing. If so, we will notify you by mail, within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That letter will include the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance.

We will review your grievance and will notify you in writing regarding the outcome. As allowed by law, we will send that letter within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days. This may occur if we need additional time to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

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 coordinate a review of all of the information submitted upon appeal. That review will consider your benefits as detailed in this *Evidence of Coverage.* You are entitled to two (2) levels of internal review.

Internal *Member* Appeals, continued

It is important that you contact us as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage, claim payment, or first level appeal denial to file an internal appeal. Appeals may be filed either verbally or in writing. IYou may file a verbal appeal. To do this, call a Member Specialist. That person will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing. Then, send it to the address listed earlier in this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and *Provider* names; and
- any supporting documentation.

Appeals Timeline

- You may file your appeal verbally or in writing. If you do this, we will notify you in writing, within three (3) business days after receiving your letter, that your letter has been received. Our letter will include the name, address, and phone number of the Appeals and Grievances Analyst coordinating the review of your appeal.
- We will review your appeal, make a decision, and send you a decision letter within fifteen (15) calendar days of receipt.
- The time limits in this process may be extended by mutual verbal or written agreement between you or your authorized representative and *Tufts Health Plan,*. The extension can be for up to 15 calendar days.

We may be waiting for medical records needed to review your appeal. If we have not received them, we may need this extension. The Appeals and Grievances Analyst handling your case will notify you in advance if an extension may be needed. The notification will include the specific information required to complete the review.

When Medical Records are Necessary

Your appeal may require the review of medical records. In this event, we will send you a form. You must sign that form to authorize your *Providers* to release to *Tufts Health Plan* medical information relevant to your appeal. You must sign and return the form to us before we can begin the review process. If you do not sign and return to the form to us within fifteen (15) calendar days of the date you filed your appeal, we may issue a response to your request without reviewing the medical records. You will have access to any medical information and records relevant to your appeal in our possession and control.

Member Satisfaction Process, continued

Who Reviews Appeals?

First level appeals of a medical necessity determination will be reviewed by a licensed practitioner:

- with the same licensure status as the ordering practitioner or a licensed provider or a licensed dentist; and
- who did not participate in any of the prior decisions on the case.

Second level appeals will be reviewed by a licensed practitioner in the same or similar specialty as typically treats the medical condition, procedure or treatment under review.

A designated reviewer will review appeals involving non-*Covered Services*. That person will be from the Appeals and Grievances Department.

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 an adverse appeal determination (a decision based on medical necessity) will include: the specific information upon which the adverse appeal determination was based; our 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; the title and credentials of the individual who reviewed the case; notification of the steps requested the next level of internal appeal or an external review by an External Appeals Agency, designated by the Rhode Island Department of Health, as appropriate; and the availability of translation services and consumer assistance programs.

Also, a first level adverse appeal determination letter will notify you that should you file a second level appeal, you have the right to: (1) inspect the appeal review file and; (2) add information prior to our reaching a final decision. Finally, a second level adverse appeal determination letter will include:

- fee information for filing an external review; and
- a statement that if *Tufts Health Plan's* decision is overturned by the external appeals agency, you will be reimbursed by *Tufts Health Plan* within sixty (60) days of the date you are notified of the overturn for your share of the appeal fee.

Expedited Appeals

We recognize that there are circumstances that require a quicker turnaround than the fifteen (15) calendar days allotted for the standard Appeals Process. We 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. Additionally, we will expedite your appeal if a medical professional determines it involves emergent health care services (defined as services provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g., severe pain) where the absence of immediate medical attention could be reasonably expected to result in placing your health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part). If your request meets the criteria for an expedited review, you may also file a request for a simultaneous external appeal.

Expedited Appeals, continued

If you feel your request meets the criteria cited above, you or your attending *Provider* should contact Member Services. Under these circumstances, you will be notified of our decision on the earlier of:

- within two (2) business days of receipt of all information necessary to complete the review;
- or seventy-two (72) hours after the review is initiated.

External Review

Tufts Health Plan provides for an independent external review by an external appeal agency for final adverse determinations. These are decisions based on medical necessity. The Rhode Island Department of Health has designated an external appeal agency who performs independent reviews of final adverse medical necessity decisions. The external review agency is not connected in any way with *Tufts Health Plan*. Please note that appeals for coverage of services excluded from coverage under your plan are not eligible for external review.

To initiate this external appeal, you must send a letter to us within four months of the receipt of your second level adverse determination letter. In that letter, you must include any additional information that you would like the external review agency to consider.

Within five (5) days of receipt of your written request, *Tufts Health Plan* will forward the complete review file, including the criteria utilized in rendering its decision, to the external appeal agency. The external appeal agency shall provide notice to you and your *Provider* of record of the outcome of the external appeal.

The external review shall be based on the following:

- the review criteria used by *Tufts Health Plan* to make the internal appeal determination;
- the medical necessity for the care, treatment or service for which coverage was denied; and
- the appropriateness of the service delivery for which coverage was denied.

The decision of the external appeals agency is binding. However, any person who is aggrieved by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

If the external appeals agency overturns *Tufts Health Plan's* appeal decision, we will send you a written notice within five (5) business days of receipt of the written decision from the appeal agency. This notice will:

- include an acknowledgement of the decision of the agency;
- advise of any 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 appeal.

Bills from *Providers*

Medical Expenses

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

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

- A completed, signed Member Reimbursement Medical Claim Form. You can obtain this from our Web site. You can also get one by contacting the Member Services Department.
- The documents required for proof of service and payment. Those documents are listed on the Member Reimbursement Medical Claim Form.

Note: We will provide the *Member* making a claim, or to the *Group* for delivery to such person, the claim forms we furnish for filing proof of loss for *Covered Services*. If we do not provide such forms within 15 days after we received notice of any claim under the *Group Contract*, the *Member* making that claim will be deemed to have met the requirements under that *Group Contract* for proof of loss, upon submitting to us within the time fixed in the *Group Contract* for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

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

Note: You must contact us regarding your bill(s) or send your bill(s) to us within 90 days from the date of service, or as soon as reasonably possible. If you do not, the bill cannot be considered for payment, unless you are legally incapacitated. In no event, except in cases of legal incapacitation, can bills be considered for payment after a period of 1 year.

If you receive *Covered Services* from a non-*Tufts Health Plan Provider*, we will pay up to the *Reasonable Charge* for the services within 60 days of receiving a completed Member Reimbursement Medical Claim Form and all required supporting documents.

IMPORTANT NOTE:
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 see our Web site at **www.tuftshealthplan.com.**

We reserve the right to be reimbursed by the *Member* for payments made due to our 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

You cannot bring an action at law or in equity to recover on this *Group Contract* prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this *Group Contract*. You cannot bring such action at all unless you bring it within three (3) years from the expiration of the time within which proof of loss is required by this *Group Contract.*

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 (a "Third Party"). "Third Party" means any person or company that is, or could be, responsible for the costs of injuries or illness to you. This includes such costs to any *Dependent* covered under this plan.

Tufts HP may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or rewards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you for Third Party injuries.

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We 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.

Subrogation, continued

Tufts Health Plan's **right of reimbursement**

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy,
- premises or homeowners medical payments coverage;
- premises or homeowners insurance coverage; and
- any other payments from a source intended to compensate you where a Third Party is responsible.

We have the right to be reimbursed up to the amount of any payment received by you. This is 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 compensate you fully for the illness or injury.

Member **cooperation**

You further agree:

- to notify us promptly and in writing when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a claim to recover damages or obtain compensation;
- to cooperate with us and provide us and provide us with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this Plan;
- to assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of health care services and supplies, and expenses, that we paid or will pay for your illness or injury;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any Third Party. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this Plan;
- to serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party responsibility;
- that we may recover the full cost of all benefits provided by this Plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from our recovery;

Subrogation, continued

Member cooperation, continued

- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party without our prior express written consent; and
- that in the event you or your representative fails to cooperate with *Tufts HP*, you shall be responsible for all benefits provided by this *Plan* in addition to costs and attorney's fees incurred by *Tufts HP* in obtaining repayment.

Workers' compensation

Employers provide workers' compensation insurance for their employees. Employers do this 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. We will not provide coverage for any injury or illness for which it determines that the *Member* is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability (2) or indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay the costs of health care services or medications for any work-related illness or injury. If we do this, we have 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 us for any work-related illness or injury, contact the Liability and Recovery Department at 1-888-880-8699, x. 1098.

Subrogation Agent

We may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as our agent.

Constructive Trust

By accepting benefits from *Tufts Health Plan*, 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. This is the case whether the payment of such benefits is made to you directly or made on your behalf, for example to a *Provider*. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to *Tufts Health Plan.*

Coordination of This *Group Contract's* Benefits with Other Benefits

Applicability

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of "This Plan" are determined before or after those of another plan. The benefits of "This Plan":
   (1) shall not be reduced when, under the order of benefit determination rules, "This Plan" determines its benefits before another plan; but
   (2) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the "Effect on the Benefits of "This Plan" " section below.

Definitions

A. "Plan" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

   (1) Group insurance or group-type coverage whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   (2) Coverage under a governmental plan, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the *Group Contract* that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether "This Plan" is a Primary Plan or Secondary Plan as to another plan covering the person. When "This Plan" is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When "This Plan" is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, "This Plan" may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under "This Plan", or any part of a year before the date this COB provision or a similar provision takes effect.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Order of Benefit Determination Rules

A. General. When there is a basis for a claim under "This Plan" and another plan, "This Plan" is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of "This Plan"; and

(2) Both those rules and "This Plan's rules, in Subsection B below, require that "This Plan"'s benefits be determined before those of the other plan.

B. Rules. "This Plan" determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph B(3) below, when "This Plan" and another plan cover the same child as a dependent of different person, called "parents:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has the rule based upon the gender of the patient, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above in Paragraph B(2) of this section.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

Effect on the Benefits of "This Plan"

A. When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules" section above, "This Plan" is a Secondary Plan as to one or more other plans. In that event the benefits of "This Plan" may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in "This Plan"'s Benefits. The benefits of "This Plan" will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expenses under "This Plan" in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of "This Plan" will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of "This Plan" are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of "This Plan".

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. *Tufts Health Plan* has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. *Tufts Health Plan* need not tell, or get the consent of, any person to do this. Each person claiming benefits under "This Plan" must give *Tufts Health Plan* any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under "This Plan". If it does, *Tufts Health Plan* may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under "This Plan". *Tufts Health Plan* will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Right of Recovery

If the amount of the payments made by *Tufts Health Plan* is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

For more information

Contact the Liability and Recovery Department at 1-888-880-8699, x.1098. You can also call a Member Specialist. That person can transfer your call to the Liability and Recovery Department.

Medicare Eligibility

Medicare eligibility

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

Tufts 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*. This notice explains how we use and disclose 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 and *Providers*

We arrange health care services. We do not provide health care services. We have agreements with *Providers* practicing in their private offices throughout the *Service 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*.

We are not liable for acts, omissions, representations or other conduct of any *Provider*.

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 our reasonable control. Such circumstances include, but are not limited to: major disaster; epidemic; strike; war; riot; and civil insurrection. In such circumstances, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of *Tufts Health Plan Providers*.

Group Contract

Acceptance of the terms of the *Group Contract*

By signing and returning the membership application form, you: (1) apply for *Group* coverage; and (2) agree, on behalf of yourself and your enrolled *Dependents*, to all the terms and conditions of the *Group Contract*, including this *Evidence of Coverage*.

Notes:

- The validity of the *Group Contract* cannot be contested, except for non-payment of *Premium*, after it has been in force for two years from its date of issue.
- A copy of the *Group's* application will be attached to the *Group Contract* when issued. All statements made by the *Group* or by *Members* in that application shall be deemed representations and not warranties.
- No agent has authority to change the *Group Contract* or waive any of its provisions. In addition, no change in the *Group Contract* shall be valid unless approved by an officer of *Tufts Health Plan* and evidenced by an amendment to the *Group Contract* signed by us. Please note, though, that any such amendment that reduces or eliminates coverage must be requested in writing by the *Group* or signed by the *Group*.

Payments for coverage

We will bill your *Group* and your *Group* will pay *Premiums* to us for you. We are 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: Your *Group* may fail to pay the *Premium* on time. If this happens, we 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*" in Chapter 4.

We 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*

We may change this *Evidence of Coverage*. Changes do not require your consent. [Notice of changes in *Covered Services* will be sent to your *Group* at least [30][60] days before the effective date of the modifications. That notice 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. It] 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*. They will not apply just to you.

Notice

Notice to *Members*: When we send a notice to you, it will be sent to your last address on file with us.

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

We may choose to waive certain terms of the *Group Contract* if applicable. This includes the *Evidence of Coverage*. This does not mean that we give up our 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 after [July 1, 2012]. It supersedes all previous *Evidences of Coverage*. We will issue a copy of the *Evidence of Coverage* to the *Group* and to all *Subscribers* enrolled under this plan.

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: A foster child is considered an *Adoptive Child* as of the date of placement for adoption.

Anniversary Date

The date when the *Group Contract* first renews. Then, each successive annual renewal date.

Annual Coverage Limitations

Annual dollar or time limitations on *Covered Services*.

[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. *BCBAs* must also be individually licensed by the Rhode Island Department of Health as a healthcare provider/clinician, and credentialed by *Tufts HP.* 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.]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.41-75, this definition only applies to groups of 51 or more*

Child

The following individuals until their 26th birthday:

- The *Subscriber's* or *Spouse's* natural child, stepchild, or *Adoptive Child* who qualifies as a *Dependent* for federal tax purposes; or
- [the *Child* of an enrolled child; or]
- any other *Child* for whom the *Subscriber* has legal guardianship.

Coinsurance

The percentage of costs you must pay for certain *Covered Services*.

- For services provided by a non-*Tufts 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. It does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.]

[Community Hospital]

[Any *Tufts Health Plan Hospital* other than a *Tertiary Hospital*.]

Community Residence

Any home or other living arrangement which is established, offered, maintained, conducted, managed, or operated by any person for a period of at least 24 hours, where, on a 24-hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, habilitation, psychological support, and/or social guidance for three or more persons with substance abuse or *Mental Disorders,* or persons with developmental disabilities or cognitive disabilities such as brain injury. Examples include, but are not limited to, group homes, halfway homes, and fully-supervised apartment programs. Semi-independent living programs, foster care, and parent deinstitutionalization subsidy aid programs are not considered *Community Residences* under this *Evidence of Coverage.*

Contract Year

The 12-month period determined by the *Group* in which benefit limits, *Deductibles*, *Out-of-Pocket Maximum,* and *Coinsurance* are calculated under this plan. A *Contract Year* can be either a calendar year or a plan year.

- Calendar year: Coverage based on a calendar year runs from January 1st through December 31st within a year.
- Plan year: Coverage based on a plan year runs during a period of 12 consecutive months that are not a calendar year. As an example, a plan year can run from July 1st in one calendar year through June 30th in the following calendar year.

For more information about the type of *Contract Year* that applies to your plan, call Member Services. You can also contact your employer.

Copayment

Fees you pay for *Covered Services*. *Copayments* are paid to the *Provider* when you receive care unless the *Provider* arranges otherwise. [*Copayments* [are] [are not] included in the *Out-of-Pocket Maximum*. 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 Services

The services and supplies for which we will pay. They must be:

- described in Chapter 3 (They are subject to the "Exclusions from Benefits" section in Chapter 3.);
- *Medically Necessary*; and
- provided or authorized by your *PCP* and in some cases, approved by *Tufts Health Plan* or its designee.

These services include *Medically Necessary* coverage of pediatric specialty care. (This includes mental health care.) by *Providers* with recognized expertise in specialty pediatrics.

[Note: *Covered Services* do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any *Provider*, *Member*, service, supply, or medication.]

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. Examples include 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) provided to a *Member* at a facility licensed by the state to perform surgery. The Member must be expected to depart the same day or in some instances within twenty-four hours. Also called "Ambulatory Surgery" or "Surgical Day Care".

[Deductible

For each *Contract Year*, the amount paid by the *Member* for certain *Covered Services* before any payments are made under this *Evidence of Coverage*. [(Any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.)] See "Benefit Overview" at the front of this *Evidence of Coverage* for more information.]

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

Dependent

The *Subscriber's Spouse*, *Child*, [*Domestic Partner*,] 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 *Provide*r has an agreement with us to provide *Inpatient* or day treatment/partial hospitalization services to *Members* assigned to the facility. Also called "Designated Facility".]

Directory of Health Care Providers

A separate booklet which lists *Tufts Health Plan PCPs*. It also lists their affiliated *Tufts Health Plan Hospital* and certain other *Tufts Health Plan Providers*.

Note: This booklet is updated from time to time. This is done 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 Services. Or, you can check our Web site at **www.tuftshealthplan.com**.

Disabled Dependent

The *Subscriber's* or *Spouse's* natural child, stepchild, or *Adoptive Child* of any age who:

- is medically determined to have a physical or mental impairment which can be expected to result in death or can be expected to last for a period of not less than 12 months; and
- who is financially dependent on the *Subscriber*.

[Domestic Partner]

[An unmarried *Subscriber's* individual partner of the same or opposite sex who:

- [is at least 18 years of age;]
- is not married;
- has not been married (or has not been in a prior domestic partner relationship) for at least the prior [0-12] consecutive months;
- is not related to the *Subscriber* by blood; and
- meets the eligibility criteria described in Chapter 2.]

[The *Subscriber* and the Domestic Partner must:

- share a mutually exclusive and enduring relationship;
- have shared a common residence for [[0-12] prior consecutive months] and intend to do so indefinitely;
- be financially interdependent;
- be jointly responsible for their common welfare; and
- be committed to a life partnership with each other.]

Note: Roommates who do not satisfy the above criteria, parents and siblings of the *Subscriber* cannot qualify as *Domestic Partners*.]

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 our 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 (This includes 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.

Evidence of Coverage

This document and any future amendments.

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 *Member* 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. The *Group* is your agent. It is not *Tufts Health Plan's* agent.

Group Contract

The agreement between *Tufts Health Plan* and the *Group* under which:

- we agree to provide *Group* coverage; and
- the *Group* agrees to pay a *Premium* to us on your behalf.

The *Group 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
- classified as an *Inpatient* for all or a part of the day.

Medically Necessary

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

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

In determining coverage for *Medically Necessary* services, we use *Medical Necessity* Guidelines. These Guidelines are:

- developed with input from practicing *Providers* in the *Service Area*;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- evidence-based, if practicable.

Member

A person enrolled in *Tufts Health Plan* under the *Group Contract*. Also referred to as "you."

Mental Disorders

Any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization and that substantially limits the life activities of the person with the illness. *Mental Disorders* do not include tobacco and caffeine in the definition of substance. In addition, *Mental Disorders* do not include: mental retardation, learning disorders, motor skills disorders, communication disorders, and mental disorders classified as "V" codes.

Observation

The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within twenty-three (23) hours or a verified diagnosis and concurrent treatment plan. At times, an observation stay may be followed by an *Inpatient* admission to treat a diagnosis revealed during the period of observation.

Open Enrollment Period

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.*

[Out-of-Pocket Maximum

The maximum amount of money paid by a *Member* during a *Contract Year* for certain *Covered Services*. The *Out-of-Pocket Maximum* consists of [*Copayments*] [,] [*Deductibles*] [and] [*Coinsurance*.] It does not include:

- [Emergency *care* [*Copayments*][*Cost Sharing Amounts*]*;]*
- [any amount you pay for prescription drugs; or]
- costs for health care services that are not *Covered Services* under the *Group Contract*.

You may meet your *Out-of-Pocket Maximum* in a *Contract Year*. If this happens, you no longer pay for [*Copayments*] [and] [*Coinsurance*] in that *Contract Year*.

See "Benefit Overview" at the front of this *Evidence of Coverage* for more information *.* **]**

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 Behavioral Analyst (BCBA)* who is a licensed health care clinician*.* As required by Rhode Island law, Board-Certified Assistant Behavioral Analysts (BCaBAs) are considered *Paraprofessionals.]*

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.41-75, this definition only applies to groups of 51 or more*

Premium

The total monthly cost of *Individual* or *Family Coverage* which the *Group* pays to us.

Primary Care *Provider* (PCP)

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

Prior Authorization

A process we use to decide if a health care service qualifies or supply as a *Covered Service*. We recommend that you get before obtaining care for certain *Covered Services*. *Covered Services* for which we suggest prior authorization include a "(PA)" notation in the "Benefit Overview" section of this document. This process is handled by *Tufts Health Plan's* [Chief Medical Officer] or someone we designate.

To request prior authorization, please call us. For mental health services, call our Mental Health Department at 1-800-208-9565. For all other *Covered Services*, call our Member Services Department at 1-800-682-8059. For more information about our prior authorization process, call Member Services or check our Web site at **www.tuftshealthplan.com**.

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; physicians; doctors of osteopathy; licensed nurse midwives; certified registered nurse anesthetists, ; certified registered 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, ;tobacco treatment specialists, ;licensed speech-language pathologists, ;licensed marriage and family therapists ; and licensed audiologists.

We will only cover services of a *Provider*, if those services are: listed as *Covered Services*; and within the scope of the *Provider's* license.

Provider Organization

A *Provider Organization* is comprised of doctors and other health care *Providers* who practice together in the same community. They often admit patients to the same hospital. A *Provider Organization* does this to give their patients a full range of care. Also called a "Provider Group".

Reasonable Charge

The lesser of:

- the amount charged; or
- the amount that we determine. We decide this amount based on nationally accepted means and amounts of claims payment. These means and amounts 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.

Service Area

The *Service Area* (This is also called the "Enrollment Service Area.") is the geographical area within which we have developed a network of 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 Rhode Island, [except Block Island]. It also includes all of Massachusetts[, except Nantucket and Martha's Vineyard]; and
- the cities and towns in New Hampshire:
  - in which *Tufts Health Plan PCP*s are located, and
  - which are a reasonable distance from *Tufts Health Plan* specialists who provide the most-often used services. Examples of these specialists are behavioral health practitioners and physicians who are surgeons or OB/GYNs.

The Extended Service Area includes [Block Island. It also includes] 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 PCP*s and specialists who provide the most-often used services. Examples of these specialists are behavioral health practitioners and *Providers* who are surgeons or OB/GYNs.

Note: You can get a list of cities and towns in the *Service Area.* To do this, call the Member Services. Or, you can check our Web site at **www.tuftshealthplan.com**.

Skilled

A type of care that is *Medically Necessary*. This care 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.

Spouse also includes the spousal equivalent of the *Subscriber* who is the registered *Domestic Partner,* civil union partner, or other similar legally recognized partner of the *Subscriber* who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Subscriber

The person who:

- is [an employee of the *Group*] [a person eligible to be a *Subscriber* under the *Group*];
- 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 the *Group Contract*.

[Tertiary Hospital]

[Each of the following hospitals:

- [Beth Israel Deaconess Medical Center (Boston, MA);]
- [Boston Medical Center (Boston, MA);]
- [Brigham & Women's Hospital (Boston, MA);]
- [Children's Hospital (Boston, MA);]
- [Dana-Farber Cancer Institute (Boston, MA);]
- [Lahey Clinic (Burlington, MA);]
- [Mary Hitchcock Memorial Hospital (Hanover, NH);]
- [Massachusetts Eye & Ear Infirmary (Boston, MA);]
- [Massachusetts General Hospital (Boston, MA);]
- [New England Baptist Hospital (Boston, MA);]
- [Rhode Island Hospital, including Hasbro Children's Hospital (Providence, Rhode Island);]
- [Tufts-New England Medical Center (Boston, MA);]
- [UMass Memorial Medical Center (Worcester, MA).]]

Tufts Health Plan

Tufts Associated Health Maintenance Organization, Inc., a Massachusetts corporation d/b/a *Tufts Health Plan*. *Tufts Health Plan* is licensed by Rhode Island as a health maintenance organization (HMO). Also called "we", "us", and "our".

Tufts Health Plan Hospital

A [*Community Hospital* or *Tertiary*] hospital that 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. 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 <u>not</u> *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; sudden extreme anxiety; a cut that needs stitches but is not actively bleeding; or symptoms of a urinary tract infection.

<u>Note</u>: Care may be provided after the *urgent* condition is treated and stabilized and the *Member* is safe for transport. This care is not considered *Urgent Care*.

Appendix B - ERISA Information

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.

ERISA RIGHTS, continued

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

Enforcing Your Rights – continued:

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.

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 1-800-682-8059 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 claims).

Urgent care claims: 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 be adequately managed without the care or treatment being requested. For urgent care claims, we will respond to you within 72 hours after receipt of the claim. If we determine that additional information is needed to review your claim, we will notify you within 24 hours after the receipt of the claim and provide you with a description of the additional information needed to evaluate your claim. You have 48 hour after that time to provide the requested information. We 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 we have already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, we 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, we 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.

PROCESSING OF CLAIMS FOR PLAN BENEFITS, continued

[Types of claims, continued

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, we will respond to you within 72 hours for an urgent request and within 15 days for a non-urgent request after receipt of the claim. If we determine that an extension is necessary for a non-urgent request 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 us to make a determination, we will notify you within 15 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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, we will respond to you within 30 days and describe the information that you need to provide to us. 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.]

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 physician 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.

An employee should contact his or her employer for details about FMLA and to make payment arrangements, if applicable.

PATIENT PROTECTION DISCLOSURE

This plan generally requires the designation of a *Primary Care Provider*. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a *Primary Care Provider,* and for a list of the participating *Primary Care Providers,* contact Member Services or see our Web site at **www.tuftshealthplan.com**.

For *Children*, you may designate a pediatrician as the *Primary Care Provider.*

You do not need prior authorization from *Tufts Health Plan* or from any other person (including a *Primary Care Provider*) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specializes in obstetrics or gynecology, contact Member Services or see our Web site at **www.tuftshealthplan.com**.

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 a 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.

Rhode Island Standard PPO Certificate for
Tufts Insurance Company (TIC)
7-2012 edition –REVISED CLEAN COPY
(submitted to Rhode Island Dept. of Business Regulation – 2-22-13)

TUFTS Health Plan
Preferred Provider Organization

CERTIFICATE OF INSURANCE

Underwritten by Tufts Insurance Company

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

Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508

[*Tufts Health Plan* Address And Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, MA 02472-1508
Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.S.T.
Friday 8:00 a.m. to 5:00 p.m. E.S.T.]

IMPORTANT PHONE NUMBERS:

Emergency Care

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

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

Liability Recovery

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

You may have questions about subrogation. If so, call a Member Specialist at 1-800-682-8059. You may not be sure about which department to call with your questions. If so, call Member Services.

Member Services Department

Call our Member Services Department at 1-800-682-8059 for: general questions; benefit questions; and information regarding eligibility for enrollment and billing.

Mental Health Services

You may need information regarding mental health benefits. If so, call the *Tufts Health Plan* Mental Health Department at 1-800-208-9565.

Services for Hearing Impaired *Members*

You may be hearing impaired. If so, these services are provided:

Telecommunications Device for the Deaf (TDD)

If you have access to a TDD phone, call 1-800-868-5850. You will reach the *Tufts Health Plan* Member Services Department.

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

Rhode Island Relay
[1-800-745-5555]

IMPORTANT ADDRESSES:

Appeals and Grievances Department
You may need to call us about a concern or appeal. If so, call a Member Specialist at 1-800-682-8059. To submit your appeal or grievance in writing, send your letter to:

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

Web site
You may want more information about *Tufts Health Plan* and or to learn about the self-service options available to you. If so, see the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

Translating Services

Translating services for 140 languages

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

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

អ្នកបកប្រែភាសា និងកិច្ចការបកប្រែទាំងឡាយ ដែលជាប់ទាក់ទងនឹងទំរង់ការខាងការចាត់ចែងការ គឺមានផ្តល់សំរាប់ជួយអ្នក ។ ដើម្បីស្នើសុំការបំរើទាំងនេះ សូមទូរស័ព្ទមកក្រសួងទំនាក់ទំនងភ្ញៀវ នៃគំរោងថែរក្សាសុខភាពរបស់ Tufts ។

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

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

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

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການທຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts , ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

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

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

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

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

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

1-800-682-8059

Telecommunications Device for the Deaf (TDD)

Call 1-800-868-5850.

Certificate of Insurance

THIS BOOKLET IS YOUR *CERTIFICATE* OF INSURANCE for health benefits underwritten by Tufts Insurance Company ("TIC"). TIC has entered into an agreement with Tufts Benefit Administrators ("TBA") for TBA to administer health benefits. TBA also makes available a network of *Providers* described in this *Certificate*. Both TIC and Tufts Benefit Administrators ("TBA") do business under the name of *Tufts Health Plan.*

Network Providers are hospitals, community-based physicians and other community-based health care professionals. They work in their own offices throughout the *Network Contracting Area*. *Tufts Health Plan* does not provide health care services to *Members*. *Network Providers* provide health care services to *Members*. These *Providers* are independent contractors. They are not the employees or agents of *Tufts Health Plan* for any purposes.

This *Certificate* describes the benefits, exclusions, conditions and limitations provided under the *Group Contract* . It applies to persons covered under the *Group Contract* . It replaces any *Certificate* previously issued to you. Read this *Certificate* for a complete description of benefits and an understanding of how the preferred provider plan works.

Introduction

Welcome to *Tufts Health Plan*. With *Tufts Health Plan*, each time you need health care services, you may choose to obtain your health care from either a *Network Provider* (*In-Network Level of Benefits)* or any *Non-Network Provider (Out-of-Network Level of Benefits).* Your choice will determine the level of benefits you receive for your health care services:

***In-Network Level of Benefits*:** If your care is provided by a *Network Provider*, you will be covered at the *In-Network Level of Benefits*.

[**IMPORTANT NOTE[S]:**

- [For *Outpatient* care: You may receive services from a *Primary Care Provider* (*"PCP"*). If this happens, your [*Copayment*] [*Coinsurance*] may be lower than for services from other *Providers*.]
- [For *Inpatient* care or *Day Surgery*: Your [*Copayment*] [*Coinsurance*] may be lower when you receive care at a *Community Hospital* than when you receive care at a *Tertiary Hospital* . See Appendix A for definitions of these facilities.]

For more information, see "Covered Services" in Chapter 3.]

See the "Benefit Overview" and "Plan and Benefit Information" sections and Chapter 3. These sections include more information on your coverage and costs for medical services under this plan.

***Out-of-Network Level of Benefits*:** If your care is provided by a *Non-Network Provider*, you will be covered at the *Out-of-Network Level of Benefits*.

[***Covered Services* Outside of the 50 United States**: *Emergency* care services you receive outside of the 50 United States qualify as *Covered Services*. In addition, *Urgent Care* services you receive while traveling outside of the 50 United States also qualify as *Covered Services.* Any other service, supply, or medication you receive outside of the 50 United States is not covered under this plan.]

For more information about these benefit levels and how to receive covered health care services, see Chapter 1. If you have any questions, call the Member Services Department.

PLEASE READ THIS *CERTIFICATE* OF INSURANCE CAREFULLY.

Table of Contents

Table of Contents, continued

Chapter 3 -- *Covered Services*, continued

Table of Contents, continued

Chapter 3 -- *Covered Services*, continued

Table of Contents, continued

Table of Contents, continued

[FILING NOTE - PPO Option 1: This section describes an option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

COPAYMENTS

• **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):**
  • [Emergency room (per Emergency room visit).....[$0-$350]]
  • [In *Provider's* office (per office visit) .....[$0-$60]]
  [Note[s]:
  • [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]
• **[*Urgent Care* (*In-Network* and *Out-of-Network Level of Benefits*):]**
  • [*In-Network Level of Benefits*: [*Copayment* varies depending on location in which service is rendered (for example, *Emergency* room, urgent care center, or physician's office).]
  • [*Out-of-Network Level of Benefits* [*Copayment* varies depending on location in which service is rendered (for example, *Emergency* room, urgent care center, or physician's office)] [then] [*Deductible* and] *Coinsurance.]*
• **Other *Covered Services* (*In-Network Level of Benefits* only):**
  • [Office Visit (per visit).....[$0-$60]]
  [Applies to *In-Network Office* Visits for:, diagnostic cytological exams (Pap Smears), immunizations, and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum)*; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.]
  *except for laboratory tests associated with routine *Outpatient* maternity care. These tests are covered in full, as required by the Affordable Care Act.
  • [*Inpatient* Services (per admission).....[$0-$1,500]]
  • [*Day Surgery* (per admission) .....[$0-$1,500]]
]
[Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*] [or] [*Coinsurance*] at the *In-Network Level of Benefits.* Please see the "Benefit Overview" chart for more information.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] *Copayments*] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most Copayments] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network* Services Only)]

[*Deductible* (Individual)]

[This *Certificate of Insurance* has an Individual *Deductible* of [$0-$5,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits*.

[*Deductible* (Family)]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible*.]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when one enrolled *Member* in a family meets his or her [$0-$5,000] Individual *Deductible*; and one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Deductible* are applied toward the [$0-$25,000] Family *Deductible*.]

[Once the Family *Deductible* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] [*Contract Year*]. Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.]

[*OUT-OF-POCKET MAXIMUM*] [(*Out-of-Network* Services Only)]

[*Out-of-Pocket Maximum* (Individual)]

[This *Certificate of Insurance* has an individual *Out-of-Pocket Maximum* of [$0-$10,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits*. [Only the [*Deductible* and] *Coinsurance* count toward the *Out-of-Pocket Maximum*.]

[*Out-of-Pocket Maximum* (Family)]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum*.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when:

- one enrolled *Member* in a family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the [$0-$50,000] Family *Out-of-Pocket Maximum*.]

[Once the Family *Out-of-Pocket Maximum* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their [$0-$10,000] Individual *Out-of-Pocket Maximums* for the remainder of that [calendar year] [*Contract Year*].]

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*]	[$0-$350] Emergency Room *Copayment*[*] [Covered in full] [*In-Network Coinsurance*]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [*Observation* services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]			
***Outpatient* Care**			
[*COVERED SERVICE*]	**[YOUR COST]**		**[PAGE]**
[Acupuncture] **[(PA)] [(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[3-2]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Allergy injections **[(PA)]**	[[$0-$60]*Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then] [*Deductible* and] [*Coinsurance*]. [For services provided by any other non-*Network Provider*:] [*Deductible* and] *Coinsurance*.	[3-2]
Allergy testing **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then] [*Deductible* and] [*Coinsurance*]. [For services provided by any other non-*Network Provider*:] [*Deductible* and] *Coinsurance*.	[3-2]
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[[*Deductible* and] *Coinsurance*.]	[3-2]
[Cardiac rehabilitation **[(PA)] [(BL)]**]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-2]
Chemotherapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care See "Spinal manipulation"]			
[Chiropractic medicine] **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*]	[3-2]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** –. *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Diabetes services and supplies (For detailed information about how diabetes supplies are covered, please see "Diabetes services and supplies" in Chapter 3.)	[Diabetic test strips: [[$0-$75] *Copayment* applies] [Covered in full] [*Coinsurance*] Diabetes self-management education: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diabetes supplies covered as *Durable Medical Equipment*: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[*Deductible* and] *Coinsurance*.	[3-3]
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(PA)] [*]**	**General imaging:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [[$0-$250] Office Visit Copayment] [Covered in full] [*Coinsurance*] [**MRI/MRA:** [[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*] **CT/CTA:** [[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*] **PET:** [[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*] [**Nuclear cardiology:** [[$0-$250] Office Visit Copayment per visit.] [Covered in full.]]] [*Coinsurance*] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Deductible* and] [[10-50%]] *Coinsurance*.	[3-3]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** –. *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Early intervention services for a *Dependent Child*	Covered in full.	Covered in full.	[3-3]
Family planning **[(PA)]** (procedures, services[, and contraceptives]) ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.*]*	**Office Visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Day Surgery*:** [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-4]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Hemodialysis **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
[House calls to diagnose and treat illness or injury]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Immunizations	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Infertility services **(PA) [*] [(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are [covered in full] [subject to [$0-$1,500] *Copayment*] [subject to [0-20%] *Coinsurance*}]	*[Deductible* and] [0-20%] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** Laboratory tests associated with routine preventive care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	[*Deductible* and] *Coinsurance*.	[3-5]
Lyme disease	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then] [*Deductible* and] [*Coinsurance*]. [For services provided by any other non-*Network Provider*:] [*Deductible* and] *Coinsurance*.	[3-6]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Nutritional counseling **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] [*Coinsurance*.]	[3-6]
Office visits to diagnose and treat illness or injury	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] **Office visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [*] ***Day Surgery***: [[$0-$1,500] *Day Surgery Copayment*] [Covered in full] [*Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**Emergency Room: [[**$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] ***Emergency* care in a *Provider's* office:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] **All other services:** [*Deductible* and] *Coinsurance*.	[3-6]
Outpatient surgery in a *Provider's* office **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-7]
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[*Deductible* and] [*Coinsurance*.]	[3-7]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive care for *Members* age 19 and under Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	Covered in full	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members* age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] All other preventive care services: [Covered in full]	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Deductible* and] *Coinsurance*. Routine mammogram: [*Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive Screenings and Diagnostic Procedures & Exams, continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$1,500] *Day Surgery Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-9]
Radiation therapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Respiratory therapy or pulmonary rehabilitation services**[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]
[Short term] speech, physical and occupational therapy services **[(PA)] [*] (BL)**	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [*Deductible* and] *Coinsurance*. [Physical therapy:] [*Deductible* and] *Coinsurance*. [Occupational therapy:] [*Deductible* and] *Coinsurance*.	[3-8]
Smoking cessation counseling services	Covered in full.	[*Deductible* and] [*Coinsurance*.]	[3-8]
[Spinal manipulation] [**(BL)**]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-8]
[*Urgent Care* in an urgent care center]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] [*Coinsurance*].	[3-9]
[Vision care services] **[(PA)]**			
[Routine eye examination]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-9]
Day Surgery			
Day Surgery	[[$0-$1,500] *Day Surgery Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] [*Coinsurance*.] [**Anesthesia**: [*Deductible* and] [[10%-40%] *Coinsurance*. **All other *Day Surgery* services**: [*Deductible* and] [[10-40% *Coinsurance*].]	[3-9]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Inpatient* Care**			
Extended care services **(PA) [*]** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-9]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*] [(BL)]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[Deductible and] [Coinsurance.]] **[Anesthesia**: [*Deductible* and] [[10-40%] *Coinsurance*. **All other hospital services**: [*Deductible* and] [10%-40%] *Coinsurance*.]	[3-10]
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-11]
Maternity Care			
Outpatient **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [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.]	[*Deductible* and] *Coinsurance*.	[3-11]
Inpatient	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-12]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient* and Intermediate)**			
To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*] –** [[$0-$60] Office Visit *Copayment* per visit.] [[0%-50%] *Coinsurance*].] [Individual session –] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [Group session – [[$0-$60] Office Visit *Copayment* per visit.]]Covered in full.]] [*Coinsurance*] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*] –** [[$0-$60] Office Visit *Copayment* per visit.] [[0%-50%] *Coinsurance*].] [Individual session -] [[$0-$60 Office Visit *Copayment*] [Covered in full.] [[0%-50%] *Coinsurance*].] [Group session -] [[$0-$60] Office Visit *Copayment*] [Covered in full.] [*Coinsurance*].]	[*Deductible* and] *Coinsurance*.	[3-12]
Inpatient services **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-12]
Intermediate care **[(PA)]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-13]
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.			
Outpatient services [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	Substance Abuse Treatment Services: [Individual session -] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]. [Group session -] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*].	[*Deductible* and] *Coinsurance*.	[3-13]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate),** continued			
To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.			
Inpatient services **(PA)** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Community Residential care **(PA) [(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]

[(PA)– *Prior authorization* is recommended for to these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services			
Ambulance services **(PA) [*]**			
Ground ambulance services	[Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Deductible* and then] [Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-14]
All other covered ambulance services	[Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-14]
[Diabetic monitoring strips]	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-14]
Durable Medical Equipment **(PA) [*]**	[Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] *Coinsurance*.	[3-15]
Hearing Aids **[(PA)] (BL)**	[Covered in full.] [We pay [50-90%]. You pay [10%-50%] *Coinsurance*.]	*[Deductible* and] [*Coinsurance*.] [Covered in full.]	[3-16]
Home health care **[(PA)] [*](BL)**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-17]
[Hospice care services **[(PA)] [*] [(BL)]]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-17]
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-18]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
Medical supplies **[(PA)]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
New cancer therapies **[(PA)]**	***Outpatient***: [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-18]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Deductible* and] *Coinsurance*.]	[3-18]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan*. Please see "How to File a Claim" in Chapter 6 for more information.]		[3-18]
[Private duty nursing **[(PA)]**]	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*].	[*Deductible* and] [*Coinsurance.*	[3-18]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%] *Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-19]
Nonprescription enteral formulas **[(PA)] [*]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Deductible* and] [*Coinsurance*.]	[3-19]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]
[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, the autism spectrum disorder benefit only applies to groups of 51 or more*

[Cardiac Rehabilitation Services]
[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

Home health care
Coverage is limited to (*In-Network* and *Out-of-Network Levels* combined):

- [6-unlimited] home visits or office visits with a physician per month;
- [3-unlimited] nursing visits per week; and
- home health aide visits of [20-unlimited] hours per week.

Infertility Services
Coverage is limited to [$100,000-unlimited] per *Member* per lifetime **(***In-Network* and *Out-of-Network Levels* combined). [Note: This limit applies to infertility services covered under the "Outpatient Care" benefit [and oral and injectable drug therapies used in the treatment of infertility and covered under the "Prescription Drug Benefit."]]

[FILING NOTE - PPO Option 1: This section describes an option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[**Mental Health *Outpatient* Services**
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30 -unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling
Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[Short-Term Speech, Physical and Occupational Therapy Services]
[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[Spinal Manipulation]
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days *for* Community Residence *services* (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services
Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*], whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is 30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 2: This section describes an option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

[*COPAYMENTS*]

- **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  - [Emergency Room (per Emergency room visit) .....[$0-$350]]
  - [In *Provider's* office (per office visit) .....[$0-$60]]

  [Note[s]:
  - [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]
- **[*Urgent Care* (*In-Network* and *Out-of-Network Levels of Benefits*):**
  - **[***In-Network Level of Benefits* [*Deductible* and then] [*Copayment. Copayment* varies depending on location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office).] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]
  - [*Out-of-Network Level of Benefits* [*Copayment*, which varies depending on location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office.] [then] *[Deductible* and then*] [Coinsurance]]*
- **[Other] *Covered Services* (*In-Network Level of Benefits* only):**
  - [Office Visit (per visit) .....[$0-$60]]

    [Applies to *In-Network Office* Visits for:] diagnostic cytological examinations (Pap Smears),], [certain disease and disorder screenings*,]; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine ob/gyn exam; routine eye exam [and other vision care]; [family planning services;] [and][routine] *Outpatient* maternity care (pre-natal and post-partum)**; [diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education].]

    [*includes disease and disorder screenings related to the following conditions: cancer; heart and vascular disease; infectious diseases; mental health conditions and substance abuse; metabolic, nutritional, and endocrine conditions ; musculoskeletal disorders; obstetric and gynecological conditions; pediatric conditions; and vision and hearing disorders. Please contact Member Services for more information. Also, please note that no Office Visit *Copayment* applies to disease and disorder preventive screenings that must be covered in full as required under the Affordable Care Act (ACA). For information on which screenings are covered in full under ACA, please see our Web site at www.tuftshealthplan.com, or call Member Services.]

    **Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.
  - [*Inpatient* Services (per admission).....[$0-$1,500]]
  - [*Day Surgery* (per admission) .....[$0-$1,500]]

[Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged [an Office Visit *Copayment*] [or the *Deductible* and *Coinsurance*] when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment,*] [*Coinsurance*] [or] [a *Deductible*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview"chart for more information.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] [[0-4] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most Copayments] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*In-Network* and *Out-of-Network* combined)] ***FILING NOTE** – Used for non-HSA plans only*

[**Individual *Deductible*** .....[$0-$5,000]]

[An Individual *Deductible* of [$0-$5,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services.*]

[**Family *Deductible***..... [$0-$25,000]]

[A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services.*]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5.000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*

[Once the Family *Deductible* has been met during a [*calendar year] [Contract Year],* all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year]* . Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.*]*

[*DEDUCTIBLE*] [(*In-Network* and *Out-of-Network* combined)]

***(FILING NOTE** – Used for HSA plans only. Deductible ranges below will be adjusted to comply with the IRS requirements for the applicable tax year.)*

[The *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Services* at both the *In-Network* and *Out-of-Network Levels of Benefits* before payments are made under this *Certificate*.

[The *Deductible* applies to all *Covered Services* at the *In-Network* and *Out-of-Network Levels of Benefits* except as listed below.]

[The amount of the *Deductible* which applies to you and the enrolled members of your family (if applicable) each [calendar year] [*Contract Year]* is:]

[Family Size — *Deductible* Amount

- One Member..... [$1,200-$5,950] per person.
- Two Members or more.....[$2,400-$6,150] per family.]

[The minimum *Deductible* dollar amount is adjusted each year to meet Internal Revenue Service requirements.]

[***Please note:** If you have two or more family members enrolled in the plan, and only one *Member* receives services in a [calendar year] [*Contract Year*], that *Member* must meet the full family *Deductible* ([$2,400-$6,150]) himself or herself before *Tufts Health Plan* will pay for any of his or her care in that year as *Covered Services*.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[Important Information About Your *Deductible*: *FILING NOTE: Used for non-HSA plans only.*

- The following are not subject to the *Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [*In-Network* Office Visits for: preventive care[*], routine cytological exams (Pap smears), preventive immunizations, and routine mammograms; [mental health and substance abuse;] routine ob/gyn exam; routine eye exam; other vision care[from an optometrist]; family planning services; *Outpatient* maternity care (pre-natal and post-partum)[**]; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] early intervention services for a *Dependent Child*, nutritional counseling; and health education.]
    [*Including diagnostic tests associated with preventive health care as described in Chapter 3.]
    [**This does not include diagnostic tests such as ultrasounds.]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology];]
  - [Laboratory tests;]
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for services, supplies, or medications which are not *Covered Services*.
  - Any amount you pay for covered early intervention services.
- Once you meet your *Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance*.**]**

[Important Information About Your *Deductible:* *FILING NOTE: Used for HSA plans only.*

- The following are not subject to the *Deductible*:
  - *In-Network* Office Visits for: adult preventive care*, well-child exams, certain disease and disorder screenings**, routine cytological screenings (Pap smears), immunizations***, and routine mammograms; routine ob/gyn exams; routine eye exams; and routine *Outpatient* maternity care (pre-natal and post-partum).

    *Including diagnostic tests associated with preventive health care, as described under "Preventive Care for *Members* Age 19 and Under" and "Preventive Care for *Members* Age 20 and Older" in Chapter 3, as well as other preventive services in accordance with the ACA.

    **includes disease and disorder screenings related to the following conditions: cancer; heart and vascular disease; infectious diseases; mental health conditions and substance abuse; metabolic, nutritional, and endocrine conditions ; musculoskeletal disorders; obstetric and gynecological conditions; pediatric conditions; and vision and hearing disorders, as well as other screening and counseling in accordance with the ACA. Please contact Member Services for more information.

    ***includes the following routine preventive immunizations:

    - For *Children* under age 18: Hepatitis B, DTP (diptheria, tetanus, pertussis), HiB (haemophilus influenza Type B), IPV (inactivated polio virus), meningococcal disease, varicella (chicken pox), pneumococcal influenza, hepatitis A, HPV (for female*Children* age 9 and older), and rotavirus vaccines.
    - For adults: TD (tetanus and diptheria), TDaP (tetanus, diphtheria, and pertussis), HPV (for adult females through age 26), varicella (chicken pox), influenza, hepatitis A, hepatitis B, meningococcal disease, and herpes zoster (shingles) vaccines.
  - Any amount you pay for services, supplies, or medications which are not *Covered Services*
- Any amounts you pay for prescription drugs are subject to the *Deductible*. For more information, see "Prescription Drug Benefit" in Chapter 3.
- Once you meet your *Deductible* in a [calendar year][*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayments* for *Covered Services* not subject to the *Deductible*; and
  - *Coinsurance*.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*OUT-OF-POCKET MAXIMUM*] [(*In-Network* and *Out-of-Network* combined)] ***FILING NOTE:*** *Used for Non-HSA plans only.*

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000]]

[An Individual *Out-of-Pocket Maximum* of [$0-$10,000] applies to each *Member* per [calendar year] *[Contract Year]* for *Covered Services*.]

[**Family *Out-of-Pocket Maximum***..... [$0-$50,000]]

[A Family *Out-of-Pocket Maximum* of [$0-$50,000] applies per [calendar year] *[Contract Year]* for all enrolled *Members* of a family for *Covered Services*.]

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

*[*The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *{Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

***OUT-OF-POCKET MAXIMUM [In-Network* and *Out-of-Network* combined)**

FILING NOTE – *Used for HSA plans only; Out-of-Pocket Maximum ranges below will be limited to comply with the IRS limits for the applicable tax year.*

[The amount of the *Out-of-Pocket Maximum* which applies to you and the enrolled members of your family (if applicable) each [calendar year] [*Contract Year*] is:

Family Size	*Out-of-Pocket Maximum Amount*
• One Member	[$0-$6,050] per person.
• Two Members or more	[$0-$12,100] per family.]

[The *Out-of-Pocket Maximum* is limited to the maximum dollar amount as defined each year by the Internal Revenue Service.]

[Important Information About Your *Out-of-Pocket Maximum*:

- Once you've satisfied your *Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - [Individual/Family *Deductibles*.]
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - [*Copayments* for *In-Network* Office Visits that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above.]
  - *Coinsurance*.
- The following cannot be used to meet the *Out-of-Pocket Maximum*, and you continue to pay for them after you have met your *Out-of-Pocket Maximum*:
  - [*Emergency* Care [*Copayments*][*Cost Sharing Amounts*].]
  - [*Copayments* for *In-Network* Office Visits [that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
  - At the *Out-of-Network Level of Benefits,* any amount you pay for costs above the *Reasonable Charge*.**]**

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[*Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and then] [$0-$350] Emergency Room *Copayment*[*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [*Observation* services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*] [(not subject to *Deductible*)]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*] [(not subject to *Deductible*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]			

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

***Outpatient* Care**			
COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
[Acupuncture] **[(PA)] [(BL)]**	[*Deductible and then*] [[$0-$60] Copayment] [Covered in full] [*Coinsurance*].	[*Deductible and then*] [[$0-$60] Copayment] [Covered in full] [*Coinsurance*].	[3-2]
Allergy injections **[(PA)]**	[*Deductible* and then] [[$0-$60]*Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [[*Deductible* and] [*Coinsurance.* For services provided by any other non-*Network Provider*:] *Deductible* and] *Coinsurance.*	[3-2]
Allergy testing **[(PA)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [[*Deductible* and] [*Coinsurance.* For services provided by any other non-*Network Provider*:] [*Deductible* and] *Coinsurance*.	[3-2]
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[[*Deductible* and then] *Coinsurance.]*	[3-2]
[Cardiac rehabilitation **[(PA)] [(BL)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-2]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Chemotherapy	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care See "Spinal manipulation"]			
[Chiropractic medicine] **[(BL)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-2]
Diabetes services and supplies (For detailed information about how diabetes supplies are covered, please see "Diabetes services and supplies" in Chapter 3.)	**[Diabetic test strips:** [[*Deductible* and then] [$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **Diabetes self-management education:** [[*Deductible* and then] [$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **Diabetes supplies covered as *Durable Medical Equipment*:** [*Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] **Diabetes supplies covered as medical supplies:** [*Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[Deductible and] Coinsurance.	[3-3]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(AR)] [*]**	**General imaging:** [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [*Deductible* and then] [[$0-$250] Office Visit Copayment] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [**MRI/MRA:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] **CT/CTA:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] **PET:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [**Nuclear cardiology:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.]] [*Coinsurance*] [(not subject to *Deductible*)]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Deductible* and] [10%-50%] *Coinsurance* [(not subject to *Deductible*)].	[3-3]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Early intervention services for a *Dependent Child* **[(PA)]** ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Deductible will only be applied to HSA plans under this Option 2.]*	[*Deductible* and then] Covered in full	[*Deductible* and then] Covered in full.	[3-3]
Family planning (procedures, services[, and contraceptives]) **[(PA)]** ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full..*]*	**Office Visit:** [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [*Coinsurance*] [Covered in full] [(Family planning services [and contraceptives] not subject to *Deductible*)] ***Day Surgery*:** [*Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [*Coinsurance*] [Covered in full] [(subject to *Inpatient* and *Day Surgery Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-4]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Hemodialysis **[(PA)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
[House calls to diagnose and treat illness or injury]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance.*	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing [**(PA)**]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
[Immunizations]	**Routine preventive immunizations:** Covered in full **All other immunizations:** [*Deductible* and then] [[$0-$60 Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[*Deductible* and] *Coinsurance*.]	[3-4]
Infertility services **(PA) [*] [(BL)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [**Note**: Approved Assisted Reproductive Technology services are [covered in full] [subject to *Coinsurance*].	[*Deductible* and] [0-20%] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** In accordance with the ACA, laboratory tests performed as part of routine preventive care are covered in full at the *In-Network Level of Benefits.*	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance.*	[3-5]
Lead screenings	Covered in full	[*Deductible* and] *Coinsurance*.	[3-5]
Lyme disease	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [[*Deductible* and] [*Coinsurance.* For services provided by any other non-*Network Provider*:] [*Deductible* and] *Coinsurance*.]	[3-6]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Nutritional counseling **[(BL)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.]	[3-6]
Office visits to diagnose and treat illness or injury	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	**Emergency Room:** [*Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] **Office Visit**: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [*] ***Day Surgery***: [*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**Emergency Room:** [*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*In-Network Coinsurance*] ***Emergency* care in a *Provider's* office:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] **All other services:** [*Deductible* and] *Coinsurance*.	[3-6]
Outpatient surgery in a Provider's office [**(PA)**]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-7]
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[*Deductible* and] *Coinsurance*.	[3-7]
Preventive care for *Members* age 19 and under Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	Covered in full	[*Deductible* and] *Coinsurance*.	[3-8]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive care for *Members* age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-50%]*Coinsurance*] [(not subject to *Deductible*)] All other preventive care services: Covered in full]	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Deductible* and] *Coinsurance*. Routine mammogram: [*Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive Screenings and Diagnostic Procedures & Exams, continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[*Deductible* and then] [$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]
Radiation therapy	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[*Urgent care* in an urgent care center]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance.*	[3-9]
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]
[Short term] speech, physical and occupational therapy services **[(PA)] [*] [(BL)]**	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical Therapy:] [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational Therapy:] [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [*Deductible* and] *Coinsurance*. [Physical Therapy:] [*Deductible* and] *Coinsurance*. [Occupational Therapy:] [*Deductible* and] *Coinsurance*.	[3-8]
Smoking cessation counseling services	Covered in full.	[[*Deductible* and] *Coinsurance*.]	[3-8]
[Spinal manipulation] [**(BL)**]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-8]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[Vision care services] **[(PA)]**			
[Routine eye examination]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-9]
[Other] Vision care services	**[Care from an optometrist:]**[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*][(not subject to *Deductible*)] **[Care from an ophthalmologist:** [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-9]
Day Surgery			
Day Surgery [Note: Endoscopies and proctosigmoidoscopies are covered under this benefit.] ***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *The note in this benefit only to be used for HSA plans.*	[[*Deductible* and then] [$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Deductible* and] [10%-50%] *Coinsurance*. **All other *Day Surgery* services**: [*Deductible* and] [10%-50%] *Coinsurance*.]	[3-9]
***Inpatient* Care**			
Extended care services **(PA) [*] [(BL)]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-9]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*] [(BL)]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] [**Anesthesia:** [*Deductible* and] [10%-40%] *Coinsurance*. **All other hospital services:** [*Deductible* and] [10%-40%] *Coinsurance*.]	[3-10]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Inpatient* Care,** continued			
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and *Coinsurance*.]	[3-11]
Maternity Care ***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Both "routine" and "non-routine" sections will appear in this outpatient care maternity benefit for HSA plans only. Non-HSA plans will not differentiate between routine and non-routine care.*			
[Routine] *Outpatient* **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [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.]	[*Deductible* and] *Coinsurance*.	[3-11]
[Non-Routine *Outpatient*]	[[*Deductible* and then][$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and] *Coinsurance*.	[3-11]
Inpatient	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-12]
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**			
[To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*] –** [Individual session –] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [Group session – [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.]]Covered in full.]] [*Coinsurance*] [(not subject to *Deductible*)] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*] –** [Individual session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-50%] *Coinsurance*].] [Group session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-50%] *Coinsurance*.]]	[*Deductible* and] *Coinsurance*.	[3-12]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate), continued**			
[**To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.**			
Inpatient services **(PA) [*]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-13]
Intermediate care **[(PA))]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-13]
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.**			
Outpatient services [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	Substance Abuse Treatment Services: [Individual session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and] *Coinsurance*.	[3-13]
Inpatient services **(PA) [*]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate), continued**			
[**To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.**			
Community Residential care **[(PA)] [[(BL)]]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Other Health Services			
Ambulance services **(PA) [*]**			
Ground ambulance services	[*Deductible* and then] [Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Deductible* and then] [Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-14]
All other covered ambulance services	[Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-14]
[Diabetic monitoring strips]	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-14]
Durable Medical Equipment **[(PA)]**	[*Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] [10% - 50%] *Coinsurance*.	[3-15]
Hearing Aids **[(PA)] (BL)**	[*Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Deductible* and] [10%-50%] *Coinsurance*.] [Covered in full.]	[3-16]
Home health care **[(PA)] [*] (BL)**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-17]
[Hospice care services **[(PA)] [*]] [(BL)]**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance]*.	[3-17]
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]]	[*Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
New cancer therapies **[(PA)]**	***Outpatient***: [*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-18]
Orthoses and Prosthetic devices **[(PA)]**	[*Deductible* and then] [Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Deductible* and] *Coinsurance*.]	[3-18]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan*. Please see "How to File a Claim" in Chapter 6 for more information.]		[3-18]
[Private duty nursing **[(PA)]**]	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*].	[*Deductible* and] *Coinsurance.*	[3-18]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[*Deductible* and then] [[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%] *Coinsurance*]	[Covered in full.] [*Deductible* and] [*Coinsurance]*.	[3-19]
Nonprescription enteral formulas **[(PA)] [*]**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Deductible* and] *Coinsurance*.]	[3-19]

[Prescription Drug Benefit]
[For information about your *Copayments* for covered prescription drugs, see the "Prescription Drug Benefit" section in Chapter 3.]
[Prescription drugs are not covered as part of this plan.]

[(PA)) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]
[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, the autism spectrum disorder benefit only applies to groups of 51 or more*

[Cardiac Rehabilitation Services]
[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids
Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

[Mental Health *Outpatient* Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling
Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Levels Network Levels* combined)

[Short-Term Speech, Physical and Occupational Therapy Services]
[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Spinal Manipulation]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days for *Community Residence* services (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services

Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*], whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-40%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

[*COPAYMENTS*]

• **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  • [Emergency room (per Emergency room visit).....[$0-$350]]
  • [In *Provider's* office (per office visit) .....[$0-$60]]
  [Note[s]:
  • [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]
• **[*Urgent Care* (*In-Network* and *Out-of-Network Levels of Benefits*):**
• [*In-Network Level of Benefits* [*In-Network Deductible* and then] [*Copayment,* which varies depending on location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office.] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]
• *[Out-of-Network Level of Benefits* [*Copayment*, which varies depending on location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office.] [then] [*Out-of-Network Deductible* and] *Coinsurance.*
 	
• **[Other] *Covered Services* (*In-Network Level of Benefits* only):**
  • [Office Visit (per visit).....[$0-$60]]
  [Applies to *In-Network Office* Visits for: diagnostic cytological exams (Pap smears), and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum)*; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.] *Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.
  • [*Inpatient* Services (per admission).....[$0-$1,500]]
  • [*Day Surgery* (per admission) .....[$0-$1,500]]
[Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. Also, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*[[*Coinsurance*] [or] [a *Deductible*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview" chart for more information.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

- [[*Copayment* Maximum per *Member* [$0-$6,000] [[0-4] *Copayments*] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most Copayments] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000]] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*In-Network*)]

[**Individual *Deductible*** .....[$0-$5,000]]

[An Individual *Deductible* of [$0-$5,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services* received at the *In-Network Level of Benefits.*]

[**Family *Deductible***..... [$0-$25,000]]

[A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year] applies* for all enrolled *Members* of a family for *Covered Services* received at the *In-Network Level of Benefits.*]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*

[Once the Family *Deductible* has been met during a [calendar year] *[Contract Year],* all enrolled Members in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year]* . Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.*]*

[Important Information About Your *In-Network Deductible*:

- The following are not subject to the *In-Network Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amount*].]
  - [*In-Network* Office Visits for: preventive care[*]; routine cytological exams (Pap Smears), preventive immunizations, and routine mammograms; screening for colon or colorectal cancer; routine prostate and colorectal exams; [mental health and substance abuse;] routine ob/gyn exam; routine eye exam; other vision care[from an optometrist]; family planning services; *Outpatient* maternity care (pre-natal and post-partum)[**]; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] early intervention services for a *Dependent Child*, nutritional counseling; and health education.]
    - [*Including diagnostic tests associated with preventive health care as described in Chapter 3.]
    - [**This does not include diagnostic tests such as ultrasounds.]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology];]
  - [Laboratory tests;]
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *In-Network Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance* [(for *Durable Medical Equipment* only)] .**]**

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network*)]

[**Individual *Deductible*** .....[$0-$8,000]

An Individual *Deductible* of [$0-$8,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services* received at the *Out-of-Network Level of Benefits*.]

[**Family *Deductible***..... [$0-$40,000]

A Family *Deductible* of [$0-$40,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services* received at the *Out-of-Network Level of Benefits*.]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when*:*

- one enrolled *Member* in family meets his or her [$0-$8,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$40,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$8,000] Individual *Deductible.]*

[Once the Family *Deductible* has been met during a [calendar year] *[Contract Year],* all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year]* . Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.*]*

[Important Information About Your *Out-of-Network Deductible*:

- The following are not subject to the *Out-of-Network Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amount*].]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology];]
  - [Laboratory tests;]
  - Any amounts you pay for early intervention services for a *Dependent Child*.
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *In-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *Out-of-Network Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - *Coinsurance*.**]**

[*OUT-OF-POCKET MAXIMUM*] [(*In-Network* and *Out-of-Network* combined)]

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000]

An Individual *Out-of-Pocket Maximum* of [$0-$10,000] applies to each *Member* per [calendar year] *[Contract Year]* for *Covered Services*.]

[**Family *Out-of-Pocket Maximum***..... [$0-$50,000]

A Family *Out-of-Pocket Maximum* of [$0-$50,000] applies per [calendar year] *[Contract Year]* for all enrolled *Members* of a family for *Covered Services*.]

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

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

[Important Information About Your *Out-of-Pocket Maximum*:

- Once you've satisfied your *Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - Individual/Family *Deductibles*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance*.
- The following cannot be used to meet the *Out-of-Pocket Maximum*, and you continue to pay for them after you have met your *Out-of-Pocket Maximum*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [*Copayments* for *In-Network* Office Visits [that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for services, supplies, or medications that are not *Covered Services***.**
  - At the *Out-of-Network Level of Benefits,* any amount you pay for costs above the *Reasonable Charge*.**]**

]

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [*Observation* services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*] [(not subject to *Deductible*)]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*] [(not subject to *Deductible*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [**A Day Surgery Copayment may apply if Day Surgery services are received.**]			
***Outpatient* Care**			
[Acupuncture] **[(PA)] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
Allergy injections **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.] [For services provided by any other non-*Network Provider*:] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
Allergy testing **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.] [For services provided by any other non-*Network Provider*:] [[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*In-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Out-of-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-2]
[Cardiac rehabilitation **[(PA)] [(BL)]]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] [*Coinsurance].*	[3-2]
Chemotherapy	*[In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Out-of-Network Deductible* and*] Coinsurance.*	[3-2]
[Chiropractic care -- See "Spinal manipulation"]			
[Chiropractic medicine] **[(BL)]**	[*n-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and *Coinsurance*]	[3-2]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Diabetes services and supplies	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [Diabetic test strips: [[*In-Network Deductible* and then] [$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes self-management education: [[*In-Network Deductible* and then] [$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes supplies covered as *Durable Medical Equipment*: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] Diabetes supplies covered as medical supplies: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-3]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Diagnostic imaging **[(PA)]** [*] • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] [**(PA)**] [*]	**General imaging***:* [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]] **[MRI/MRA:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] [(not subject to *Deductible*)] **CT/CTA:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] [(not subject to *Deductible*)] **PET:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [**Nuclear cardiology:** *[In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.]]] [*Coinsurance*.] [(not subject to *Deductible*)] [Note: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. [(not subject to *Deductible*)]	[3-3]
Early intervention services for a *Dependent Child* **[(PA)]**	Covered in full.	Covered in full.	[3-3]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Family planning (procedures, services[, and contraceptives]) **[(PA)]** *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w)(3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.*]*	**Office visit**: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] [(Family planning services [and contraceptives] not subject to *In-Network Deductible*)] ***Day Surgery*:** [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[House calls to diagnose and treat illness or injury]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance.]*	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Immunizations	**Routine preventive immunizations:** Covered in full **All other immunizations:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Infertility services **(PA) [*] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are [covered in full] [subject to [0-20%] *Coinsurance*].]	[*Out-of-Network Deductible* and] [0-20%] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** Routine laboratory tests associated with preventive care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Lyme disease	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.] [For services provided by any other non-*Network Provider*:] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Nutritional counseling **[(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]
Office visits to diagnose and treat illness or injury	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] **Office visit**: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] ***Day Surgery***: [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**Emergency Room:** [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*In-Network Coinsurance*] **Emergency care in a *Provider's* office:** [[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] **All other services:** [*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Outpatient surgery in a *Provider's* office **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-7]
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-7]
Preventive care for *Members* age 19 and under Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	Covered in full	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive care for *Members*-age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)] All other preventive care services: Covered in full]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Out-of-Network Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Out-of-Network Deductible* and] *Coinsurance*. Routine mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive Screenings and Diagnostic Procedures & Exams, continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Radiation therapy	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
[Short term] speech, physical and occupational therapy services **[(PA)] [*] [(BL)]**	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*. [Physical Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*. [Occupational Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Smoking cessation counseling services	Covered in full.	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-8]
[Spinal manipulation] [**(BL)**]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-8]
[*Urgent Care* in an urgent care center]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance.]*	[3-9]

FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[Vision care services] [**(PA)]**			
[Routine eye examination]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	[**Care from an optometrist:]**[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[Care from an ophthalmologist:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
Day Surgery			
Day Surgery	[*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. **All other *Day Surgery* services:** [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.]	[3-9]
***Inpatient* Care**			
Extended care services **(PA) [*]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*] [(BL)]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and] *Coinsurance*.] [**Anesthesia:** [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*. **All other hospital services:** [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*.]	[3-10]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Inpatient* Care,** continued			
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-11]
Maternity Care			
Outpatient **Note:** Routine laboratory tests associated with matnerity care are covered in full at the *In-Network Level of Benefits*, in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [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.]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-11]
Inpatient	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-12]

[(PA)– *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**			
***[*To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.]**			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*]** [Individual session –] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [Group session – [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)]] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*]** [Individual session -] [*In-Network Deductible* and then] [[$0-$60 Office Visit *Copayment* per visit] [Covered in full.] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60 Office Visit *Copayment* per visit] [Covered in full.] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-12]
Inpatient services **(PA) [*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-13]
Intermediate care **[(PA)]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-13]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.]**			
Outpatient services [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	Substance Abuse Treatment Services: [Individual session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*].[(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)].	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-13]
Inpatient services **(PA)[*]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.]**			
Community Residential care **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
Other Health Services			
Ambulance services **(PA)[*]**			
Ground ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Out-of-Network Deductible* and then] [Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-14]
All other covered ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-14]
[Diabetic monitoring strips]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of--Network Deductible* and] *Coinsurance*.]	[3-14]
Durable Medical Equipment **[(PA)]**	[*In-Network Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.	[*Out-of--Network Deductible* and] [10%-50%] *Coinsurance*.	[3-15]
Hearing Aids **[(PA)] (BL)**	[*In-Network Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Out-of-Network Deductible* and] [[10%-50%] *Coinsurance.*] [Covered in full.]	[3-16]
Home health care **[(PA)] [*] (BL)**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of--Network Deductible* and] *Coinsurance*.	[3-17]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services			
[Hospice care services **[(PA)] [*] [(BL)]]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of--Network Deductible* and] [*Coinsurance]*.	[3-17]
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of--Network Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of--Network Deductible* and] *Coinsurance*.	[3-18]
New cancer therapies **[(PA)]**	***Outpatient***: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of--Network Deductible* and] *Coinsurance*.	[3-18]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Out-of--Network Deductible* and]*Coinsurance*.]	[3-18]
[Prescription infant formulas"	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan.* Please see "How to file a Claim" in Chaper 6 for more information.]		[3-18]
[Private duty nursing] **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance.*	[3-18]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of--Network Deductible* and] *Coinsurance*.	[3-18]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%]*Coinsurance*]	[Covered in full.] [*Out-of--Network Deductible* and] [*Coinsurance]*.	[3-19]
Nonprescription enteral formulas **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Out-of--Network Deductible* and] *Coinsurance*.]	[3-19]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, this autism spectrum disorders benefit only applies to groups of 51 or more*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

[Mental Health *Outpatient* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling

Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or wigs for cancer or leukemia patients

Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[**Short-term Speech, Physical and Occupational Therapies**

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Spinal Manipulation]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days of Inpatient substance abuse services (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services

Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*], whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

[*COPAYMENTS*]

- **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  - [Emergency room (per Emergency room visit).....[$0-$350]]
  - [In *Provider's* office (per office visit) .....[$0-$60]]

  [Note[s]:
  - [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]
- **[*Urgent Care* (*In-Network* and *Out-of-Network Level of Benefits*):]**
  - [*In-Network Level of Benefits* [*In-Network Deductible* and then] [*Copayment,* which varies depending on location in which service is rendered (for example, *Emergency* room, urgent care center, or physician's office.]
  - [*Out-of-Network Level of Benefits* [*Copayment,* which varies depending on location in which service is rendered (for example, *Emergency* room, urgent care center, or physician's office)] [then,] [*Out-of-Network Deductible* and] *Coinsurance.]*
- **[Other] *Covered Services* (*In-Network Level of Benefits* only):**
  - [Office Visit (per visit).....[$0-$60]]

    [Applies to *In-Network Office* Visits for: diagnostic cytological exams (Pap Smears), and ; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum)*; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.]

    *Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.
  - [*Inpatient* Services (per admission).....[$0-$1,500]]
  - [*Day Surgery* (per admission) .....[$0-$1,500]]

  [Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*] [*Coinsurance*] [or] [a *Deductible*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview" chart for more information.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(In-Network Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] [[0-4] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most Copayments] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000]] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(In-Network)]

[**Individual *Deductible*** .....[$0-$5,000]
An Individual *Deductible* of [$0-$5,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services* received at the *In-Network Level of Benefits.*]

[**Family *Deductible***..... [$0-$25,000]
A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services* received at the *In-Network Level of Benefits.*]
*[*All amounts any enrolled *Members* in a family pay toward their Individual *Deductibles* are applied toward the Family *Deductible.]*
[The Family Deductible is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*
[Once the Family *Deductible* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] [*Contract Year] .]*

[Important Information About Your In-Network *Deductible*:

- The following are not subject to the In-Network *Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amount*].]
  - [In-Network Office Visits for: preventive care[*]; routine cytological exams (Pap Smears), preventive immunizations, and routine mammograms; screening for colon and colorectal cancer; routine prostate and colorectal exams; [mental health and substance abuse;] routine ob/gyn exam; routine eye exam; other vision care[from an optometrist]; family planning services; *Outpatient* maternity care (pre-natal and post-partum)[**]; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] early intervention services for a *Dependent Child*, nutritional counseling; and health education.]
    [*Including diagnostic tests associated with preventive health care as described in Chapter 3.]
    [**This does not include diagnostic tests such as ultrasounds.]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology];]
  - [Laboratory tests;]
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *In-Network Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance* [(for *Durable Medical Equipment* only)] .**]**

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network*)]

[**Individual *Deductible*** .....[$0-$5,000]

An Individual *Deductible* of [$0-$5,000] per [calendar year] [*Contract Year]* applies to each *Member* for *Covered Services* received at the *Out-of-Network Level of Benefits.*]

[**Family *Deductible***..... [$0-$25,000]

A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services* received at the *Out-of-Network Level of Benefits.*]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*

*[*Once the Family *Deductible* has been met during a [calendar year] *[Contract Year],* all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year]* . Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible.]*

[Important Information About Your *Out-of-Network Deductible*:

- The following are not subject to the *Out-of-Network Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology];]
  - [Laboratory tests;]
  - Any amounts you pay for early intervention services for a *Dependent Child*,
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *In-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *Out-of-Network Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - *Coinsurance*.**]**

[*OUT-OF-POCKET MAXIMUM*] [(In-Network)]

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000]

An Individual *Out-of-Pocket Maximum* of [$0-$10,000] applies to each *Member* per [calendar year] *[Contract Year]* for *Covered Services* received at the *In-Network Level of Benefits.*]

[**Family *Out-of-Pocket Maximum*** ..... [$0-$50,000]

A Family *Out-of-Pocket Maximum* of [$0-$50,000] applies per [calendar year] *[Contract Year]* for all enrolled *Members* of a family for *Covered Services* received at the *In-Network Level of Benefits.*]

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

*[*The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[Important Information About Your *In-Network Out-of-Pocket Maximum*:

- Once you've satisfied your *In-Network Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - *In-Network* Individual/Family *Deductibles*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
- The following cannot be used to meet the In-Network *Out-of-Pocket Maximum*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [*Copayments* for *In-Network* Office Visits [that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*. **]**

[*OUT-OF-POCKET MAXIMUM] [(Out-of-Network*)]

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000] per [calendar year] [*Contract Year*]]

[Family *Out-of-Pocket Maximum*..... [$0-$50,000] per [calendar year] [*Contract Year*]]

[This Family *Out-of-Pocket Maximum* applies for all enrolled *Members* of a family.]

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

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

[Important Information About Your *Out-of-Network Out-of-Pocket Maximum*:

- Once you've satisfied your *Out-of-Network Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - *Out-of-Network* Individual/Family *Deductibles*.
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
- The following cannot be used to meet the *Out-of-Network Out-of-Pocket Maximum*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *In-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
  - At the *Out-of-Network Level of Benefits,* any amount you pay for costs above the *Reasonable Charge*.**]**

]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

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).

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [*Observation* services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*] [(not subject to *Deductible*)]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*] [(not subject to *Deductible*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]			

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care**			
[Acupuncture] **[(PA)] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
Allergy injections **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.] [For services provided by any other non-*Network Provider*:] [*Out-of-Network Deductible* and] *Coinsurance.*	[3-2]
Allergy testing **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.] [For services provided by any other non-*Network Provider*:] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
[Autism spectrum disorder – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*In-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*In-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-2]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[Cardiac rehabilitation **[(PA)] [(BL)]]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] [*Coinsurance]*.	[3-2]
Chemotherapy	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care See "Spinal manipulation"]			
[Chiropractic medicine] **[(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance.]*	[3-2]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Diabetes services and supplies	[Diabetic test strips: [[*In-Network Deductible* and then] [$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes self-management education: [[*In-Network Deductible* and then] [$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes supplies covered as *Durable Medical Equipment*: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] Diabetes supplies covered as medical supplies: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-3]
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(PA)] [*]**	**General imaging:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment*] [Covered in full] [*Coinsurance*][(not subject to *Deductible*)] [**MRI/MRA:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*][(not subject to *Deductible*)] **CT/CTA:** [*In-Network Deductible* and then] [[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] **PET:** [*In-Network Deductible* and then][[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [**Nuclear cardiology:** [*In-Network Deductible* and then] [[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible)]*] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*[(not subject to *Deductible*)].	[3-3]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Early intervention services for a *Dependent Child* **[(PA)]**	Covered in full.	Covered in full.	[3-3]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Family planning (procedures, services[, and contraceptives]) **[(PA)]** *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w)(3)(A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.*]*	**Office visit**: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] [(Family planning services [and contraceptives] not subject to *In-Network Deductible*)] ***Day Surgery*:** [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
[House calls to diagnose and treat illness or injury]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] [*Coinsurance*]	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing [**(PA)**]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Out-of-Network Deductible* and] *Coinsurance.*	[3-4]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Immunizations	**Routine preventive immunizations:** Covered in full **All other immunizations:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Infertility services **(PA)[*] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are [covered in full] [subject to *Coinsurance*].]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** In accordance with the ACA, laboratory tests performed as part of routine preventive care are covered in full at the *In-Network Level of Benefits*.	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	[*Out-of-Network Deductible* and] [0-20%] *Coinsurance*.	[3-5]
Lyme disease	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[For services provided by an allergist or dermatologist:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.] [For services provided by any other non-*Network Provider*:] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Nutritional counseling **[(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]
Office visits to diagnose and treat illness or injury	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA)[*]**	***Emergency* care in an Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] ***Emergency* care in a *Provider's* office:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] **Office visit**: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] ***Day Surgery***: [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	***Emergency* care in an Emergency Room:** [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*In-Network Coinsurance*] ***Emergency* care in a *Provider's* office: [** [$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] **All other services:** [*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Outpatient surgery in a *Provider's* office **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-7]
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-8]

[**(PA)** –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Preventive care for *Members* age 19 and under Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)] All other preventive care services: Covered in full]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members*-age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	Covered in full	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Out-of-Network Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Out-of-Network Deductible* and] *Coinsurance*. Routine mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Preventive Screenings and Diagnostic Procedures & Exams, continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Radiation therapy	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
[Short term] speech,, physical and occupational therapy services **[(PA)] [*] [(BL)]**	[Speech Therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical Therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational Therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*. [Physical Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*. [Occupational Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
[Spinal manipulation] [**(BL)**]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
[*Urgent Care* in an urgent care center]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance.]*	[3-9]
[Vision care services] **[(PA)]**			
[Routine eye examination]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	**[Care from an optometrist:]**[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[Care from an ophthalmologist:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
Day Surgery			
Day Surgery	[*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. **All other *Day Surgery* services**: [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.]	[3-9]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Inpatient* Care**			
Extended care services **(PA)[*]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA)[*] [(BL)]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and]*Coinsurance*.] [**Anesthesia**: [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*. **All other hospital services:** [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*.]	[3-10]
Reconstructive surgery and procedures and mastectomy surgeries **(PA)[*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-11]
Maternity Care			
Outpatient **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [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.]	[*Out-of-Network Deductible* and]*Coinsurance*.	[3-11]
Inpatient	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-12]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Mental Disorder Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)			
[**To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.]**			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]***	**[Visits 1-30 in a [calendar year] [*Contract Year*]** [Individual session –] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [Group session – [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*]** [Individual session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] per visit] [Covered in full.] [[0%-50%]*Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60] *Copayment* per visit] [Covered in full] [[0%-50%] *Coinsurance*] [(not subject to *Deductible)*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-12]
Inpatient services **(PA)[*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-13]
Intermediate care **[AR)]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and]*Coinsurance*.	[3-13]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[(PA)* – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.**]**

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.**]**

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.]**			
Outpatient services [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	Substance Abuse Treatment Services: [Individual session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)].	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-13]
Inpatient services **(PA)[*]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate), continued**			
Community Residential care **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
Other Health Services			
Ambulance services **(PA)[*]**			
Ground ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Out-of--Network Deductible* and then] [Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-14]
All other covered ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-14]
[Diabetic monitoring strips]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[Out-*of-Network Deductible* and] *Coinsurance*.]	[3-14]
Durable Medical Equipment **(PA)[*]**	[*In-Network Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.	[*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.	[3-15]
Hearing Aids[**[(PA)] (BL)**	[*In-Network Deductible* and then] [Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Out-of-Network Deductible* and] [[10%-50%] *Coinsurance*.] [Covered in full.]	[3-16]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
Home health care **[(PA)] [*] (BL)**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-17]
[Hospice care services **[(PA)] [*] [(BL)]]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] [*Coinsurance]*.	[3-17]
[Injectable, infused or inhaled Medications] **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and]*Coinsurance*.	[3-18]
New cancer therapies **[(PA)]**	***Outpatient***: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of--Network Deductible* and] *Coinsurance*.	[3-18]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-18]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan.* Please see "How to File a Claim" in Chapter 6 for more information.]		[3-18]
[Private duty nursing **[(PA)]**]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance.]*	[3-18]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-18]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%]*Coinsurance*]	[Covered in full.] [*Out-of-Network Deductible* and] [*Coinsurance]*.	[3-19]
Nonprescription enteral formulas **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Out-of-Network Deductible* and] [*Coinsurance*.]	[3-19]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]
[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, this autism spectrum disorder benefit only applies to groups of 51 or more.*

[Cardiac Rehabilitation Services]
[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids
Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

[Mental Health *Outpatient* Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30 -unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling
Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[Short-Term Speech, Physical and Occupational Therapy Services]
[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Spinal Manipulation]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days for *Community Residence* services (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services

Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*] , whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]** **[Important Note**: For *Outpatient* care, when you receive services from a *Primary Care Provider* (*"PCP"*), we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less). The *Member* pays the remaining [0%-35%].] For *Inpatient* care or *Day Surgery*, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* received at a *Community Hospital*. See Appendix A for definitions of these facilities. For more information, please see "*Covered Services*" in Chapter 3.]
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10% -50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*. [*Important Note: *Covered Services* that are listed as "covered in full" or are subject to an Office Visit *Copayment* at the *In-Network Level of Benefits* in this Benefit Overview are covered at [50%-90%] of the *Reasonable Charge* when provided by a *Non-Network Provider*. The *Member* pays the remaining [10% -50%] and is also responsible for any charges in excess of the *Reasonable Charge*.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*COPAYMENTS*]

- **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):**
  - [Emergency room (per Emergency room visit).....[$0-$350]]
  - [In *Provider's* office (per office visit) ..... [$0-$60] [*Copayment* for care received from a *PCP.*
  - [$0-$75] *Copayment* for care received from any other *Provider*].]

  [Note[s]:
  - [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]
- **[*Urgent Care* (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  - [*In-Network Level of Benefits* [*Copayment* varies depending on type of *Provider* (*PCP* or specialist) and location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office).]]
  - [*Out-of-Network Level of Benefits* [*Copayment* varies depending on type of *Provider* (*PCP* or specialist) and location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office). *Copayment*] [then,] [*Deductible* and] *Coinsurance*.]
- **Other *Covered Services* (*In-Network Level of Benefits* only):**

  [Office Visit (per visit) .....[$0-$60]]

  [Applies to *In-Network Office* Visits for:, diagnostic cytological exams (Pap Smears), and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum); diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.]

  *Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.
  - [*Inpatient* Services (per admission).....[$0-$1,500]]
  - [*Day Surgery* (per admission) .....[$0-$1,500]]

] [
  - [Lower Office Visit *Copayment*..... [[$0 - $60] *Copayment* per visit.] [Covered in full.]

    [Note: This *Copayment* applies to covered *Outpatient* care provided by a *PCP*, as well as for *Outpatient* [physical, occupational, or speech therapy services,] [spinal manipulation,] [chiropractic medicine,] [mental health and substance abuse services;] [cardiac rehabilitation services,] [, and] [routine eye care.]]
  - Higher Office Visit *Copayment*..... [[$0 - $75] *Copayment* per visit.] [Covered in full.]

    [Note: This *Copayment* applies to all covered *Outpatient* care subject to an Office Visit *Copayment,* except for care obtained from the *Providers* or for the services listed above under Lower Office Visit *Copayment*.]
  - *Inpatient* Services at a *Community Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]
  - *Inpatient* Services at a *Tertiary Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]
  - *Day Surgery* at a *Community Hospital*..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]
  - *Day Surgery* at a *Tertiary Hospital*..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] **]**

  [Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*] [or] [*Coinsurance*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview" chart for more information.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most *Copayments*] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network* Services Only)]

[*Deductible* (Individual)]

[This *Certificate of Insurance* has an Individual *Deductible* of [$0-$5,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits,* other than early intervention services for a *Dependent Child*.

[*Deductible* (Family)]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible*.]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when one enrolled *Member* in a family meets his or her [$0-$5,000] Individual *Deductible*; and one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Deductible* are applied toward the [$0-$25,000] Family *Deductible*.]

[Once the Family *Deductible* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] [*Contract Year*]. Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.]

[*OUT-OF-POCKET MAXIMUM*] [(*Out-of-Network* Services Only)]

[*Out-of-Pocket Maximum* (Individual)]

[This *Certificate of Insurance* has an individual *Out-of-Pocket Maximum* of [$0-$10,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits*. [Only [the *Deductible* and] *Coinsurance* count toward the *Out-of-Pocket Maximum*.]]

[*Out-of-Pocket Maximum* (Family)]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum*.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when:

- one enrolled *Member* in a family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the [$0-$50,000] Family *Out-of-Pocket Maximum*.]

[Once the Family *Out-of-Pocket Maximum* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their [$0-$10,000] Individual *Out-of-Pocket Maximums* for the remainder of that [calendar year] [*Contract Year*].]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided By a *PCP*]	**[Care Provided by Any Other *Network Provider*]**		
	Coverage		**Coverage**	
***Emergency* Care**				
Treatment in an Emergency room	[[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*]		[$0-$350] Emergency Room *Copayment*[*] [Covered in full] [*In-Network Coinsurance*]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [*Observation* services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]			
Treatment in a *Provider's* office	[Care provided by a *PCP*:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*] [Care from any other *Network Provider*: [[$0-$75] Office Visit *Copayment*.] [Covered in full.] [*Coinsurance*]] [(waived if admitted as an *Inpatient* or for *Day Surgery)*]		[[$0-$75] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery)*]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]				

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

***Outpatient* Care**				
COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided By Your *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**	**Coverage**	
[Acupuncture] **[(PA)] [(BL)]**	[[$0-$60] *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*.]	[[$0-$75] *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*.]	[*Deductible* and] [*Coinsurance*.]	[3-2]
Allergy injections **[(PA)]**	[[$0-$60]*Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$75] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance.]* [For services provided by any other non-*Network Provider*:] [*Deductible* and] *Coinsurance*.	[3-2]
Allergy testing **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[For services provided by an allergist or dermatologist:] [[$0-$75] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance.]* [For services provided by any other non-*Network Provider*:] [*Deductible* and] *Coinsurance*.	[3-2]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[*Deductible* and] [*Coinsurance*.]	[3-2]
[Cardiac rehabilitation **[(PA)]]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-2]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Chemotherapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care -- See "Spinal manipulation"]				
[Chiropractic medicine] **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance.*	[3-2]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Diabetes services and supplies	[Diabetic test strips: [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes self-management education: [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes supplies covered as *Durable Medical Equipment*: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[Diabetic test strips: [[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes self-management education: [[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes supplies covered as *Durable Medical Equipment*: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[Diabetic test strips: [*Deductible* and] *Coinsurance*. Diabetes self-management education: [*Deductible* and] *Coinsurance*. Diabetes supplies covered as *Durable Medical Equipment*: [*Deductible* and] *Coinsurance*. Diabetes supplies covered as medical supplies: [*Deductible* and] *Coinsurance*. [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[3-3]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(PA)] [*]**	**General imaging:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [[$0-$250] Office Visit Copayment] [Covered in full] [[0%-20%]*Coinsurance*] [**MRI/MRA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*] **CT/CTA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] **PET:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] [**Nuclear cardiology:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [0%-20%] *Coinsurance*.]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	**General imaging:** [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [[$0-$250] Office Visit Copayment] [Covered in full] [[0%-20%]*Coinsurance*] [**MRI/MRA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*] **CT/CTA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] **PET:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] [**Nuclear cardiology:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [0%-20%] *Coinsurance*.]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Deductible* and] [[10-50%]] *Coinsurance*.	[3-3]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Early intervention services for a *Dependent Child*	Covered in full.	Covered in full.	Covered in full.	[3-3]

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

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Family planning **[(PA)]** (procedures, services[, and contraceptives]) ***[FILING NOTE* TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: *: Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.*]*	**Office Visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Day Surgery*:** [[$0-$1,500] *Day Surgery Copayment* [*] per *Day Surgery* admission to a *Community Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* [and] [*Day Surgery*] *Copayment* Maximum)]	**Office Visit**: [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Day Surgery*:** [[$0-$1,500] *Day Surgery Copayment* [*] per *Day Surgery* admission to a *Tertiary Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
[House calls to diagnose and treat illness or injury]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Cionsurance*]	[[$0-$75] Office Visit *Copayment*] [then,] [*Deductible* and] [*Coinsurance*].	[3-4]

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

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Human leukocyte antigen testing or histocompatibility locus antigen testing **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Immunizations	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Infertility services **(PA)[*] [(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are covered in full] [subject to *Coinsurance*}.	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are covered in full] [subject to *Coinsurance*}.	[*Deductible* and] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** In accordance with the ACA, laboratory tests performed as part of routine preventive care are covered in full at the *In-Network Level of Benefits.*	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	*[Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	Covered in full	[*Deductible* and] *Coinsurance*.	[3-5]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Lyme disease	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[For services provided by an allergist or dermatologist:] [[$0-$75] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance.]* [For services provided by any other non-*Network Provider*:]*Deductible* and] *Coinsurance*.	[3-6]
Nutritional counseling **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[[$0-$75] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.]	[3-7]
Office visits to diagnose and treat illness or injury	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-6]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Oral health services **(PA)[*]**	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] **Office visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [*] ***Day Surgery***: [[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Community Hospital* [Covered in full] [[0%-20%] *Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] **Office visit**: [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [*] ***Day Surgery***: [[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Community Hospital* [Covered in full] [[0%-20%] *Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**Emergency Room:** [[$0-$350] Emergency Room *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Emergency* care in a *Provider's* office:** [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20% *Coinsurance*] **All other services:** [*Deductible* and] *Coinsurance*.	[3-6]
	[*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.]			
Outpatient surgery in a *Provider's* office **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-7]

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

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***	**PAGE**
	Coverage	**Coverage**	
***Outpatient* Care,** continued			
[Pediatric dental for *Members* under age 12] **[(PA)]**	Covered in full	[[*Deductible* and] *Coinsurance*.]	[3-7]

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Preventive care for *Members* age 19 and under **Note:** Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	Covered in full	Covered in full	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members* age 20 and over **Note:** Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] All other preventive care services: Covered in full]	[Covered in full] [Hearing screenings: [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] All other preventive care services: Covered in full]	[*Deductible* and] *Coinsurance*.	[3-8]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Preventive Screenings and Diagnostic Procedures & Exams				
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Out-of-Network Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Out-of-Network Deductible* and] *Coinsurance*. Routine mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Preventive Screenings and Diagnostic Procedures & Exams - continued				
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and procto-sigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Radiation therapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]
[Short term] speech, physical and occupational therapy services **[(PA)] [*] (BL)**	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [Physical therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [Occupational therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[Speech therapy:] [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance]* [Physical therapy:] [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance]* [Occupational therapy:] [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[Speech therapy:] [*Deductible* and] *Coinsurance*. [Physical therapy:] [*Deductible* and] *Coinsurance*. [Occupational therapy:] [*Deductible* and] *Coinsurance*.	[3-8]
Smoking cessation counseling services	Covered in full.	Covered in full.	[*Deductible* and] *Coinsurance*.	[3-8]
[Spinal manipulation] [**(BL)**]	[[$0-$60] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-8]
[*Urgent Care* in an urgent care center]	[[$0-$60] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*.]	[[$0-$75] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*.]	[[[$0-$75] *Copayment*] [then,] [*Deductible* and] *Coinsurance*.]	[3-9]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
[Vision care services] **[(PA)]**				
[Routine eye examination]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]
Day Surgery				
Day Surgery	[[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Community Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Tertiary Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Deductible* and] [10%-40%] *Coinsurance*. **All other *Day Surgery* services**: [*Deductible* and] [10-40% *Coinsurance*].]	[3-9]
	[*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.]			

***Inpatient* Care**			
COVERED SERVICE	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***	**PAGE**
	Coverage	**Coverage**	
Extended care services **(PA)[*]** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-9]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided at a Community Hospital]	**[Care Provided at a Tertiary Hospital]**		
	Coverage	**Coverage**		
***Inpatient* Care, continued**				
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*] [(BL)]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] **[Anesthesia**: [*Deductible* and] [10-40%] *Coinsurance*. **All other hospital services**: [*Deductible* and] [10%-40%] *Coinsurance*.]	[3-10]
Reconstructive surgery and procedures and mastectomy surgeries **(PA)[*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-11]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Maternity Care				
Outpatient **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [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.]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [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.]	[*Deductible* and] *Coinsurance*.	[3-11]

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided at a Community Hospital]	**[Care Provided at a Tertiary Hospital]**		
	Coverage	**Coverage**		
Maternity Care				
Inpatient	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-12]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient* and Intermediate)**			
[To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.]			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*]** [Individual session –] [[$0-$75] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [Group session – [[$0-$75] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*]** [Individual session -] [[$0-$75 Office Visit *Copayment* per visit] [Covered in full.] [[0%-50%] *Coinsurance*].] [Group session -] [[$0-$75] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-50%] *Coinsurance*.]	*Deductible* and *Coinsurance*.	[3-12]
Inpatient services **(PA)[*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-13]
Intermediate care **[(PA)]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-13]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	*Out-of-Network Level of Benefits*	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[To contact the *Tufts Health Plan* Mental Health Department, call 1-800-208-9565.]			
Outpatient services [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	Substance Abuse Treatment Services: [Individual session -] [[$0-$75] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]. [Group session -] [[$0-$75] Office Visit *Copayment*] [Covered in full] [*Coinsurance*].	[*Deductible* and] *Coinsurance*.	[3-13]
Inpatient services **(PA)** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	*Out-of-Network Level of Benefits*	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate), continued**			
Community Residential care **(PA) [(BL)]** ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Other Health Services			
Ambulance services **(PA)[*]**			
Ground ambulance services	[Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-14]
All other covered ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-14]
[Diabetic monitoring strips]	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-14]
Durable Medical Equipment **(PA)[*]**	[Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] *Coinsurance*.	[3-15]
Hearing Aids **(PA) (BL)**	[Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] [*Coinsurance*.] [Covered in full.]	[3-16]
Home health care **[(PA)] [*] (BL)**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-17]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
[Hospice care services **[(PA)] [*] [(BL)]]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-17]
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
New cancer therapies **[(PA)]**	***Outpatient***: [Annual *Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.	[3-18]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Deductible* and] *Coinsurance*.]	[3-18]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan*. Please see "How to File a Claim" in Chapter 6 for more information.]		[3-18]
[Private duty nursing **[(PA)]]**	[[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*.]]	[[*Deductible* and] *Coinsurance*.]	[3-18]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
[Special medical formulas]			
[Low protein foods **[(PA)] [*]**	[[$0-$75] *Copayment* per 30-day supply] [Covered in full] [[0%-50%]*Coinsurance*]	[Covered in full.] [*Deductible* and] [*Coinsurance*.]	[3-19]
[Nonprescription enteral formulas **[(PA)] [*]]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Deductible* and] *Coinsurance*.]	[3-19]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[(PA) –*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*. See page 3-1 for more information.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*]. See page 3-1 for more information.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Law 27.18-71, this autism spectrum disorder benefit only applies to groups of 51 or more*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

Home health care

Coverage is limited to (*In-Network* and *Out-of-Network Levels* combined):

- [6-unlimited] home visits or office visits with a physician per month;
- [3-unlimited] nursing visits per week; and
- home health aide visits of [20-unlimited] hours per week.

Infertility Services

Coverage is limited to [$100,000-unlimited] per *Member* per lifetime **(***In-Network* and *Out-of-Network Levels* combined).

[Mental Health *Outpatient* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling

Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients

Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Short-Term Speech, Physical and Occupational Therapy Services]

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[Spinal Manipulation]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days *for Community Residence services* (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services

Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per calendar year, whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Chapter 1

How Your Preferred Provider Plan Works

Eligibility for Benefits

You can obtain health care services from either a *Network Provider* (*In-Network Level of Benefits*); or a *Non-Network Provider* (*Out-of-Network Level of Benefits*). Your choice will determine the level of benefits you receive for your health care services. We cover only the services and supplies described as *Covered Services* in Chapter 3.

Important Note[s]:

- There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.
- [You may be a *Member* living outside of Rhode Island. If so, your coverage may also include benefits required by the laws of your state. For more information, call Member Services.]

In-Network Level of Benefits

You may receive care from a *Network Provider.* If so, you are covered at the *In-Network Level of Benefits*.

You pay [*Coinsurance*] [a *Copayment*] for certain *Covered Services* you receive at the *In-Network Level of Benefits*. For more information about your *Member* costs for medical services, see "Benefit Overview".

[**IMPORTANT NOTE – [*COPAYMENTS*] [*COINSURANCE*] AT THE *IN-NETWORK LEVEL OF BENEFITS*:**

***Outpatient* care**: You may receive *Outpatient* services from a *PCP.* If so, your [Office Visit *Copayment*] [*Coinsurance*] may be lower than for services from other *Providers*. The lower *Copayment* also applies to: physical, occupational, or speech therapy services; spinal manipulation; and routine eye care.]

[*Inpatient* care [or *Day Surgery*]: You may receive *Inpatient* care [or *Day Surgery*] at a *Community Hospital.* If so, your [*Copayment]* [*Coinsurance*] may be lower than when you receive care at a *Tertiary Hospital*.]

For more information, please see "*Covered Services*" in Chapter 3.]

When a *Network Provider* provides your care, you do not have to submit any claim forms. The *Network Provider* will submit the claim forms to us for you.

In-Network Level of Benefits, continued

Selecting a *Provider*

In order to receive coverage at the *In-Network Level of Benefits*, you must receive care from a *Network Provider*. *Network Providers* are listed in the *Directory of Health Care Providers*. Choose a *Provider* who is in a location near to you.

Note:
[Under certain circumstances required by law, if your *Provider* is not in the *Tufts Health Plan* network, you will be covered for a short period of time for services provided by your *Provider*. A Member Specialist can give you more information. Please see "Continuity of Care" later in this chapter.]

No *Preregistration* by You

When your *Inpatient* procedure is provided by a *Network Provider*, you do not have to the procedure. Your *Network Provider* will *Preregister* the procedure for you.

Canceling Appointments

If you have to cancel an appointment with any *Network Provider*, give him or her at least 24 hours notice. The *Network Provider* may charge you for missed appointments not canceled in advance. If so, you will have to pay the charges. We will not pay for missed appointments that you did not cancel in advance.

Changes to *Provider* network

We offer *Members* access to an extensive network of physicians, hospitals, and other *Providers.* They are located throughout the *Network Contracting Area*. *Network Providers* may change during the year.

This can happen for many reasons. Examples include: a *Provider's* retirement; moving out of the *Network Contracting Area*; or failure to continue to meet credentialing standards. Also, note that *Providers* are independent contractors. They may leave the network if they do not reach agreement on a network contract.

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

Out-of-Network Level of Benefits

Out-of-Network Level of Benefits

You may get care from a *Non-Network Provider.* If so, your coverage will be at the *Out-of-Network Level of Benefits*. [[A *Deductible*] [An *Out-of-Network Deductible*] and *Coinsurance* may apply for this care.] For more information, see "Benefit Overview".

You must submit a claim form for care received from a *Non-Network Provider*. For more information, see Chapter 6.

Covered Services Not Available from a *Network Provider*

Some *Covered Services* may not be available from a *Network Provider.* If so, with our approval, you may go to a *Non-Network Provider* and receive these services *Covered Services* at the *In-Network Level of Benefits* up to the *Reasonable Charge*.

Out-of-Network Level of Benefits, continued

[*Covered Services* Outside of the 50 United States

Emergency care services you receive outside of the 50 United States are *Covered Services*. *Urgent Care* services you receive while traveling outside of the 50 United States also qualify as *Covered Services*. However, any other service, supply, or medication you receive outside of the 50 United States is not covered under this plan.]

[Continuity of Care

If you are an existing *Member*

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

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

If you are enrolling as a new *Member*

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

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* for up to 30 days from your *Effective Date*;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* through your first postpartum visit; or
- you are terminally ill. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *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 us.**]**

Inpatient Mental Health and Substance Abuse Services

In-Network Level of Benefits: You may need *Inpatient* or intermediate mental health or substance abuse services. If you wish be covered for these services at the *In-Network Level of Benefits*, you must receive them from a *Inpatient* or intermediate mental health or substance abuse services must be provided by a *Network Provider*. [These services are covered at [*Copayment*] {*Coinsurance*] Level 1.] There is no need to contact us first. Simply call or go directly to any *Network Provider*. Identify yourself as a *Tufts Health Plan Member*. The *Network Provider i*s responsible for providing all *Inpatient/*intermediate mental health and substance abuse services. [You are not responsible for *Preregistering* your admission at a *Network Provider*.]

Out-of-Network Level of Benefits: You may want to receive *Inpatient* mental health or *Inpatient* substance abuse services from a *Non-Network Provider.* If so, your coverage will be at the *Out-of-Network Level of Benefits*. [You will pay [a *Deductible* and] *Coinsurance.*]*Prior authorization* is recommended for *Inpatient* [or intermediate] mental health or substance abuse services at the *Out-of-Network Level of Benefits*. This will let you know in advance whether these services will be covered. Please call [the *Tufts Health Plan* Mental Health Department at 1-800-208-9565] for more information.

Emergency Admission to a Non-*Network Provider*

In an *Emergency,* you may be admitted to a Non-*Network Provider.* In this case, you will be covered at the *In-Network Level of Benefits.* Once it is determined that transfer to a *Network Provider* is medically appropriate, you will be transferred to a *Network Provider*. If you want to remain at the [Non-*Network Provider* and refuse to be transferred, then you will be covered at the *Out-of-Network Level of Benefits*.]

Emergency Care

To Receive *Emergency* care

If you have an *Emergency*, seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. 911 services may not be available in your area. In this event, call the local number for emergency medical services.

Outpatient Emergency care

You may receive *Emergency* services and not be admitted as an *Inpatient*. If this happens, you will be covered at the *In-Network Level of Benefits*. You will pay a [*Copayment*][*Cost Sharing Amount*] for each Emergency room visit.

You may receive *Emergency Covered Services* from a *Non-Network Provider.* If this happens, *Tufts Health Plan* will pay up to the *Reasonable Charge*. You pay [the applicable *Copayment.*] [the *Cost Sharing Amount*.]]

Emergency Care, continued

Inpatient Emergency care

You may receive *Emergency* services and be admitted as an *Inpatient.* If this happens, you or someone acting for you should notify us as soon as possible. If you are admitted as an *Inpatient* to a hospital that is a *Non-Network Provider* after receiving *Emergency* care, an *Inpatient Copayment* will apply.

Financial Arrangements between *Tufts Health Plan* and *Network Providers*

Methods of payment to *Network Providers*

Our goal in paying *Providers* is to encourage preventive care and active illness management. We strive to be sure that our financial reimbursement system: (1) encourages appropriate access to care; and (2) rewards *Providers* for providing high quality care to our *Members*. We use a variety of mutually agreed upon methods to compensate *Network Providers* [with whom we contract].

The *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 that can be both harmful and costly to *Members*.

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

Member Identification Card

Introduction

We give each *Member* a member identification card (Member ID card).

Reporting errors

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

Identifying yourself as a *Tufts Health Plan Member*

Your Member ID card is important; it identifies you as a *Tufts Health Plan Member*. Please: (1) carry your Member ID card at all times; (2) have your Member ID card with you for medical, hospital and other appointments; and (3) show your card to any *Provider* before you receive health care services. When you receive services, tell the staff that you are a *Tufts Health Plan Member*.

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, call a Member Specialist.

Utilization Management

Utilization management

The purpose of the utilization management program is to control health care costs. It does this by evaluating whether health care services provided to *Members* are: (1) *Medically Necessary*; and (2) provided in the most appropriate and efficient manner. [This program sometimes includes prospective, concurrent, and retrospective review of health care services.]

[We use **prospective review** to determine if proposed treatment is *Medically Necessary* . This review happens before that treatment begins. It is also called "Pre-Service Review".

We use **concurrent review** to: (1) monitor the course of treatment as it occurs; and (2) to determine when that treatment is no longer *Medically Necessary*.

We use **retrospective review** to evaluate care <u>after</u> it is provided. Sometimes, we use retrospective review to more accurately decide if a *Member's* health care services are appropriate. It is also called "Post-Service Review".]

[TIMEFRAMES FOR TUFTS HEALTH PLAN TO REVIEW YOUR COVERAGE REQUEST

Type of Review:	Timeframe for Determinations:[*]
Prospective (Pre-Service) Review.	Urgent: [Within 72 hours of receipt of the request.] [Within 72 hours of receiving all necessary information.] Non-urgent: [Within 15 business days of receipt of the request.] [Within 15 business days of receiving all necessary information.]
Concurrent Review.	[Prior to the end of the current certified period.] [Urgent: Within 24 hours of receipt of the request.]
Retrospective (Post-Service) Review.	[Within 30 days of receipt of the request.] [Within 30 business days of receipt of a request for payment with all supporting information.]

]

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

We may deny your coverage request. If this happens, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal.

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

<u>IMPORTANT NOTE</u>: *Members* can call *Tufts Health Plan* at these 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 - [1-800-682-8059].

Utilization Management, continued

Specialty case management

Some *Members* with Severe Illnesses or Injuries may warrant case management intervention under a specialty case management program. Under this program, we: (1) encourage the use of the most appropriate and cost-effective treatment; and (2) support the *Member's* treatment and progress.

We may contact the *Member* and his or her *Network Provider*. We may do this to discuss a treatment plan and establish short and long term goals. A 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 Network Provider* if we identify alternatives to the *Member's* current treatment plan are identified 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*;
- cancer;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- serious heart or lung disease;
- certain neurological diseases;
- severe traumatic injury.

[Individual case management (ICM)]

[In certain circumstances, we may approve 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 approve coverage for alternative services and supplies that do not otherwise qualify as *Covered Services* for that *Member*. This will occur only if *Tufts Health Plan* determines, in its sole discretion, that all of the following conditions are satisfied:

- the *Member's* condition is expected to require medical treatment for an extended duration;
- the alternative services and supplies are *Medically Necessary*;
- the alternative services and supplies are provided directly to the *Member* with the condition;
- the alternative services and supplies are in place of more expensive treatment that qualifies as *Covered Services*;
- the *Member* and *Tufts Health Plan* or its designee agree to the alternative treatment program; and
- the *Member* continues to show improvement in his or her condition. *Tufts Health Plan* or its designee will determine this periodically.

We may approve an ICM plan. If this happens, 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*.

Tufts Health Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. We may decide, at any time, that these services and supplies fail to satisfy any of the conditions described above. In this event, we may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.]

[*Preregistration*

Preregistration is a process to confirm approval for all *Inpatient* admissions and transfers. A review team will: (1) verify eligibility at that time; and (2) assign an anticipated length-of-stay guideline if the admission is approved. The review team may also review your proposed medical care, verify *Medical Necessity* or recommend an alternative treatment setting.

Preregistration does not guarantee payment. We are not obligated to pay claims that have been *Preregistered* for: (1) persons who are not *Members* on the date of service; (2) who are not eligible for coverage ; (3) who receive care that is determined not to be *Medically Necessary*; or (4) if the claim is not for a *Covered Service*.

If you get care at the *In-Network Level of Benefits,* your *Network Provider* is responsible for *Preregistering* your *Inpatient* admission or transfer. You do not need to *Preregister* the admission or transfer.

Extension of Hospitalization

All *Inpatient* hospitalizations are monitored. It may be *Medically Necessary* for you to stay in the hospital longer than the originally approved length-of-stay. If this happens, *Tufts Health Plan* staff will request additional clinical information from your attending *Provider* or hospital so that we can approve a longer hospital stay, if *Medically Necessary*. Additional *Medically Necessary* hospital days may be authorized.

Note: After consulting your *Provider,* we may determine that *Inpatient* hospitalization is no longer *Medically Necessary*. If this happens, we will notify you that any additional hospital days will not be covered. You will be responsible for paying for all hospital and *Provider* charges if you choose to stay in the hospital beyond the discharge date.

]

Chapter 2

Eligibility, Enrollment, & Continuing Eligibility

Eligibility

Subscribers

[You are eligible to enroll as a *Subscriber* when you are in the class of eligible employees established by the *Group*.]

[You are [eligible as a *Subscriber* only if you are an employee of a *Group*] [a *Subscriber* only if you are eligible to be a *Subscriber* under your *Group*] and you:

- meet your *Group's* and *Tufts Health Plan's* eligibility rules; and
- maintain primary residence in the *Network Contracting Area*; and
- live in the *Network Contracting Area* for at least 9 months in each period of 12 months*.

*Note: The 12-month period begins with the first month you do not live in the *Network Contracting Area*.]

Dependents

[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 *Certificate*; and
- meets your *Group's* and *Tufts Health Plan's* eligibility rules.]

[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 *Certificate*; and
- meets your *Group's* and *Tufts Health Plan's* eligibility rules; and
- maintains primary residence in the *Network Contracting Area**; and
- lives in the *Network Contracting Area* for at least 9 months in each period of 12 months*.

*Notes:

- The 12-month period begins with the first month you do not live in the *Network Contracting Area*.
- In some cases, *Dependents* who live outside of the *Network Contracting Area* can be eligible for coverage under this plan. See "If you live outside of the *Network Contracting Area*" below for more information.
- *Children* are not required to maintain primary residence in the *Network Contracting Area.* However, care outside of the *Network Contracting Area* is only covered at the *Out-of-Network Level of Benefits.*]

If you live outside of the *Network Contracting Area*

If you live outside of the *Network Contracting Area*, you can be covered only if:

- you are a *Child;* or
- you are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced *Spouse* that *Tufts Health Plan* must cover.

Eligibility, continued

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: (1) during the annual *Open Enrollment Period* ; or (2) within 30 days of the date you or your *Dependent* is first eligible for this coverage.

Note: You may fail to enroll for this coverage when first eligible. If this happens, 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
- and you have acquired a *Dependent* through marriage, birth, adoption, or placement for adoption.

In these cases, you or your eligible *Dependent* may enroll 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 within 60 days after either of the following events:

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

Effective Date of coverage

We may accept your application and receive the needed *Premium.* When this happens, coverage starts on the date your *Group* chooses. Enrolled *Dependents'* coverage starts when the *Subscriber's* coverage starts, or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

You or your enrolled *Dependent* may be an *Inpatient* on your *Effective Date.* If so, 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* not currently enrolled in *Tufts Health Plan* only:

- during your *Open Enrollment Period*; or
- within 30 days after any of the following events:
  - a change in your marital status;
  - the birth of a *Child*;
  - the adoption of a *Child* as of the earlier of the date the *Child* is placed with you for the purpose of adoption or the date you file a petition to adopt the *Child*;
  - a court orders you to cover a *Child* through a qualified medical child support order;
  - a *Dependent* loses other health care coverage involuntarily;
  - [a *Dependent* moves into the *Network Contracting Area*;] or
  - if your *Group* has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add *Dependents*

You may have *Family Coverage*. If so, fill out a membership application form listing the *Dependents*. Give this form to your *Group* during your *Open Enrollment Period* . Or, give your *Group* the form within 30 days after the date of an event listed above, under "When *Dependents* may be added".

You may not have *Family Coverage.* In this case, ask your *Group* to change your *Individual Coverage* to *Family Coverage*. Then, follow the above procedure.

Effective Date of *Dependents'* coverage

We may accept your application to add *Dependents.* If so, 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.

Availability of benefits after enrollment

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

Note: We will only pay for *Covered Services* provided on or after your *Effective Date*.

Newborn *Children* and *Adoptive Children*

Importance of enrolling newborn *Children* and *Adoptive Children*

Newborn *Child*: You must notify *Tufts Health Plan* of the birth of a newborn *Child* and pay the required *Premium* within 31 days after the date of birth. Otherwise, that *Child* will not be covered beyond such 31-day period. No coverage is provided for a newborn *Child* who remains hospitalized beyond that 31-day period and has not been enrolled in this plan.

***Adoptive Child*:** You must enroll your *Adoptive Child* within 31 days after the *Child* has been adopted or placed for adoption with you. This is required 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*.

Continuing Eligibility for *Dependents*

When coverage ends
Dependent coverage for a *Child* ends on the *Child's* 26th birthday.

Note: This age limit does not apply to a *Child* who qualifies as a *Disabled Dependent* at any age.

Coverage after termination
When a *Child* loses coverage under this *Certificate,* he or she may be eligible for federal or state continuation. He or she may also be able to enroll in *Individual Coverage*. See Chapter 5 for more information.

Disabled Dependents

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* disability.

Coverage after termination
The former *Disabled Dependent* may be eligible to enroll in *Individual Coverage.* See Chapter 5 for more information.

Rule for former *Spouses* (Also see Chapter 5)
If you and your *Spouse* divorce, your former *Spouse* may continue coverage as a *Dependent* under your *Family Coverage* in accordance with Rhode Island law if the order for continued coverage is included in the judgment when entered.

Note: Coverage for your divorced *Spouse* ends:

- when either you or your divorced *Spouse* remarry;
- until such time as provided by the judgment for divorce; or
- when your divorced *Spouse* becomes eligible for coverage in a comparable plan through his or her own employment.

How to continue coverage for former *Spouses*
To continue coverage for a former *Spouse*, call a Member Specialist within 30 days after the divorce decree is issued. Do this to tell us about your divorce. Send us proof of your divorce when asked.

[*Domestic Partners]*

[You have elected coverage of *Domestic Partners*. In oder to enroll a *Domestic Partner*, the *Subscriber* must provide the *Group*:

- proof of common residence for [[0-12] prior consecutive months]. This proof may include a driver's license, canceled rent check, utility bill, lease, or mortgage; and
- a completed and sign enrollment statement certifying that the relationship between the *Subscriber* and the *Domestic Partner* satisfies the criteria described in Appendix A.]

[A *Subscriber* may have only one *Domestic Partner* at a time. If a *Domestic Partner's* coverage ends, the *Subscriber* may not enroll another *Domestic Partner* until the later of:

- [[0-12] consecutive months] following the termination of the former *Domestic Partner's* coverage; or
- the date that relationship between the *Subscriber* and the new *Domestic Partner* satisfies that criteria.]

[The *Covered Services* available to a *Spouse* are available to a *Domestic Partner.* The *Covered Services* available to a *Child* are available to the child of a *Domestic Partner.]*

Keeping *Tufts Health Plan's* records current

You must notify us of any changes that affect your 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 *Network Contracting Area* or temporarily residing out of the *Network Contracting Area* for more than 90 consecutive days;]
- address changes; and
- changes in an enrolled *Dependent's* status as a *Child* or *Disabled Dependent*.

We have forms to report these changes. The forms are available from your *Group* or Member Services.

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 Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available on our Web site at **www.tuftshealthplan.com.** You can also call Member Services.]
- [obtained within the 50 United States. The only exceptions to this rule are *Emergency* care services or *Urgent Care* services while traveling, which are *Covered Services* when provided outside of the 50 United States; and]
- provided to treat an injury, illness or pregnancy, except for preventive care.

Important Notes:

- A *Covered Service* is one which is described in this chapter. We will only pay claims which are for *Covered Services*.
- *Prior authorization* is recommended for certain *Covered Services*. We will only a cover a service listed in this *Certificate* if we or our designee determine that the care is *Medically Necessary*. For services you receive at the *In-Network Level of Benefits*, your *Network Provider* is responsible for obtaining *prior authorization*. For services you receive from a *Non-Network Provider*, we recommend that you obtain the *prior authorization* by contacting *Tufts Health Plan*. Please contact [Member Services , or, for mental health and substance abuse services] the *Tufts Health Plan* Mental Health Department at 1-800-208-9565 for more information. *Covered Services* for which we suggest *prior authorization* include a "(PA)" notation in the "Benefit Overview" section of this document.

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 services that qualify as *Covered Services*.

Notes:

- For information about your costs for the *Covered Services* listed below (for example, *Copayments*, *Coinsurance*, *Deductibles* [and] [*Out-of-Pocket Maximums*]), see the "Benefit Overview" section earlier in this document.
- Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:
- **Preventive care services** described in the ACA guidelines, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.
- The "Benefit Limits" section earlier in this document lists Information about the day, dollar, and visit limits under this plan. Certain limits are also listed in some *Covered Services* listed below.

***Emergency* Care**

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

[Notes:

- [The Emergency Room [*Copayment*][*Cost Sharing Amount*] is waived if the Emergency room visit results in immediate hospitalization [or *Day Surgery*].]
- You may receive *Emergency Covered Services* from a *Non-Network Provider.* In this case, *Tufts Health Plan* will pay up to the *Reasonable Charge*. [You pay the applicable [*Copayment*][*Cost Sharing Amount*].]
- [You may register in an Emergency room but leave that facility without receiving care. If this happens, an Emergency Room [*Copayment*][*Cost Sharing Amount*] may apply.]
- [You may receive *Day Surgery* services. If this happens, a *Day Surgery Copayment* may apply.] [[The Annual *Deductible* and then] [A [$0-$1,500] *Copayment* per admission] may apply [in addition to *Coinsurance*] if *Day Surgery* services are received.]

***Outpatient* care**

[Acupuncture services]

[Note[s]: [The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family (*In-Network* and *Out-of-Network Levels* combined).] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-50] visits per person. (*In-Network* and *Out-of-Network Levels* combined)] [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Allergy testing

Allergy testing (including antigens) and treatment, and allergy injections. [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Outpatient care - continued

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15
(*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits.* See page 3-1 for more information.)
Coverage is provided, in accordance with Rhode Island law, for the diagnosis and treatment of autism spectrum disorders for *Children* under age 15. 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*:

- applied behavioral analysis services (ABA)*, supervised by a *Board-Certified Behavior Analyst (BCBA)* who is a licensed health care clinician. [These services are covered up to [$32,000-unlimited] per [calendar year] [*Contract Year*].] For more information about these services, call the *Tufts Health Plan* Mental Health Department at 1-800-208-9565.
- Therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, or physical therapists), covered under your "[Short-term] speech, physical and occupational therapy services" benefit, described later in this chapter.

*For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modification, using behavioral stimuli and consequences, to product socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, this autism spectrum disorder benefit only applies to groups of 51 or more.*

Cardiac rehabilitation services
Outpatient treatment of documented 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[s]:

- We do not cover the program phase that maintains rehabilitated cardiovascular health.
- *Prior authorization* is recommended for these services. See page 3-1 for more information.
- [Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

Chemotherapy

[Chiropractic care
See "Spinal manipulation."]

Outpatient care - continued

[Chiropractic medicine]

[Coverage is provided for *Medically Necessary* visits for the purpose of chiropractic treatment or diagnosis, regardless of the place of service.

Members are covered for up to three of the following modalities per visit: application of hot or cold pack; mechanical traction; electrical stimulation; ultrasound; myofascial release; diathermy.]

Diabetes services and supplies

In accordance with Rhode Island General Law § 27-18-38, coverage is provided for the following services and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, or gestational diabetes, when *Medically Necessary* and prescribed by a *Provider*:

- blood glucose monitors and blood glucose monitors for the legally blind (covered as "Durable Medical Equipment: - see page XX);
- test strips for glucose monitors and/or visual reading [(covered under your "Prescription Drug Benefit" – see page XX)] [covered as "Other Health Services" – see page XX)];
- insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar [(covered under your "Prescription Drug Benefit" – see page XX)] [covered as "Other Health Services" – see page XX)];
- insulin pumps and related supplies and insulin infusion devices (covered as "Medical Supplies" – see page XX);
- therapeutic/molded shoes for the prevention of amputation (covered as "Durable Medical Equipment" - see page XX); and
- diabetes self-management education, including medical nutrition therapy.

Upon the approval of the United States Food and Drug Administration, new or improved diabetes equipment and supplies will be covered when *Medically Necessary* and prescribed by a *Provider*.

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Coverage for test strips, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar will be provided as part of the "Diabetes services and supplies" listed above for plans that **include** prescription drug coverage. For plans that **exclude** prescription drug coverage, those items will be covered under the "Prescription Drug Benefit" found later in this chapter.]*

Diagnostic imaging

This includes general imaging (such as x-rays and ultrasounds). This also includes MRI/MRA, CT/CTA, and PET tests [and nuclear cardiology].

[Important Note: [*Prior authorization* is recommended for diagnostic imaging] [MRI/MRA, CT/CTA, and PET tests [and nuclear cardiology]]. Please page 3-1 for more information.]

Outpatient care - continued

Early intervention services

Services provided by early intervention programs that meet standards established by the Rhode Island Department of Human Services. *Medically Necessary* early intervention services include, but are not limited to:

- evaluation and case management;
- nursing care;
- occupational therapy;
- physical therapy'
- speech and language therapy;
- nutrition;
- service plan development and review; and
- assistive technology services and devices.

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

[**Note:** *Prior authorization* is recommended for these services. See page 3-1 for more information.]

Family planning

[Coverage is provided for *Outpatient* contraceptive services. This includes consultations, procedures and medical services. These services must be related to the use of all contraceptive methods approved by the United States Food and Drug Administration.]

- **[Procedures**
  - [sterilization][; and
  - [pregnancy terminations, when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest].
- **[Services**
  - medical examinations;
  - consultations;
  - birth control counseling;
  - genetic counseling.]
- **[Contraceptives**
  - cervical caps;
  - implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants;
  - Intrauterine devices (IUDs);
  - Depo-Provera or its generic equivalent;
  - any other *Medically Necessary* contraceptive device approved by the United States Food and Drug Administration[*].

[*Notes:

- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]
- We cover certain contraceptives under a Prescription Drug Benefit. Those contraceptives include oral contraceptives and diaphragms. If those contraceptives are covered under that benefit, they are not covered here. **]**

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Contraceptives and female sterilization procedures and services will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.]]*

<u>*Outpatient* care - continued</u>

Hemodialysis

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

[*Prior authorization* is recommended for these services. See page 3-1 for more information.]

[**House calls to diagnose and treat illness or injury]**
[A licensed physician must provide this care.]

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. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. Includes costs of testing for A, B or DR antigens. [Limited to one testing per lifetime.]
[*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Immunizations

[Infertility services
In accordance with Rhode Island General Law § 27-18-30, coverage is provided for *Medically Necessary* diagnosis and treatment of infertility. We only cover these services for a woman who is:

- between the ages of 25 and 42;
- married, in accordance to the laws of the state in which she resides;
- unable to conceive or sustain a pregnancy during a period of one year; and
- a presumably healthy individual.

<u>Notes</u>:

- <u>Oral and injectable drug therapies may be used to treat infertility. These therapies are considered *Covered Services* for *Members* covered by a Prescription Drug Benefit. Your plan may include prescription drug coverage. If so, see the "Prescription Drug Benefit" section in this chapter for information about drug therapy benefit levels.</u>
- <u>These infertility services are covered at the benefit level shown in the "Benefit Overview" section. Also, these services are subject to the maximum benefit listed in the "Benefit Limits" section *Certificate*. Your plan may include prescription drug coverage. If so, those drug therapies are also subject to that maximum benefit.</u>

Laboratory tests
These include, but are not limited to: blood tests; urinalysis; throat cultures; glycosolated hemoglobin (A1c) tests; genetic testing; and urinary protein/microalbumin and lipid profiles. (**<u>Important</u>**: *Prior authorization* is recommended for certain laboratory tests (e.g., genetic testing). See page 3-1 for more information. Also, please note that, in accordance with the ACA, laboratory tests associated with routine preventive care are covered in full at the *In-Network Level of Benefits.*)

Outpatient care - continued

Lead screenings

Includes lead screening related services, and diagnostic evaluations for lead poisoning in accordance with Rhode Island law.

Lyme Disease

Medically Necessary diagnostic testing and, to the extent not covered under a Prescription Drug Benefit, long-term antibiotic treatment of chronic Lyme disease. Treatment for Lyme disease otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, *Experimental or Investigative.*

Nutritional counseling

Office visits to diagnose and treat illness or injury

- *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions.
- Office visits for evaluations and consultations.

  [Note: Coverage for diagnostic laboratory tests and x-rays associated with these office visits is described in the "Diagnostic imaging" and "Diagnostic tests and laboratory services" benefits.]

Outpatient care - continued

Oral health services

The following oral services are covered. If you want to make sure that a planned service is a *Covered Service,* call Member Services.

- *Emergency* care

  X-rays and *Emergency* oral surgery in a *Provider's* office or emergency room. This care must be done 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

  Important Note: *Prior authorization* is recommended *for* all Non-*Emergency* oral health services performed in an *Inpatient* or *Day Surgery* setting.

  - **[**Hospital, physician, and surgical charges for the following conditions:
    - Surgical treatment of skeletal jaw deformities; or
    - Surgical treatment for Temporomandibular Joint Disorder (TMJ).
  - In certain specific instances, the costs of *Inpatient* services and *Day Surgery* for certain additional oral health services are covered. For these services (see 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. (An example of this is hemophilia.), AND
    - the *Member* requires these services in order to maintain his/her health (Also, the services cannot be cosmetic or *Experimental.*).

IF you meet the above criteria and require these services…	**THEN you are covered for:**
Surgical removal of impacted teeth when embedded in bone.	Hospital, physician, and surgical charges.
Surgical removal of unerupted teeth when embedded in bone.	Hospital, physician, and surgical charges.
Extraction of seven or more permanent teeth during one visit.	Hospital, physician, and surgical charges.
Any other non-covered dental procedure that meets the above criteria.	Hospital charges only.

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

Outpatient care - continued

Oral health services, continued

[

IF you require these services…	THEN you are covered for:
Surgical removal of impacted or unerupted teeth when embedded in bone.	Hospital, physician, and surgical charges.
Extraction of seven or more permanent teeth during one visit.	Hospital, physician, and surgical charges.
Surgical treatment of skeletal jaw deformities.	Hospital, physician, and surgical charges.
Surgical repair related to Temporomandibular Joint Disorder.	Hospital, physician, and surgical charges.

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

- Coverage for hospital charges **only** may be provided. This is the case when a *Member* requires treatment in an *Inpatient* or *Day Surgery* setting for oral health services not described in this benefit. The *Member* must meet the following criteria. Otherwise, hospital services will not be covered:
  - the *Member* cannot safely and effectively receive oral health services in an office setting. This must be due to a specific and serious nondental organic impairment (An example of this is hemophilia.), AND
  - the *Member* requires these services in order to maintain their health (Also, the services cannot be cosmetic or *Experimental.*).]

Outpatient **surgery in a *Provider's* office** [*Prior authorization* is recommended for certain laboratory tests (e.g., genetic testing). See page 3-1 for more information.]

[[Pediatric dental care for *Members* under age 12]

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

Important: You must choose a dentist for your *Dependent Child.* Choose one from the preferred dental provider directory. For more information, call Delta Dental [of Massachusetts] [at 617-886-1234 or 800-872-0500]. [*Prior authorization* is recommended for certain laboratory tests (e.g., genetic testing). See page 3-1 for more information.]]

Outpatient care - continued

Preventive care for *Members* through age 19

Coverage is provided for pediatric preventive care for a *Child* from birth to age 19, in accordance with the guidelines established by the American Academy of Pediatrics and as required by Rhode Island General Laws Section § 27-38.1

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*

Preventive care for *Members* age 20 and over

- routine physical examinations. These include appropriate immunizations and lab tests as recommended by a *Provider*;
- routine annual gynecological exam. This includes any follow-up obstetric or gynecological care we decide is *Medically Necessary* as a result based on of that exam;
- hearing examinations and screenings.

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*

Outpatient **care - continued**

Preventive Screenings and Diagnostic Procedures & Exams

IMPORTANT NOTE: Your coverage level under this plan at the *In-Network Level of Benefits* will be different for these **preventive screenings** (covered in full) versus **diagnostic services** (subject to *Member Cost Sharing)*. For more information, see "Preventive Screenings" and "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

Coverage is provided for the following Preventive Screenings (with no *PCP* referrals required):

Note: These routine screenings and exams are covered in full under this plan at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings"" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

- Preventive screenings for colon and colorectal cancer.

  Examples include colonoscopy and sigmoidoscopy screenings.

- Routine annual cytology (Pap Smear) examinations.

  Coverage for routine pap smears is provided in accordance with guidelines established by the American Cancer Society. This includes coverage for one annual screening for women age 18 and older.

- Routine mammograms, in accordance with guidelines established by the American Cancer Society.
- Routine prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines.

Coverage is provided for the following Diagnostic Procedures & Exams:

Note: These diagnostic procedures and exams may be subject to *Member Cost Sharing* under this plan. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

- Diagnostic colon or colorectal procedures. (*Prior authorization* is recommended for these services. See page 3-1 for more information.)

  Examples include diagnostic colonoscopy, endoscopy and proctosigmoidoscopy procedures.

- Diagnostic cytology (Pap Smear) examinations.

  Coverage for diagnostic pap smears is provided in accordance with guidelines established by the American Cancer Society.

- Diagnostic mammograms, in accordance with guidelines established by the American Cancer Society.
- Diagnostic prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines.

Outpatient **care - continued**

Radiation therapy

Respiratory therapy or pulmonary rehabilitation services [*Prior authorization* is recommended for certain laboratory tests (e.g., genetic testing). See page 3-1 for more information.]

[Short term] speech, physical and occupational therapy services

[These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or illness [and the *Member's* condition is subject to significant improvement within a period of [0-90] days from the initial treatment. That improvement needs to be a direct result of these therapies.]]

Massage therapy may be covered as a treatment modality. This is the case when done 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.

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year*.]] *(In-Network* and *Out-of-Network Levels* combined).

[Important Note[s]:

- [This benefit limit does not apply to [short-term] speech, physical or occupational therapy provided in conjunction with a *Provider's* approved home health care plan.]
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]]

***Outpatient* care - continued**

Smoking cessation counseling sessions

Coverage is provided for individual, group, and telephonic smoking cessation counseling services that:

- are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
- meet the requirements of the Rhode Island Office of the Health Insurance Commissioner Regulation 14.

[Note: Coverage is also provided for prescription and over-the-counter smoking cessation agents. For more information, see the "What is Covered" provision within the "Prescription Drug Benefit" later in this chapter.]

[Spinal manipulation

Manual manipulation of the spine.

Note: The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] per person or [10-unlimited visits] [$300-$5,000] per family.] (*In-Network* and *Out-of-Network Levels* combined). Spinal manipulation services are not covered for *Members* age 12 and under.]

[*Urgent Care* in an urgent care center]

Vision care services [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Coverage* is provided for services and supplies for the treatment of visual impairments, such as: regular eye exams; prescription eyewear; contact lenses; refractive laser eye surgery; and optometric vision therapy.]

[*Note: The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$350] per person and [$0-$750] per family. This limitation does not apply to contact lenses. It also does not apply to eyeglasses (one pair per prescription change) to replace the natural lens of the eye or following cataract surgery. For more information, see "*Durable Medical Equipment*".]

- [Routine eye examination: Coverage is provided for one routine eye examination [every [zero-twenty-four] months] [per [calendar year] [*Contract Year*]] [every other [calendar year] [*Contract Year*]] (*In-Network* and *Out-of-Network Levels* combined).]

  Note: You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network in order to be covered at the *In-Network Level of Benefits*. Go to **www.tuftshealthplan.com** or contact Member Services for more information.
- [Other vision care services: Coverage is provided for eye examinations and necessary treatment of a medical condition.]

Day Surgery

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.
- You must be shown on the facility's census as an *Outpatient*.

[Note: Endoscopies and proctosigmoidoscopies are covered under this benefit.]

***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** The Note in this benefit will only be used for HSA plans.*

Inpatient care

Extended care services

Extended care services are *Skilled* nursing, rehabilitation or chronic disease hospital services. These services are provided in a Medicare-certified:

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

Notes:

- **Extended care services are covered up to [100-unlimited] days per [calendar year] [*Contract Year*] [in a skilled nursing facility. Extended care services in a rehabilitation hospital or chronic hospital are covered up to any combination of [60-unlimited] days per [calendar year] [*Contract Year*]. These limits apply at the *In-Network* and *Out-of-Network Levels* combined.**
- *Custodial Care* is not covered.
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Hematopoietic stem cell transplants and human solid organ transplants

[*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Hematopoietic stem cell transplants and human solid organ transplants which are generally accepted in the medical community for *Members* who are the stem cell or solid organ recipients. When the recipient is a *Member*, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:

- evaluation and preparation of the donor; and
- surgical intervention and recovery services related 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. *Prior authorization* is recommended for additional donor search expenses for unrelated donors.
- We cover a *Member's* human leukocyte antigen (HLA) testing. See "*Outpatient* care" for more information.
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]
- [A lifetime maximum benefit of [$0-$10,000] applies per *Member* for transportation, accommodations, and special expense costs related to covered transplants. The services must be provided by a *Network Provider.* Authorization by *Tufts Health Plan* applies.]

***Inpatient* care,** continued

Hospital services (Acute care)

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

**Prior authorization* is recommended for these services. See page 3-1 for more information.

Reconstructive surgery and procedures and mastectomy surgeries

- services required to relieve pain or to restore a bodily function impaired as a result of: a congenital defect; birth abnormality; traumatic injury; or covered surgical procedure;
- the following services in connection with mastectomy:
  - surgical procedures known as a mastectomy;
  - axilary node dissection;
  - 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).

  Inpatient care in hospital for mastectomies is covered for:
  - a minimum of 48 hours following a surgical procedure known as a mastectomy; and
  - a minimum of 24 hours following an axilary node dissection.

  Any decision to shorten this minimum coverage shall be made by the attending physician in consultation with and upon agreement by the *Member. [*If the *Member* agrees to an early discharge,] coverage shall also include a minimum of one home visit conducted by a physician or registered nurse.

  Note: Breast prostheses are covered as described under "Prosthetic devices" in this chapter.

Removal of a breast implant. This is covered when:

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

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

Notes:

- Cosmetic surgery is not covered.
- [Except as described above in connection with a mastectomy, *prior authorization* is recommended for any reconstructive surgery or procedure. See page 3-1 for more information.]

Maternity care

Maternity care (*Outpatient*) [- Routine and Non-Routine Care]

FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: *Bracketed text in the title of this benefit will only be used for HSA plans.*

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

[Note: *Providers* may collect *Copayments* in a variety of ways for this coverage. For example, the *Provider* may collect your *Copayment* at the time of your first visit, at the end of your pregnancy or in installments. Please check with your *Provider*. Also, please note that in accordance with the ACA, laboratory tests associated with routine maternity care are covered in full at the *In-Network Level of Benefits.*]

Maternity care (*Inpatient*)

- hospital and delivery services; and
- 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. The newborn *Child's* coverage consists of coverage of injury or sickness. This coverage includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, as well as routine well-baby care services.

Any decision to shorten these minimum coverages will be made by the attending health care provider. (This may be the attending obstetrician, pediatrician, family practitioner, general practitioner, or certified nurse midwife attending the mother and newborn *Child.*) In addition, the decision must be made in consultation with the mother.

Coverage of the newly-born *Child* will continue for 31 days after birth. For coverage to continue beyond this 31-day period, you must enroll the *Child* as described under "Newborn *Children* and *Adoptive Children*".

Note[s]:

- [In case of an early discharge,] *Covered Services* will include: one home visit by a registered nurse, physician, or certified nurse midwife; and additional *Medically Necessary* home visits, when provided by a licensed health care provider. *Covered Services* will include, but not be limited to: parent education, assistance, and training in breast or bottle feeding; and the performance of any necessary and appropriate clinical tests.
- [These *Covered Services* will be available to a mother and her newborn *Child.* This is the case whether or not there is an early discharge. (This means: (1) a hospital discharge less than 48 hours following a vaginal delivery; or (2) 96 hours following a caesarean delivery.)]

***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**

***Outpatient* mental health care services**

Services to diagnose and treat *Mental Disorders.* This includes individual, group and family therapies.

Note: Psychopharmacological services and neuropsychological assessment services are covered as *Outpatient* medical care. This is described earlier in this chapter.

Important Note[s]:

- [***Outpatient* mental health care services are covered up to [30 -unlimited visits] per [calendar year] [*Contract Year*] (combined).**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*
- [*Prior authorization* is recommended for psychological testing and neuropsychological assessment services. See page 3-1 for more information.]

***Inpatient* and intermediate mental health care services**

- *Inpatient* mental health services for *Mental Disorders* in a general hospital, a mental health hospital, or a substance abuse facility.

  Important Notes:
  - *Inpatient* mental health services must be obtained at a *Network Provider* in order to be covered at the *In-Network Level of Benefits*. See "*Inpatient* Mental Health and Substance Abuse Services" for more information.
  - *Prior authorization* is recommended for *Inpatient* mental health services. See page 3-1 for more information.

- Intermediate mental health care services. These services are more intensive than traditional *Outpatient* mental health care services. They are less intensive than 24-hour hospitalization. Some examples of Covered intermediate mental health care services are:
  - [level III community-based detoxification;]
  - intensive *Outpatient* programs; and
  - [acute residential treatment* (longer term residential treatment is not covered).]
  - [crisis stabilization;]
  - day treatment/partial hospital programs;

  Important Notes:
  - No visit limit applies to *Inpatient* or intermediate mental health care services.
  - Intermediate mental health care services must be obtained at a *Network Provider* to be covered at the *In-Network Level of Benefits*. See "*Inpatient* Mental Health and Substance Abuse Services" for more information. [*Prior authorization* is recommended for intermediate mental health services. See page 3-1 for more information.]

Mental Disorder Services for Substance Abuse (_Outpatient_, _Inpatient_ and Intermediate)

(Note: Treatment for the abuse of tobacco or caffeine is not covered under these substance abuse services benefits.)

Outpatient substance abuse services

Outpatient substance abuse treatment services.

[Note:

Outpatient substance abuse treatment services are covered for [30-unlimited] hours per [calendar year] [_Contract Year_] (_In-Network_ and _Out-of-Network Levels_ combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Inpatient and Intermediate Substance Abuse Services

- _Inpatient_ substance abuse detoxification and treatment services in a general hospital, substance abuse facility, or _Community Residence_.
- Intermediate substance abuse services. These services are more intensive than traditional _Outpatient_ substance abuse services. They are less intensive than 24-hour hospitalization. Some examples of Covered intermediate substance abuse services are day treatment/partial hospital programs and intensive _Outpatient_ programs.

  Notes:

  - [**No visit limit applies to _Inpatient_ substance abuse treatment or intermediate substance abuse services. _Inpatient_ detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per calendar year, whichever occurs first (_In-Network_ and _Out-of-Network Levels_ combined). The maximum benefit payable in each [calendar year] [_Contract Year_] is [30-unlimited] days of _Community Residential_ care services (_In-Network_ and _Out-of-Network Levels_ combined).**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*
  - _Inpatient_ substance abuse services must be obtained at a _Network Provider_ in order to be covered at the _In-Network Level of Benefits_. See "_Inpatient_ Mental Health and Substance Abuse Services" for more information. [_Prior authorization_ is recommended for _Inpatient_ substance abuse services. See page 3-1 for more information.]
  - Intermediate substance abuse services must be obtained at a _Network Provider_ in order to be covered at the _In-Network Level of Benefits_. See "_Inpatient_ Mental Health and Substance Abuse Services" for more information. [_Prior authorization_ is recommended for intermediate substance abuse services. See page 3-1 for more information]

Other health services

Ambulance services

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

*Prior recommendation is recommended for these services. See page 3-1 for more information.

Important Note[s]:

- You may be treated by Emergency Medical Technicians (EMTs) or other ambulance staff. At that time, you may refuse to be transported to the hospital or other medical facility. In this case, you will be responsible for the costs of this treatment.
- [Covered sea, helicopter, and airplane ambulance transportation service (for example, Medflight) is covered up to [$3,000-unlimited] per [calendar year][*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined). This limit does not apply to the ground ambulance services we cover.]

[Diabetic monitoring strips]

[The following diabetic monitoring strips for home use. These strips must be ordered by a *Provider*, in writing, to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes:

- blood glucose monitoring strips;
- urine glucose strips; and
- ketone strips.]

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;
- 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. *Tufts Health Plan* determines this.

Tufts Health Plan may decide that equipment is: (1) non-medical in nature; and (2) used primarily for non-medical purposes. (This may occur even though that equipment has some limited medical use.) In this case, the equipment will not be considered *Durable Medical Equipment.* It will not be covered under this benefit.

(Note: *Prior authorization* is recommended for certain *Durable Medical Equipment*]. [See page 3-1 for more information.]

Important Note: You may need to pay towards the cost of the *Durable Medical Equipment* we cover. Your *Durable Medical Equipment* benefit may be subject to a *Deductible* or *Coinsurance*. See the "Benefit Overview" and "Benefit Limits" sections.

These are examples of covered and non-covered items. They are for illustration only. Call a Member Specialist to see if we cover a certain piece of equipment.

- **Examples of covered items. (This list is not all-inclusive.):**
  - contact lenses or eyeglass lenses (One pair per prescription change are covered.) to replace the natural lens of the eye or following cataract surgery. [Note: Eyeglass frames are covered up to a maximum of $69 per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels of Benefits* combined). They must be provided in association with these lenses.];
  - gradient stockings (Up to three pairs are covered per calendar year);
  - [insulin pumps;]
  - oral appliances for the treatment of sleep apnea;
  - prosthetic devices, except for arms, legs or breasts*;
    * Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Orthoses and prosthetic devices" benefit.
  - [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: See "Scalp hair prostheses or wigs for cancer or leukemia patients".);]
  - [power/motorized wheelchairs;]
  - therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease;

We will decide whether to purchase or rent the equipment for you. At the *In-Network Level of Benefits*, this equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with us to provide such equipment.

(continued on next page)

Durable Medical Equipment, continued

- **Examples of non-covered items (This list is not all-inclusive.):**
  - 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 trays, and bed wedges;
  - car seats;
  - car/van modifications;
  - comfort or convenience devices;
  - dentures;
  - ear plugs;
  - fixtures to real property. Examples are ceiling lifts, elevators, ramps, stair lifts or stair climbers;
  - exercise equipment and saunas;
  - .orthoses and prosthetic devices (see “Orthoses and prosthetic devices” for information about these *Covered Services*);
  - 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, see “Prosthetic devices” [;and
  - scooters].

Hearing Aids [(*Prior authorization* is recommended for these services. See page 3-1 for more information**.)**

Coverage is provided for:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid;
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid.

Other Health Services - continued

Home health care

This is a *Medically Necessary* program to: (1) reduce the length of a hospital stay; or (2) delay or eliminate an otherwise *Medically Necessary* hospital admission. Coverage includes:

- home visits by a *Provider*;
- skilled [intermittent] nursing care;
- [*Medically Necessary* private duty nursing care. A certified home health care agency must provide this care];
- physical therapy;
- speech therapy;
- occupational therapy;
- medical/psychiatric social work;
- nutritional consultation;
- prescription drugs and medication;
- medical and surgical supplies (Examples include dressings, bandages and casts.);
- laboratory tests, x-rays, and E.K.G. and E.E.G. evaluations;
- the use of *Durable Medical Equipment*, and
- the services of a part-time home health aide.

[Note[s]:

- Home health care services for speech, physical and occupational therapies may follow an injury or illness. If this occurs, the services are only covered to the extent provided to restore function lost or impaired. This is described under “Short term speech, physical and occupational therapy services.” However, those home health care services are [not] subject to: (1) the [0-90]-day period for significant improvement requirement] [or; (2) the visit limits] listed under “Short term speech, physical and occupational therapy services”.
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]]

Other Health Services - continued

[Hospice care services [*Prior authorization* is recommended for these services. See page 3-1 for more information.]]

We will cover the following services for who are terminally ill. (This means 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 (This includes bereavement counseling services for the *Member's* family. This applies for up to one year after 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.]

[Note: Covered up to [0-unlimited] visits per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels combined*) for any combination of home visits and *Inpatient* facility visits.]

[Injectable, infused or inhaled medications

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

Notes:

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

Medical supplies

We cover the cost of certain types of medical supplies. These supplies include:

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

Note[s]: Contact a Member Specialist with coverage questions. [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Other Health Services - continued

New cancer therapies

Coverage is provided for new cancer therapies (both *Inpatient* and *Outpatient*) still under investigation as required by Rhode Island General Laws Section § 27-18-36.

[Prior approval by an *Authorized Reviewer* applies at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on page 3-1 for more information.]

Orthoses and prosthetic devices

We cover the cost of orthoses and prosthetic devices (This includes repairs.), as required by Rhode Island law. This includes breast prostheses*, as required by federal law. Coverage is provided for the most appropriate model that adequately meets the *Member's* needs. His or her treating *Provider* determines this. [(*Prior authorization* is recommended for these services. *)]

[*Important Note: Breast prostheses provided in connection with a mastectomy are not subject to any *prior authorization*. See page 3-1 for more information.]

[Prescription infant formulas]

[Infant formulas are covered when *Medically Necessary.* The formulas must be prescribed for infants and children up to age 2.

Contact Member Services for more information.]

[Private duty nursing]

[We cover private duty nursing. It must be *Medically Necessary.* Also, it needs to be ordered by a physician and performed by a certified home health care agency. Private duty nursing services are covered when the patient requires continuous skilled nursing observation and intervention.]

[*Prior authorization* is recommended for these services. See page 3-1 for more information.**]**

Scalp hair prostheses or wigs for cancer or leukemia patients

Coverage is provided for scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer. (See "*Durable Medical Equipment*" earlier in this chapter.)

Note: Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined).

Other Health Services – continued

[Special medical formulas

Includes nonprescription enteral formulas and low protein foods. A *Provider* must prescribe the formula or food for these treatments:

Low protein foods:

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

Note: [*Prior authorization* is recommended for these formulas. See page 3-1 for more information.**]**

Nonprescription enteral formulas:

- For home use for treatment of malabsorption caused by: Crohn's disease; ulcerative colitis; gastroesophageal reflux; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids.

[Note: *Prior authorization* is recommended for these services. See page 3-1 for more information.]

[Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. These topics are included here. They 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 may be considered *Covered Services*. This occurs only if they comply with the *Tufts Health Plan Pharmacy Management Programs* section below and are:

- listed below under *What is Covered*;
- provided to treat an injury, illness, or pregnancy; and
- *Medically Necessary*.

We have a current list of covered drugs. See our Web site at **www.tuftshealthplan.com.** You can also call a Member Specialist.

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

- [Tier-0 drugs [are covered in full] [have the lowest *Cost Sharing Amount*].]
- Tier-1 drugs have the [lowest] [lower] level *Cost Sharing Amount*; many generic drugs are on Tier-1.
- Tier-2 drugs have the [middle] [higher] level *Cost Sharing Amount*.
- [Tier-3 drugs have the [higher] [highest] level *Cost Sharing Amount*.]
- [[Tier-4] [Special Designated Pharmacy Program] drugs have the highest *Cost Sharing Amount*.]

[Note: Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law are covered in full. [However, if a generic equivalent is available, non-generic oral contraceptives, diaphragms and hormonal contraceptives are subject to the applicable Tier *Copayment.]]*

FILING NOTE: *As of 8/1/12, contraceptives and sterilization services will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after that date for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.*

PRESCRIPTION DRUG COVERAGE TABLE

INFERTILITY MEDICATIONS

[0-20%] *Coinsurance**]], for up to a 30-day supply [(This is subject to the [prescription drug deductible] below.].

*Notes:

- *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.
- [Coverage for infertility is limited to[$100,000-unlimited] per *Member* per lifetime (This maximum is for *In-Network* and *Out-of-Network Levels* combined.). This limit applies to both: (1) infertility services covered under the "*Outpatient* Care" benefit; and (2) oral and injectable drug therapies used to treat infertility and covered under this "Prescription Drug Benefit."]

(continued on next page)

PRESCRIPTION DRUG COVERAGE TABLE – continued

ALL OTHER MEDICATIONS

DRUGS OBTAINED AT A RETAIL PHARMACY:

- Coverage When Drugs **Are Obtained** Through a *Tufts Health Plan* Designated Retail Pharmacy:

  Covered prescription drugs (This includes both acute and maintenance drugs.). You must obtain these drugs directly from a *Tufts Health Plan* designated retail pharmacy.

[Tier-0 drugs:	**Tier-1 drugs:**	**Tier-2 drugs:**	**Tier-3 drugs:**
[[[$0-$50] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$50] ,] for a 1-30 day supply	[[[$0-$50] *Copayment*] [[10-50%] *Coinsurance**] [, up to a maximum of [$0-$50],] for a 1-30 day supply	[[[$0-$75] *Copayment]* [[10-50%] *Coinsurance**] [, up to a maximum of [$0-$75],] for a 1-30 day supply	[[[$0-$150] *Copayment]* [[10-60%] *Coinsurance**]] [, up to a maximum of [[$0-$150],] for a 1-30 day supply.
[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 31-60 day supply]	[[[$0-$300]*Copayment*] [[10-60%] *Coinsurance**]] [, up to a maximum of [$0-$300],] or a 31-60 day supply]
[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 61-90 day supply]	[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 61-90 day supply]	[[[$0-$225] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$225],] for a 61-90 day supply]	[[[$0-$450] *Copayment*] [[10-60%] *Coinsurance**]] [, up to a maximum of [$0-$450],] for a 61-90 day supply]

[(subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] described below)]

- Coverage When Drugs **Are Not Obtained** Through a *Tufts Health Plan* Designated Retail Pharmacy:

  You may choose to obtain a covered prescription drug at a retail pharmacy which is **not** a *Tufts Health Plan* designated pharmacy. If so, you pay [20%-50%] *Coinsurance* for that drug.

  [(This is subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] described below.)]

[DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY:

- Coverage When Drugs **Are Obtained** Through a *Tufts Health Plan* Designated Mail Services Pharmacy:

  Most maintenance medications, when mailed to you through a *Tufts Health Plan* designated mail services pharmacy.

[Tier-0 drugs:	**Tier-1 drugs:**	**Tier-2 drugs:**	**[Tier-3 drugs:**
[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 1-[30-9]0 day supply]	[[[$0-$100 *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 1-[30-90]-day supply]	[[[$0-$150 *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 1-[30-90]- day supply]	[[[$0-$450*Copayment*] [[10-60%] *Coinsurance**]] [, up to a maximum of [$0-$450],] for a 1-[30-90] day supply]

[(This is subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] described below.)]

- Coverage When Drugs **Are Not Obtained** Through a *Tufts Health Plan* Designated Mail Services Pharmacy:

  You may choose to obtain a covered prescription drug through a mail services pharmacy that is **not** a *Tufts Health Plan* designated pharmacy. If so, you pay 20% *Coinsurance* for that drug.

  [(This is subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] below.)]

*Note: *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.

PRESCRIPTION DRUG COVERAGE TABLE – continued

[DRUGS OBTAINED THROUGH THE SPECIAL DESIGNATED PHARMACY PROGRAM **

The following drugs must be obtained through a special designated pharmacy: medications used in the treatment of infertility, multiple sclerosis; hemophilia; hepatitis C; growth hormone deficiency; rheumatoid arthritis; and cancers treated with oral medications.

[Tier-4 drugs:]

[[[$0-$125] *Copayment*] [[10-70%] *Coinsurance**]], [, up to a maximum of [$0-$300],] for up to a 30-day supply.

[(This is subject to the [prescription drug deductible] [and] [the [calendar year] [*Contract Year*] maximum benefit] below.)]

*Note: *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates that we receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.

For more information, see "*Tufts Health Plan* Pharmacy Management Programs". **]

***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** If implemented, this Special Designated Pharmacy Program will not be limited to mail order.]*

[Prescription drug deductible]

[A [$0-$600] prescription drug deductible applies to [prescription drugs on Tiers 2 and 3 for] each *Member* per [calendar year] [*Contract Year*]. This is the amount you must first pay for covered prescription drugs [obtained at a [*Tufts Health Plan* designated] retail pharmacy] [obtained through a [*Tufts Health Plan* designated] mail order pharmacy] [on Tiers 2 and 3] before we will pay for any covered [retail] [mail order] prescription drugs.] [Upon initially joining *Tufts Health Plan*, any deductible amount you paid for covered [retail] [mail order] prescription drugs under another health plan during the current calendar year may be used to satisfy your prescription drug deductible for that year.]

[Note: This prescription drug deductible does **not** apply to [generic drugs, regardless of their tier] [prescription drugs on Tier 1] [prescription and over-the-counter smoking cessation agents.]

[Any combination of enrolled *Members* of a covered family may satisfy the [$0-$1,800] family prescription drug deductible during a [calendar year] [*Contract Year*]. In this case, the remainder of the covered *Members* of that family will not need to satisfy an individual prescription drug deductible for the rest of that [calendar year] [*Contract Year*].]

[Any deductible amount you pay for covered [retail] [mail order] prescription drugs [on Tiers 2 and 3] under this plan in the last [0-12] months of a [calendar year] [*Contract Year*] may be used to satisfy your prescription drug deductible during the following year.]

[The deductible is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates that we receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.]

Prescription Drug Benefit – continued

[*Deductible*]

[Prescription drugs are subject to the *Deductible*. For more information, see the "Benefit Overview" section.]

Note[s]:

- You may fill your prescription in a state that allows you to request a brand-name drug even though your *Provider* authorizes the generic equivalent. In this case, you will pay the applicable Tier *Cost Sharing Amount.* You will also pay the difference in cost between the brand-name drug and the generic drug.
- [You always pay the applicable *Cost Sharing Amount*. This is the case even if the cost of the drug is less than the *Cost Sharing Amount*.]

]

[Generic Incentive Program]

[Your *Provider* may prescribe a brand-name drug that has a generic equivalent. This can happen in Massachusetts and many other states. In this case, you will receive the generic drug and pay the applicable Tier *Copayment*. Wherever you fill your prescription, your *Provider* may request that you receive a covered brand-name drug only. In this case, you will pay the *Copayment* for the generic drug. You must also pay the difference between the cost of the generic drug and the cost of the covered brand-name drug. In many cases, there may be a significant difference in price between the brand-name drug and the generic drug. This may result in a significant difference in what you need to pay.]

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Text in "What is Covered" and "What is Not Covered" provisions in this "Prescription Drug Benefit" will include coverage for oral contraceptives and diaphragms for groups with prescription drug **except** upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C. section 3121**[**(w)(3)(A) and (B).**]**]*

[Prescription Drug Benefit – continued

What is covered

We cover the following under this Prescription Drug Benefit:

- Prescribed drugs that by law require a prescription and are not listed under *What is Not Covered* (See "Important Notes" below.).
- [Test strips for glucose monitors and/or visual aid reading, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar levels.]

  *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Coverage for test strips, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar will be provided as part of the "Prescription Drug Benefit" listed above for plans that **include** prescription drug coverage. For plans that **exclude** prescription drug coverage, those items will be covered under the "Diabetes services and supplies" in the "Outpatient Care" section earlier in this chapter.]*
- 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 (e.g., patches, rings) that by law require a prescription. See "Family planning" above for information about other covered contraceptive drugs and devices.]
- Fluoride for *Children*.
- [Injectables and biological serum included in the list of covered drugs on our Web site. For more information, call Member Services. Also, see our Web site at **www.tuftshealthplan.com**.]
- Prefilled sodium chloride for inhalation (This is covered both by prescription and over-the-counter).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer 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. These are only covered 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. Also, see our Web site at **www.tuftshealthplan.com**.]
- Prescription and over-the-counter smoking cessation agents. These must be recommended and prescribed by a *Provider*.

[Note: Certain prescription drug products may be subject to one of the *Tufts Health Plan Pharmacy Management Programs* described below.]

]

[Prescription Drug Benefit - continued

What is not covered

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

- Drugs that by law do not require a prescription (unless listed as covered in the *What is Covered* section above).
- Drugs not listed on the "Tufts Health Plan Prescription Drug List". See the list at **www.tuftshealthplan.com.** Also, you can call Member Services for more information.
- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for *Children*[and supplements for the treatment of mitochondrial disease]).
- Medications for the treatment of idiopathic short stature.
- Topical and oral fluorides for adults.
- Cervical caps, IUDs, implantable contraceptives (Implanon® (etonorgestrel), levonorgestrel implants, Depo-Provera or its generic equivalent [(These are covered under your *Outpatient* care benefit earlier in this Chapter.)] [oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription].
- 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" above.
- **[**Prescriptions written by *Providers* who do not participate in *Tufts Health Plan.* These drugs are excluded except in cases of authorized referral or *Emergency* care.]
- [Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.]
- 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*.
- [Drugs dispensed in an amount or dosage that exceeds our established quantity limitations.]
- 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 [is not] [may not be] covered. Also, the entire class of prescription medications may also not be covered. For more information, call Member Services. You can also check our Web site at **www.tuftshealthplan.com**. **Note:** This restriction on prescription drugs does not apply to prescription and over-the-counter smoking cessation agents.
- Prescription medications when packaged with non-prescription products.
- Oral non-sedating antihistamines.

(continued on next page)

[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 these Pharmacy Management Programs:]

[[Quantity Limitations Program]:

We limit the quantity of selected medications *Members* can receive in a given time period. We do this for cost, safety and/or clinical reasons.]

[Prior Authorization Program:

We restrict the coverage of certain drug products. These are drugs with a narrow indication for usage, may have safety concerns and/or are extremely expensive. We require the prescribing *Provider* to obtain prior approval from us for such drugs.]

Step Therapy PA Program

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

[Special Designated Pharmacy Program]:

We have designated special pharmacies to supply a select number of medications. This includes medications used to treat 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. They are staffed with clinicians to provide support services to *Members*. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time. [Medications are delivered directly to the *Member's* home via mail. This is NOT part of the mail order pharmacy benefit.] Extended day supplies and *Copayment* savings to not apply to these special designated drugs.]

***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** If implemented, this Special Designated Pharmacy Program will not be limited to mail order.]*

Non-Covered Drugs:

While *Tufts Health Plan* covers over 4,500 drugs. However, a small number of drugs (less than 1%) are not covered. This is because there are safe, effective and more affordable alternatives available. Drugs may not be covered for safety reasons, if they are new on the market, if they become available over-the-counter, or if a generic version of a drug becomes 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). They are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. For up-to-date information on these non-covered drugs and their suggested alternatives, please call *Member Services,* or see the web site at www.tuftshealthplan.com.

[Prescription Drug Benefit - continued

[*Tufts Health Plan* Pharmacy Management Programs, continued]

[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. This is usually within 6 months of the drug product's availability.]

[IMPORTANT NOTES:

- [Your *Provider* may feel it is *Medically Necessary* for you to take medications that are restricted under any of the *Tufts Health Plan Pharmacy Management Programs* described above. In this case, he or she may submit a request for coverage. We will approve the request if it meets our guidelines for coverage. For more information, call Member Services.]
- 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, a brand drug's patent may expire. In this case, we may [move] [change the drug's status by either (a) moving] the brand drug from Tier - 2 to Tier – 3 [or (b) no longer covering the brand drug] when a generic alternative becomes available. Many generic drugs are available on Tier-1.
- You may have questions about your prescription drug benefit. You may want to know the tier of a particular drug. [You might like to know if your medication is part of a Pharmacy Management Program.]For these issues, check our Web site at **www.tuftshealthplan.com.** You can also call Member Services at 1-800-682-8059.

Prescription Drug Benefit - continued

Filling your prescription

Where to fill prescriptions:

You can fill your prescriptions at any pharmacy. You must fill your prescriptions at a *Tufts Health Plan* designated pharmacy in order to receive coverage at the *In-Network Level of Benefits*. *Tufts Health Plan* designated pharmacies include:

- [for the majority of prescriptions,] many of the pharmacies in Massachusetts and Rhode Island. They also include additional pharmacies nationwide; [and]
- [for a select number of drug products, a small number of special designated pharmacy providers. (See "*Tufts Health Plan* Pharmacy Management Programs" above.)] You may have questions about where to fill your prescription. If so, call Member Services.]

How to fill prescriptions:

- When you fill a prescription, provide your Member ID to any *Tufts Health Plan* designated pharmacy and pay your *Cost Sharing Amount*.
- The cost of your prescription may be less than your *Copayment.* In this case, you [must pay for the actual cost of the prescription] [must pay that *Copayment*].
- If you have any problems using this benefit, call the *Tufts Health Plan* Member Services Department.

Important: If you fill a prescription at a non-*Tufts Health Plan* designated pharmacy, call the Member Services Department. They will explain how to submit your prescription drug claims for reimbursement.

[Filling Prescriptions for Maintenance Medications:

You may need to take a *maintenance* medication. If so, 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. This is done through a *Tufts Health Plan* designated mail services pharmacy.

  [Note: Please see the "Preventive Medication Benefit" at the front of this document for more information.]

*These drugs 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 [;or] [
- 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 from Benefits

Tufts Health Plan 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 that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- [A service, supply, or medication that is obtained outside of the 50 United States. The only exceptions to this rule are for *Emergency* care services or *Urgent Care* services while traveling, which qualify as *Covered Services* when provided outside of the 50 United States.]
- *Custodial Care*.
- Services related to non-*Covered Services.* This does not apply to complications related to pregnancy terminations.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

  This exclusion does not apply to:
  - treatment of chronic Lyme disease;
  - new cancer therapies, as described earlier in this chapter [; or
  - off-label uses of prescription drugs for the treatment of cancer, if you have a Prescription Drug Benefit]

  which meet the requirements of Rhode Island law.

  A treatment may be is *Experimental or Investigative.* If this case, we will not pay for any related treatments provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter.
- The following exclusions apply to services provided by the relatives of a *Member*:
  - Services provided by a relative who is not a *Provider* are not covered;
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Provider*, are not covered.
  - If you are a *Provider*, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay. Services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.
- Care for conditions that state or local law requires to be treated in a public facility.

Exclusions from Benefits, continued

- 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 see if your *Provider* charges such a fee.
- Charges incurred when the *Member*, for his or her convenience, chooses to remain an *Inpatient* beyond the discharge hour.
- Facility charges or related services if the procedure being performed is not a *Covered Service*, except as provided under "Oral health services" earlier in this chapter.
- [Preventive dental care [, except as provided under "Pediatric dental care for *Members* under age 12" earlier in this chapter]; [periodontal treatment;] [orthodontia, even when it is an adjunct to other surgical or medical procedures;] [dental supplies;] [dentures;] [restorative services including, but not limited to, crowns, fillings, root canals, and bondings;] [skeletal jaw surgery, except as provided under "Oral health services" earlier in this chapter;] [alteration of teeth;] [care related to deciduous (baby) teeth;] [splints and oral appliances (except for sleep apnea, as described earlier in this chapter), including those for TMJ disorders.] TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or TMJ appliance-related therapies, are not covered.]
- [Surgical removal or extraction of teeth, except as provided under "Oral health services" earlier in this chapter.]
- Cosmetic (This means 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.
- [Contraceptives] [and] [contraceptive services].
- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcision performed in any setting other than a hospital, *Day Surgery,* or a *Provider's* office.
- Infertility services for *Members* who do not meet the definition of Infertility as described in the "*Outpatient* Care" section earlier in this chapter; *Experimental* infertility procedures; the costs of surrogacy; [sterilization;] reversal of voluntary sterilization; long-term (longer than 90 days) [sperm or] embryo cryopreservation unless the *Member* is in active infertility treatment; costs associated with donor recruitment and compensation; Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization [; infertility services for male *Members*;] [; 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 authorization* is recommended for these services.
- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the *Member* is the sole recipient of the donor's eggs. *Prior authorization* is recommended for these services.
- [Pregnancy terminations, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest.]
- [Preimplantation genetic testing and related procedures performed on gametes or embryos.]

Exclusions from Benefits, continued

- 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.
- 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" (This is 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;] [chiropractic medicine;] [spinal manipulation services for *Members* age 12 and under;] *Inpatient* and *Outpatient* weight-loss programs and clinics; [nutritional counseling, except as described earlier in this chapter;] relaxation therapies; massage therapies, except as described under "Short-term speech, 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. All services, procedures, labs and supplements associated with this type of medicine.
- Any service, supply, or procedure performed in a non-conventional setting (This includes, but is 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 authorization* is recommended for these services.);
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (*Prior authorization* is recommended for these services.).
- Devices and procedures intended to reduce snoring. These include, but are not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.
- Examinations, evaluations or services for educational purposes or developmental purposes. This includes 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 not caused by an underlying medical illness or condition.

Exclusions from Benefits, continued

- [Eyeglasses, lenses or frames, except as described under "*Durable Medical Equipment*" earlier in this chapter; [refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery]. [Routine eye exams.] Except as described earlier in this chapter, we will not pay for contact lenses or contact lens fittings.]
- Methadone maintenance or methadone treatment [related to substance abuse].
- [Private duty nursing (block or non-intermittent nursing)[, except as described under “Home health care” earlier in this chapter].
- Routine foot care. Examples include: 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; or other non-orthotic support devices for the feet.

  Note: This exclusion does not apply to routine foot care for *Members* diagnosed with diabetes.
- Transportation, including, but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in “Ambulance services” in this chapter.
- Lodging related to receiving any medical service[, except as described under “Hematopoietic stem cell transplants and human organ transplants” earlier in this chapter].
- [Bariatric surgery.]
- [The prescription drug, RU-486, or its therapeutic equivalent.]
- [Telephone consultations.]
- [Supervision of maintenance therapy for chronic disease which is not aggravated by surgery and would not ordinarily require hospitalization; rehabilitation for maintenance purposes.]
- [Sleep studies performed in the home.]
- [Bone marrow blood supply MRIs.]
- [Non-cadaveric small bowel transplants.]

Chapter 4
When Coverage Ends

Reasons coverage ends

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

- you lose eligibility because you no longer meet your *Group's* or *Tufts Health Plan's* eligibility rules;
- [you are a *Subscriber* or *Spouse* and you move out of the *Network Contracting Area**;]
- you choose to drop coverage;
- you commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to any *Provider*, any *Tufts Health Plan Member*, *Tufts Health Plan* or any *Tufts Health Plan* employee;
- you commit an act of misrepresentation or fraud; or
- your *Group Contract* with us ends. (For more information, see "Termination of a *Group Contract*" later in this chapter.)

*Note: *Children* are not required to maintain primary residence in the *Network Contracting Area.* In addition, there are a few other exceptions in which *Dependents* are still eligible for coverage even if they live outside of the *Network Contracting Area*. However, care outside of the *Network Contracting Area* is only covered at the *Out-of-Network Level of Benefits.* Please see "If you live outside of the *Network Contracting Area*" in Chapter 2 for more information.

Benefits after termination

If you are totally disabled when your coverage ends, you may be able to continue your coverage as described in "Extension of Benefits" later in this chapter. Otherwise, we 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 converted plans

Once your coverage ends, you may be eligible to continue your coverage with your *Group.* Or, you may be able to enroll in a converted coverage plan. 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. This is done back to the date you are no longer eligible for coverage.

When a *Member* is No Longer Eligible, continued

If you move out of the *Network Contracting Area*

If you are a *Subscriber* or *Spouse* and you move out of the *Network Contracting Area*, coverage ends on the date you move*. *Children* are not required to maintain primary residence in the *Network Contracting Area*. However, care outside of the *Network Contracting* is only covered at the *Out-of-Network Level of Benefits.*

Before you move, tell your *Group* or call a Member Specialist before you move to notify us of your move. You may have kept a residence in the *Network Contracting Area* but been out of the *Network Contracting Area* for more than 90 days. If this happens, coverage ends 90 days after the date you left the *Network Contracting Area*.

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

*Note: There are a few other exceptions in which *Dependents* are still eligible for coverage even if they live outside of the *Network Contracting Area*. Please see "If you live outside of the *Network Contracting Area*" in Chapter 2 for more information.

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. See Chapter 2, "Continuing Eligibility for *Dependents*", for more information.

You choose to drop coverage

Coverage ends if you decide you no longer want coverage and you meet any qualifying event your *Group* requires. To end your coverage, notify your *Group.* You must do this 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

We 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

We may terminate your coverage for misrepresentation or fraud during the first two years of coverage under this plan. If your coverage is terminated for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an individual plan 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 we terminate your coverage for misrepresentation or fraud, your coverage will end as of a later date chosen by us. During the first two years of coverage, we reserve the right to revoke coverage and deny payment of claims retroactive to your *Effective Date* for any false or misleading information on your application.

Payment of claims

We will pay for all *Covered Services* you received between:

- your *Effective Date*; and
- your termination date, as chosen by us. We retroactively terminate your coverage back to a date no earlier than your *Effective Date*.

We may 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 us back; or
- not pay for those services. In this case, you will have to pay the *Provider* for the services.

The *Premium* may be more than is needed to pay for *Covered Services* you received after your termination date. In this case, we will refund the excess to your *Group*.

Despite the above provisions related to *Member* termination for misrepresentation or fraud:

- the validity of the *Group Contract* will not be contested, except for non-payment of *Premiums*, after the *Group Contract* has been in force for two years from its date of issue; or
- no statement made for the purpose of effecting insurance coverage with respect to a *Member* under this *Group Contract* shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits thereunder after that *Member's* insurance under this *Group Contract* has been in force for a period of two years during his or her lifetime, nor unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to him or her.

Termination of a *Group Contract*

End of *Tufts Health Plan's* and *Group's* relationship

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.

*Note: In accordance with the provisions of the *Group Contract,* the *Group* is entitled to a one-month grace period for the payment of any *Premium* due, except for the first month's *Premium*. During that one-month grace period, the *Group Contract* will continue to stay in force. However, upon termination of the *Group Contract*, the *Group* will be responsible for the payment of Premium, prorated based on the actual date of the termination. That termination date will be at the end of the grace period, unless the *Group* notifies us of an earlier termination date.

Extension of Benefits

If you are totally disabled on the date the *Group Contract* ends, you will continue to receive *Covered Services* for 12 months.

The following conditions apply:

- the *Covered Services* must be:
  - *Medically Necessary*,
  - provided while the total disability lasts, and
  - directly related to the condition that caused the *Member* to be totally disabled on that date; and
- all of the terms, conditions, and limitations of coverage under the *Group Contract* will apply during the extension of benefits.

The extension of benefits will end on the earliest of:

- the date the total disability ends;
- the date you become eligible for coverage under another plan; or
- 12 months after your extended benefits began.

Transfer to Other Group Health Plans

Conditions for transfer

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 *Network Contracting 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.

Obtaining a Certificate of Creditable Coverage

Certificates of Creditable Coverage are mailed to each Subscriber and/or *Dependent* upon termination. This is done in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting us. Call the Member Services Department at 1-800-682-8059.

Chapter 5

Continuation of *Group Contract* Coverage and Conversion Privilege

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 Group 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.

FEDERAL COBRA - DURATION OF COVERAGE		
Qualifying Event(s)	**Qualified Beneficiaries**	**Maximum Period of Coverage**
• Termination of *Subscriber's* employment for any reason other than gross misconduct. • Reduction in the *Subscriber's* work hours.	*Subscriber*, *Spouse*, and *Dependent Children*	18 months*
Subscriber's divorce, legal separation, entitlement to Medicare, or death.	*Spouse* and *Dependent Children*	36 months
Subscriber's or *Spouse's* enrolled *Dependent* ceases to be a *Dependent Child*.	*Dependent Child*	36 months
*__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 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.

Rhode Island Continuation Coverage

If your employment is terminated because of involuntary layoff or death, or as a result of the workplace ceasing to exist, or the permanent reduction in size of the workforce, the benefits under this *Group Contract* may be continued as provided under Rhode Island General Laws, Chapter 27-19.1. The period of this continuation will be for up to eighteen (18) months from your termination date. The continuation period cannot exceed the shorter of:

- the period that represents the period of your continuous employment preceding termination with your *Group;* or
- the time from your termination date until the date that you or any other covered *Member* under your plan becomes employed by another employer and eligible for benefits under another group plan.

Note: We must receive the applicable *Premium* in order to continue coverage under this provision.

Rhode Island Conversion Privilege

You may be entitled to enroll in a separate health benefit contract ("converted contract") if your coverage under this *Group Contract*:

- has been terminated for any reason other than discontinuance of the *Group Contract* in its entirety or with respect to an insured class; and
- you have been continuously covered under the *Group Contract* (and under any employer contract providing similar benefits which it had replaced) for at least three (3) months immediately prior to termination.

Notes:

- You will not be entitled to coverage under a converted contract if your coverage under the *Group Contract* ended because (1) you failed to pay any required contribution or (2) any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days.
- You must submit written application for the converted contract and pay us the first required contribution no later than thirty-one (31) days after such termination.

For more information about converted contracts, please call Member Services.

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

How to File a Claim and *Member* Satisfaction

How to File a Claim

Network Providers

You may get care from a *Network Provider.* If so, you do not have to submit claim forms. The *Network Provider* will submit claim forms to us for you. We will make payment directly to the *Network Provider*.

Non-*Network Providers*

You may get care from a *Non-Network Provider*. If so, it may be necessary to file a claim form. Claim forms are available from the *Group* or *Tufts Health Plan* (See "To Get Claim Forms" and "Time Limit for Providing Claim Forms" below).

Hospital Admission or *Day Surgery*

You may get care from a hospital that is a *Non-Network Provider.* In this case, have the hospital complete a claim form. The hospital should submit the claim form directly to us. If you are responsible for any part of the hospital bill, we will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the Non-*Network Hospital*.

Outpatient Medical Expenses

When you receive care from a *Non-Network Provider*, you are responsible for completing claim forms. (Check with the *Non-Network Provider* to see if he or she will submit the claim directly to us. If not, you must submit the claim form directly to us.)

If you sign the appropriate section on the claim form, we will make payment directly to the *Non-Network Provider*. If you are responsible for any portion of the bill, we will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the *Non-Network Provider*.

If you do not sign the appropriate section on the claim form, we will make payment directly to you. If you have not already paid, you will be responsible for paying the *Non-Network Provider* for the services you received. If you are responsible for any part of the bill, we will send you an explanation of benefits statement. The explanation of benefits statement will tell you how much you owe the *Non-Network Provider*.

To Get Claim Forms

You can get claim forms from the *Group*. Or, you can call Member Services.

Where to Forward Medical Claim Forms

Send completed claim forms to:

[*Tufts Health Plan*
Claims Department
P.O. Box 9185
Watertown, MA 02471-9185]

You should submit separate claim forms for each family member.

How to File a Claim, continued

Pharmacy Expenses

You may obtain a prescription at a non-designated or out of network pharmacy. If so, you must pay for the prescription up front. Then, submit a claim for reimbursement. You can get a pharmacy claim forms by calling Member Services. Or, see our Web site at **www.tuftshealthplan.com**.

Time Limit for Providing Claim Forms

We will provide the *Member* making a claim, or to the *Group* for delivery to such person, the claim forms we furnish for filing proof of loss for *Covered Services* obtained at the *Out-of-Network Level of Benefits*. If we do not provide such forms within 15 days after we received notice of any claim under the *Group Contract*, the *Member* making that claim will be deemed to have met the requirements under that *Group Contract* for proof of loss, upon submitting to us within the time fixed in the *Group Contract* for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Member Satisfaction Process

Tufts Health Plan has a multi-level Member Satisfaction process including:

- Internal Inquiry;
- *Member* Grievance Process;
- Two levels of Internal *Member* Appeals; and
- External Review by an External Appeals Agency designated by the Rhode Island Department of Health.

Mail all grievances and appeals to us:

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

You can also call us at **1-800-682-8059**.

Internal Inquiry

Call a Member Specialist to discuss concerns you have about your health care coverage. We will make every effort to resolve your concerns. You may choose to file a grievance or appeal. If you do this, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Member Grievance Process

A grievance is a formal complaint about actions taken by *Tufts Health Plan* or a *Network 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 us as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. You may choose to file a grievance verbally. If you do this, please call a *Tufts Health Plan* Member Specialist. That person 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. Then, send it to the address at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and *Provider* names; and
- any supporting documentation.

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

Administrative Grievances

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

Administrative Grievance Timeline

- You may file your grievance verbally or in writing. If you do this, we will notify you by mail. We will notify you within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That notification will provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- We will review your grievance and will send you a letter regarding the outcome. As allowed by law, we will send that 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. This will be done by 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. You may have concerns about your medical care. If so, you should discuss them directly with your *Provider*. You may not be satisfied with your *Provider's* response or not want to address your concerns directly with your *Provider.* If so, you may contact Member Services to file a clinical grievance.

You may file your grievance verbally or in writing. If so, we will notify you by mail, within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That letter will include the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.

We will review your grievance and will notify you in writing regarding the outcome. As allowed by law, we will send that letter within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days. This may occur if we need additional time to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

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 coordinate a review of all of the information submitted upon appeal. That review will consider your benefits as detailed in this *Certificate.* You are entitled to two (2) levels of internal review.

It is important that you contact us 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, or first level appeal denial to file an internal appeal. Appeals may be filed either verbally or in writing. You may file a verbal appeal. To do this, call a Member Specialist. That person will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing. Then, send it to the address listed earlier in this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and *Provider* names; and
- any supporting documentation.

Member Satisfaction Process, continued

Appeals Timeline

- You may file your appeal verbally or in writing. If you do this, we will notify you in writing, within three (3) business days after receiving your letter, that your letter has been received. Our letter will include the name, address, and number of the Appeals and Grievances Analyst coordinating the review of your appeal.
- We will review your appeal, make a decision, and send you a decision letter within fifteen (15) calendar days of receipt.
- The time limits in this process may be extended by mutual verbal or written agreement between you or your authorized representative and *Tufts Health Plan*. The extension can be for up to 15 calendar days.

We may be waiting for medical records needed to review your appeal. If we have not received them, we may need this extension. The Appeals and Grievances Analyst handling your case will notify you in advance if an extension may be needed. The notification will include the specific information required to complete the review.

When Medical Records are Necessary

Your appeal may require the review of medical records. In this event, we will send you a form. You must sign that form to authorize your *Providers* to release to *Tufts Health Plan* medical information relevant to your appeal. You must sign and return the form to us before we can begin the review process. If you do not sign and return the form to us within fifteen (15) calendar days of the date you filed your appeal, we may issue a response to your request without reviewing the medical records. You will have access to any medical information and records relevant to your appeal in our possession and control.

Who Reviews Appeals?

First level appeals of a medical necessity determination will be reviewed by a licensed practitioner:

- with the same licensure status or a licensed physician or a licensed dentist; and
- who did not participate in any of the prior decisions on the case.

Second level appeals will be reviewed by a licensed practitioner in the same or similar specialty as typically treats the medical condition, procedure or treatment under review.

A designated reviewer will review appeals involving non-*Covered Services*. That person will be from the Appeals and Grievances Department.

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 an adverse appeal determination (a decision based on medical necessity) will include: the specific information upon which the adverse appeal determination was based; our 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; the title and credentials of the individual who reviewed the case; notification of the steps requested the next level of internal appeal or an external review by an External Appeals Agency, designated by the Rhode Island Department of Health, as appropriate; and the availability of translation services and consumer assistance programs.

Appeal Response Letters, continued

Also, a first level adverse appeal determination letter will notify you that should you file a second level appeal, you have the right to: (1) inspect the appeal review file; and (2) add information prior to our reaching a final decision. Finally, a second level adverse appeal determination letter will include:

- fee information for filing an external review; and
- a statement that if *Tufts Health Plan's* decision is overturned by the external appeals agency, you will be reimbursed by *Tufts Health Plan* within sixty (60) days of the date you are notified of the overturn for your share of the appeal fee.

Expedited Appeals

We recognize that there are circumstances that require a quicker turnaround than the fifteen (15) calendar days allotted for the standard Appeals Process. We 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. Additionally, we will expedite your appeal if a medical professional determines it involves emergent health care services (defined as services provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g., severe pain) where the absence of immediate medical attention could be reasonably expected to result in placing your health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part). If your request meets the criteria for an expedited review, you may also file a request for a simultaneous external appeal.

If you feel your request meets the criteria cited above, you or your attending *Provider* should contact Member Services. Under these circumstances, you will be notified of our decision on the earlier of:

- within two (2) business days of receipt of all information necessary to complete the review; or
- seventy-two (72) hours after the review is initiated.

External Review

Tufts Health Plan provides for an independent external review by an external appeal agency for final adverse determinations. These are decisions based on medical necessity. The Rhode Island Department of Health has designated an external appeal agency who performs independent reviews of final adverse medical necessity decisions. The external review agency is not connected in any way with *Tufts Health Plan*. Please note that appeals for coverage of services excluded from coverage under your plan are not eligible for external review.

To initiate this external appeal, you must send a letter to us within four months of the receipt of your second level adverse determination letter. In that letter, you must include any additional information that you would like the external review agency to consider.

Within five (5) days of receipt of your written request, *Tufts Health Plan* will forward the complete review file, including the criteria utilized in rendering its decision, to the external appeal agency. The external appeal agency shall provide notice to you and your *Provider* of record of the outcome of the external appeal.

External Review, continued

The external review shall be based on the following:

- the review criteria used by *Tufts Health Plan* to make the internal appeal determination;
- the medical necessity for the care, treatment or service for which coverage was denied; and
- the appropriateness of the service delivery for which coverage was denied.

The decision of the external appeals agency is binding. However, any person who is aggrieved by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

If the external appeals agency overturns *Tufts Health Plan's* appeal decision, we will send you a written notice within five (5) business days of receipt of the written decision from the appeal agency. This notice will:

- include an acknowledgement of the decision of the agency;
- advise of any 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 appeal.

Bills from *Providers*

Bills from *Providers*

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

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

- A completed, signed Member Reimbursement Medical Claim Form. You can obtain this form from our Web site. You can also get one by contacting our Member Services Department; and
- the documents required for proof of service and payment. Those documents are listed on the Member Reimbursement Medical Claim Form.

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

Note: You must contact *Tufts Health Plan* regarding your bill(s) or send your bill(s) to us within 90 days from the date of service, or as soon as reasonably possible. If you do not, the bill cannot be considered for payment, unless you are legally incapacitated. In no event, except in cases of legal incapacitation, can bills be considered for payment after a period of 1 year.

If you receive *Covered Services* from a *Non-Network Provider*, we will pay up to the *Reasonable Charge* for the services within 60 days of receiving a completed Member Reimbursement Medical Claim Form and all required supporting documents.

We reserve the right to be reimbursed by the *Member* for payments made due to our error.

IMPORTANT NOTE:

We will directly reimburse you for *Covered Services* you receive from most *Non-Network Providers* within our *Network Contracting Area.* Some examples of these types of *Non-Network Providers* include:

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

You will be responsible to pay the *Non-Network Provider* for those *Covered Services.*
For more information, call Member Services, or check our Web site at **www.tuftshealthplan.com.**

[Notice to Michigan Residents

Tufts Health Plan will promptly process a complete and proper claim for *Covered Services.* made by a *Member* will be promptly processed by *Tufts Health Plan.* However, in the event there are delays in processing claims, the *Member* shall have no greater rights to interest or other remedies against *Tufts Health Plan's* third party administrator, Tufts Benefit Administrators, Inc., than as otherwise afforded to him or her by law.]

Limitation on Actions

You cannot bring an action at law or in equity to recover on this *Group Contract* prior to the expiration of sixty (60) days after a claim has been filed in accordance with the requirements stated under "How to File a Claim" earlier in this chapter. You cannot bring such action at all unless you bring it within three (3) years from the expiration of the time within which a claim must be filed as listed under "Bills from Providers" earlier in this chapter.

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 (a "Third Party"). "Third Party" means any person or company that is, or could, be, responsible for the costs of injuries or illness to you. This includes such costs to any *Dependent* covered under this plan.

Tufts Health Plan may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source. This includes, but is not limited to:

- payment made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or rewards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you for Third Party injuries.

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We 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.

Tufts Health Plan's right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy;
- premises or homeowners medical payments coverage;
- premises or homeowners insurance coverage; and
- any other payments from a source intended to compensate you where a Third Party is responsible.

We have the right to be reimbursed up to the amount of any payment received by you. This is 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 compensate you fully for the illness or injury.

Member cooperation

You further agree:

- to notify us promptly and in writing when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a claim to recover damages or obtain compensation;
- to cooperate with us and provide us with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this *Plan*;
- to assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of health care services and supplies, and expenses, that we paid or will pay for your illness or injury;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any Third Party. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this Plan;
- to serve as a constructive trustee for the benefit of this Plan over any settlement or recovery funds received as a result of Third Party responsibility;
- that we may recover the full cost of all benefits provided by this Plan without regard to any claim of fault on your party, whether by comparative negligence or otherwise;
- tht no court costs or attorney fees may be deducted from our recovery;
- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party without our prior express written consent; and
- that in the event you or your representative fails to cooperate with *Tufts Health Plan,* you shall be responsible for all benefits provided by this *Plan* in addition to costs and attorney's fees incurred by *Tufts Health Plan* in obtaining repayment.

Workers' compensation

Employers provide workers' compensation insurance for their employees. Employers do this 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. We will not provide coverage for any injury or illness for which it determines that the *Member* is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability; or (2) indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay for costs of health care services or medications for any work-related illness or injury. If we do this, we have 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 us for any work-related illness or injury, contact the Liability and Recovery Department at 1-888-880-8699, x. 1098.

Subrogation, continued

Subrogation Agent

We may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as our agent.

Constructive Trust

By accepting benefits from *Tufts Health Plan*, 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. This is the case whether the payment of such benefits is made to you directly or made on your behalf, for example to a.*Provider.* Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to *Tufts Health Plan.*

Coordination of This *Group Contract's* Benefits with Other Benefits

Applicabililty

A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of "This Plan" are determined before or after those of another plan. The benefits of "This Plan":

   (1) shall not be reduced when, under the order of benefit determination rules, "This Plan" determines its benefits before another plan; but

   (2) may be reduced when, under the order of benefits determinationrules, another plan determines its benefits first. The above reduction is described in the "Effect on the Benefits of "This Plan" " section below.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Definitions

A. "Plan" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the *Group Contract* that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether "This Plan" is a Primary Plan or Secondary Plan as to another plan covering the person. When "This Plan" is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When "This Plan" is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, "This Plan" may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under "This Plan", or any part of a year before the date this COB provision or a similar provision takes effect.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Order of Benefit Determination Rules

A. General. When there is a basis for a claim under "This Plan" and another plan, "This Plan" is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of "This Plan"; and

(2) Both those rules and "This Plan's"' rules, in Subsection B below, require that "This Plan's" benefits be determined before those of the other plan.

B. Rules. "This Plan" determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph B(3) below, when "This Plan" and another plan cover the same child as a dependent of different person, called "parents:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has the rule based upon the gender of the patient, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Order of Benefit Determination Rules, continued

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above in Paragraph B(2) of this section.

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

Effect on the Benefits of "This Plan"

A. When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules" section above, "This Plan" is a Secondary Plan as to one or more other plans. In that event the benefits of "This Plan" may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in "This Plan"'s Benefits. The benefits of "This Plan" will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expenses under "This Plan" in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of "This Plan" will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of "This Plan" are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of "This Plan".

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. *Tufts Health Plan* has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. *Tufts Health Plan* need not tell, or get the consent of, any person to do this. Each person claiming benefits under "This Plan" must give *Tufts Health Plan* any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under "This Plan". If it does, *Tufts Health Plan* may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under "This Plan". *Tufts Health Plan* will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Right of Recovery

If the amount of the payments made by *Tufts Health Plan* is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

For more information

Contact the Liability and Recovery Department at 1-888-880-8699, x.1098. You can also call a Member Specialist. That person can transfer your call to the Liability and Recovery Department.

Medicare Eligibility

Medicare eligibility

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

Tufts 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.* This notice explains how we use and disclose 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 and *Providers*

Tufts Health Plan arranges health care services. We do not provide health care services. We have agreements with *Providers* practicing in their private offices throughout the *Network Contracting Area*. These *Providers* are independent. They are not *Tufts Health Plan* employees, agents or representatives. *Providers* are not authorized to change this *Certificate* or assume or create any obligation for *Tufts Health Plan*.

We are 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, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of *Network Providers.*

Group Contract

Acceptance of the terms of the *Group Contract*

By signing and returning the membership application form, you: (1) apply for *Group* coverage; and (2) agree, on behalf of yourself and your enrolled *Dependents*, to all the terms and conditions of the *Group Contract*, including this *Certificate*.

Notes:

- The validity of the *Group Contract* cannot be contested, except for non-payment of *Premium*, after it has been in force for two years from its date of issue.
- A copy of the *Group's* application will be attached to the *Group Contract* when issued. All statements made by the *Group* or by *Members* in that application shall be deemed representations and not warranties.
- No agent has authority to change the *Group Contract* or waive any of its provisions. In addition, no change in the *Group Contract* shall be valid unless approved by an officer of *Tufts Health Plan* and evidenced by an amendment to the *Group Contract* signed by us. Please note, though, that any such amendment that reduces or eliminates coverage must be requested in writing by the *Group* or signed by the *Group*.

Payments for coverage

We will bill your *Group* and your *Group* will pay *Premiums* to us for you. We are 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: Your *Group* may fail to pay the *Premium* on time. If this happens, we 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*" in Chapter 4.

We may change the *Premium*. If the *Premium* is changed, the change will apply to all *Members* in your *Group*.

Changes to this *Certificate*

We may change this *Certificate*. Changes do not require your consent. [Notice of changes in *Covered Services* will be sent to your *Group* at least [30] [60] days before the effective date of the modifications. That notice will: (1) include information regarding any changes in clinical review criteria; and (2) detail the effect of such changes on a *Member's* personal liability for the cost of such charges.]

An amendment to this *Certificate* describing the changes [will be sent to you. It] 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.* They will not apply just to you.

Notice

Notice to *Members*: When we send a notice to you, it will be sent to your last address on file with us.

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
We may choose to waive certain terms of the *Group Contract*, if applicable. This includes the *Certificate*. This does not mean that we give up our rights to enforce those terms in the future.

When this *Certificate* Is Issued and Effective
This *Certificate* is issued and effective on your *Group Anniversary Date* on or after [July 1, 2012]. It supersedes all previous *Certificates*. We will issue a copy of the *Certificate* to the *Group* and to all *Subscribers* enrolled under this plan.

Appendix A
Glossary of Terms And Definitions

This section defines the terms used in this *Certificate*.

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: A foster child is considered an *Adoptive Child* as of the date of placement for adoption.

Anniversary Date

The date when the *Group Contract* first renews. Then, 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. *BCBAs* must also be individually licensed by the Rhode Island Department of Health as a healthcare provider/clinician, and credentialed by *Tufts HP.* 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.]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, the autism spectrum disorder benefit and this definition only apply to groups of 51 or more*

Certificate

This document, and any future amendments, which describes the health benefits under the *Group Contract*.

Child

The following individuals until their 26th birthday:

- The *Subscriber's* or *Spouse's* natural child, stepchild, or *Adoptive Child* who qualifies as a *Dependent* for federal tax purposes; or
- [the *Child* of an enrolled child; or]
- any other *Child* for whom the *Subscriber* has legal guardianship.

Coinsurance

The *Member's* share of costs for *Covered Services* not provided by *Network Providers*. For services provided by a *Non-Network Provider*, the *Member's* share is a percentage of the *Reasonable Charge* [For services provided by a *Network Provider*, the *Member's* share is a percentage of: (1) the applicable Network fee schedule amount for those services and (2) the *Network Provider's* actual charges for those services, whichever is less.]

[Note: The *Member's* share percentage is based on the *Network Provider* payment at the time the claim is paid. It does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.]

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

[Community Hospital]

[Any *Network Hospital* other than a *Tertiary Hospital*.]

Community Residence

Any home or other living arrangement which is established, offered, maintained, conducted, managed, or operated by any person for a period of at least 24 hours, where, on a 24-hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, habilitation, psychological support, and/or social guidance for three or more persons with substance abuse or *Mental Disorders,* or persons with developmental disabilities or cognitive disabilities such as brain injury. Examples include, but are not limited to, group homes, halfway homes, and fully-supervised apartment programs. Semi-independent living programs, foster care, and parent deinstitutionalization subsidy aid programs are not considered *Community Residences* under this *Certificate.*

Contract Year

The 12-month period determined by the *Group* in which benefit limits, *Deductibles*, *Out-of-Pocket Maximum,* and *Coinsurance* are calculated under this plan. A *Contract Year* can be either a calendar year or a plan year.

- Calendar year: Coverage based on a calendar year runs from January 1st through December 31st within a year.
- Plan year: Coverage based on a plan year runs during a period of 12 consecutive months that are not a calendar year. As an example, a plan year can run from July 1st in one calendar year through June 30th in the following calendar year).

For more information about the type of *Contract Year* that applies to your plan, call Member Services. You can also contact your employer.

[Copayment]

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

[**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 we will pay. They must be:

- described in Chapter 3 of this *Certificate* (They are subject to the "Exclusions from Benefits" section in Chapter 3.); and
- *Medically Necessary*.

These services include *Medically Necessary* coverage of pediatric specialty care (This includes mental health care.) by *Providers* with recognized expertise in specialty pediatrics.

[Note: *Covered Services* do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any *Provider*, *Member*, service, supply or medication.]

Custodial Care

- Care provided primarily to assist in the activities of daily living. Examples include 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) provided to a *Member* at a facility licensed by the state to perform surgery. The *Member* must be expected to depart the same day, or in some instances, within 24 hours. Also called "Ambulatory Surgery" or "Surgical Day Care".

[**Deductible**

For each [calendar year] [*Contract Year*], the amount paid by the *Member* for [certain] *Covered Services* [not provided by a *Network Provider*] before any payments are made under this *Certificate*. [(Any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a [calendar year] [*Contract Year*] shall be carried forward to the next [calendar year's] [*Contract Year's*] *Deductible*.)] [*Copayments* do not count toward the *Deductible*.] See "Benefit Overview" at the front of this *Certificate* for more information.]

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

Dependent

The *Subscriber's Spouse*, *Child*, [*Domestic Partner*,] 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.

Directory of Health Care Providers
A separate booklet which lists Network physicians. It also lists their affiliated *Network Hospital(s)*, and certain other *Network Providers*. Note: This directory is updated from time to time to reflect changes in *Network Providers*. For information about the *Providers* listed in the *Directory of Health Care Providers*, you can call [Member Services.] [Or, you can check our Web site at **www.tuftshealthplan.com]**.

Disabled Dependent
The *Subscriber's* or *Spouse's* natural child, stepchild, or *Adoptive Child* of any age who:
- is medically determined to have a physical or mental impairment or has a disability which can be expected to result in death, or can be expected to last for a period of not less than 12 months; and
- who is financially dependent on the *Subscriber*.

[Domestic Partner]
[An unmarried *Subscriber's* individual partner of the same or opposite sex who:
- [is at least 18 years of age;]
- is not married;
- has not been married (or has not been in a prior domestic partner relationship) for at least the prior [0-12] consecutive months;
- is not related to the *Subscriber* by blood; and
- meets the eligibility criteria described in Chapter 2.]

[The *Subscriber* and the *Domestic Partner* must:
- share a mutually exclusive and enduring relationship;
- have shared a common residence for [[0-12] prior consecutive months] and intend to do so indefinitely;
- be financially interdependent;
- be jointly responsible for their common welfare; and
- be committed to a life partnership with each other.]

Note: Roommates who do not satisfy the above criteria, parents and siblings of the *Subscriber* cannot qualify as *Domestic Partners*.]

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 our 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 (This includes 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 we have 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. The *Group* is your agent. It is not *Tufts Health Plan's* agent.

Group Contract
The agreement between *Tufts Health Plan* and the *Group* under which:

- we agree to provide *Group* coverage; and
- the *Group* agrees to pay a *Premium* to us on your behalf.

The *Group Contract* includes this *Certificate* and any amendments.

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

In-Network Level of Benefits
The level of benefits that a *Member* receives when *Covered Services* are provided by a *Network Provider*. See Chapter 1 for more information.

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.

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, we use *Medical Necessity* Guidelines. These Guidelines are:

- developed with input from practicing physicians in the *Network Contracting Area*;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- evidence-based, if practicable.

Member
A person enrolled in *Tufts Health Plan* under the *Group Contract*. Also referred to as “you”.

Mental Disorders

Any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization and that substantially limits the life activities of the person with the illness. *Mental Disorders* do not include tobacco and caffeine in the definition of substance. In addition, *Mental Disorders* do not include: mental retardation, learning disorders, motor skills disorders, communication disorders, and mental disorders classified as "V" codes.

Network Contracting Area

The geographic area within which we have developed or arranged for a network of *Providers* to afford *Members* with adequate access to *Covered Services*.

Note: For information about *Providers* in the *Network Contracting Area*, call [Member Services] [or check our Web site at **www.tuftshealthplan.com]**.

Network Hospital

A hospital which has an agreement either with *Tufts Health Plan* directly or with a *provider* network with whom we have a contract to provide certain *Covered Services* to *Members*. *Network Hospitals* are independent. They are not owned by *Tufts Health Plan*. *Network Hospitals* are not *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees. *Network Hospitals* are subject to change.

Network Provider

A *Provider* who has an agreement either with *Tufts Health Plan* directly or with a provider network with whom we have a contract to provide *Covered Services* to *Members*. *Network Providers* are located throughout the *Network Contracting Area*.

Non-Network Provider

A *Provider* who does not have an agreement either with *Tufts Health Plan* directly or with a provider network with whom we have a contract to provide *Covered Services* to *Members*.

Observation

The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within twenty-three (23) hours or a verified diagnosis and concurrent treatment plan. At times, an observation stay may be followed by an *Inpatient* admission to treat a diagnosis revealed during the period of observation.

Open Enrollment Period

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*.

Out-of-Network Level of Benefits

The level of benefits that a *Member* receives when *Covered Services* are not provided by a *Network Provider*. See Chapter 1 for more information.

Outpatient

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

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

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

[Out-of-Pocket Maximum]

[The maximum amount of money paid by a *Member* during a [calendar year] [*Contract Year*] for [certain] *Covered Services* [which are not provided by a *Network Provider*]. The *Out-of-Pocket Maximum* consists of [*Copayments,*] [the *Deductible*] [and] [*Coinsurance*]. It does not include [*Copayments*], or costs for health care services that are not *Covered Services* under the *Group Contract*.]

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

[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 Behavioral Analyst (BCBA)* who is a licensed health care clinician. As required by Rhode Island law, Board-Certified Assistant Behavioral Analysts (BCaBAs) are considered *Paraprofessionals.]*

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, the autism spectrum disorder benefit and this definition only apply to groups of 51 or more*

[Pre-Existing Condition]

[A condition which had during the six months immediately preceding your *Effective Date*, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received. Pregnancy is not considered a pre-existing condition.]

Premium

The total monthly cost of *Individual* or *Family Coverage* that [the *Group* pays] [is paid] to *Tufts Health Plan*.

Preregistration

Tufts Health Plan's process of verifying authorization required for all *Inpatient* admissions and transfers. *Preregistration* is not a guarantee of payment. See Chapter 1 for further information.

Prior Authorization

A process we use to decide if a health care service or supply qualifies as a *Covered Service* and is *Medically Necessary*. We recommend that you get prior authorization before obtaining care for certain *Covered Services*. *Covered Services* for which we suggest prior authorization include a "(PA)" notation in the "Benefit Overview" section of this document. This process is handled by *Tufts Health Plan's* [Chief Medical Officer] or someone we designate. For services you receive at the *In-Network Level of Benefits*, your *Network Provider* is responsible for obtaining *prior authorization*.

To request prior authorization, please call us. For mental health services, call our Mental Health Department at 1-800-208-9565. For all other *Covered Services*, call our Member Services Department at 1-800-682-8059. For more information about our prior authorization process, call Member Services or check our Web site at **www.tuftshealthplan.com**.

[Primary Care Provider]

[A *Network Provider* who is a general practitioner, family practitioner, nurse practitioner, internist, pediatrician, or obstetrician/gynecologist who provides primary care 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, licensed nurse midwives, certified registered nurse anesthetists, certified registered 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, tobacco treatment specialists, licensed speech-language pathologists, licensed marriage and family therapists; and licensed audiologists.

We will only cover services of a *Provider*, if those services are listed as *Covered Services* and within the scope of the *Provider's* license.

Reasonable Charge

The lesser of:

- the amount charged by the *Non-Network Provider*; or
- the amount that we determine to be reasonable. We decide this amount based on nationally accepted means and amounts of claims payment. These means and amounts include, but are not limited to: Medicare fee schedules and allowed amounts; CMS medical coding policies; AMA CPT coding guidelines; nationally recognized academy and society coding; and clinical guidelines.

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

Skilled

A type of care which is *Medically Necessary*. This care 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.

Spouse also includes the spousal equivalent of the *Subscriber* who is the registered *Domestic Partner,* civil union partner, or other similar legally recognized partner of the *Subscriber* who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Subscriber

The person:

- who is [employed by the *Group*] [a person eligible to be *Subscriber* under the *Group*];
- 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 a *Group Contract*.

[Tertiary Hospital]

[Each of the following hospitals:

- [Beth Israel Deaconess Medical Center (Boston, MA);]
- [Boston Medical Center (Boston, MA);]
- [Brigham & Women's Hospital (Boston, MA);]
- [Children's Hospital (Boston, MA);]
- [Dana-Farber Cancer Institute (Boston, MA);]
- [Lahey Clinic (Burlington, MA);]
- [Mary Hitchcock Memorial Hospital (Hanover, NH);]
- [Massachusetts Eye & Ear Infirmary (Boston, MA);]
- [Massachusetts General Hospital (Boston, MA);]
- [New England Baptist Hospital (Boston, MA);]
- [Rhode Island Hospital, including Hasbro Children's Hospital (Providence, Rhode Island);]
- [Tufts-New England Medical Center (Boston, MA);]
- [UMass Memorial Medical Center (Worcester, MA).]]

Tufts Health Plan

Tufts Insurance Company (TIC) which is authorized to offer POS and PPO products. TIC has entered into an agreement with Tufts Benefit Administrators, Inc. (TBA) for TBA to administer the health benefits and make available a network of *Providers* described in this *Certificate*.

Both TIC and TBA do business under the name *Tufts Health Plan*. *Tufts Health Plan* is also called "we", "us", and "our".

[**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 may be provided after the *Urgent* condition is treated and stabilized and the *Member* is safe for transport. This care is not considered *Urgent Care*.]

Appendix B - ERISA Information

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 (EBSA).
- 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).
- 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] [includes] a preexisting condition exclusion.

(continued on next page)

ERISA RIGHTS, continued

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.

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 1-800-682-8059 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 claims: 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, we will respond to you within 72 hours after receipt of the claim. If we determine 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. We 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 we have already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, we 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, we 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.

PROCESSING OF CLAIMS FOR PLAN BENEFITS, continued

Types of claims, continued

[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, we will respond to you within 72 hours for an urgent request and within 15 days for a non-urgent request after receipt of the claim. If we determines that an extension is necessary for a non-urgent request 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 us to make a determination, we will notify you within 15 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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, we will respond to you within 30 days after receipt of the claim. If we 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 us to make a determination, we will notify you within 30 days and describe the information that you need to provide to us. 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.]

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 physician 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 entitlted to up to 12 weeks of leave because of "any qualifying exigency" due to the fact that the spouse, son, daugheter, 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.

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/esa/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.

How We Use and Disclose Your PHI, continued

- **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.

How We Use and Disclose Your PHI, continued

- **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*.

NOTICE OF PRIVACY PRACTICES, continued

Your Individual Rights, continued

- **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 a 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.

Rhode Island CareLink PPO Certificate for
Tufts Insurance Company (TIC)

7-2012 edition –REVISED CLEAN COPY

(submitted to Rhode Island Dept. of Business Regulation – 3-18-13)

TUFTS Health Plan

Preferred Provider Organization

CareLink SM

Open Access Plan

CERTIFICATE OF INSURANCE

Underwritten by Tufts Insurance Company

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

[There is a pre-existing condition limitation under this plan. See Chapter 7 for more information.]

Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508

[*Tufts Health Plan* Address And Telephone Directory

TUFTS HEALTH PLAN
705 Mount Auburn Street
Watertown, MA 02472-1508
Hours: Monday – Thursday 8:00 a.m. to 7:00 p.m. E.S.T.
Friday 10:00 a.m. to 5:00 p.m. E.S.T.]

IMPORTANT PHONE NUMBERS:

Emergency Care

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

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

Liability Recovery

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

You may have questions about subrogation. If so, call a *CareLink* Member Specialist at 1-866-352-9114. Yyou may not be sure about the department to call with your questions. If so, call Member Services.

Member Services Department

Call our Member Services Department at 1-866-352-9114 for: general questions; benefit questions; and information regarding eligibility for enrollment and billing.

Mental Health Services

You may need information regarding mental health benefits. If so, contact *CareLink* at 800-232-1164.

Services for Hearing Impaired *Members*

You may be hearing impaired. If so, the following services are provided:

Telecommunications Device for the Deaf (TDD)

You may have access to a TDD phone. If so, call 1-800-868-5850. You will reach the *CareLink* Member Services.

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

Rhode Island Relay
[1-800-745-5555]

IMPORTANT ADDRESSES:

Appeals and Grievances Department
You may need to call *CareLink* about a concern or appeal. If so, contact a Member Specialist at 1-866-352-9114. To submit your appeal or grievance in writing, send your letter to:

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

Web site
You may want information about *Tufts Health Plan* or to learn about the self-service options are available to you. If so, see the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

Translating Services

Translating services for 140 languages

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

English:
CareLink will provide to you, upon request, interpreter and translation services related to administrative procedures.

Arabic: سوف توفر لكCareLink، في حالة الطلب، خدمات الترجمة الشفهية والخطية المتعلقة بالإجراءات الإدارية.

Brazilian Portugese:
A CareLink lhe fornecerá, sob pedido, serviços de interpretação e tradução relacionados aos procedimentos administrativos.

Continental Portugese:
CareLink disponibilizar-lhe-á, mediante pedido, serviços de interpretação e de tradução relacionados com procedimentos administrativos.

French:
CareLink vous fournira sur demande des services de traduction et d'interprétation relatifs à vos procédures administratives.

Greek:
H CareLink θα σας παρέχει, μετά από αίτησή σας, υπηρεσίες διερμηνείας και μετάφρασης σχετικά με τις διαδικασίες διαχείρησης.

Italian:
Su richiesta CareLink vi procurerà servizi di interpretariato e di traduzione in relazione alle procedure amministrative.

Khmer:
CareLink នឹងផ្តល់អ្នកបកប្រែ និងកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងនឹងរបៀបចាត់ចែងការ ទៅឲ្យអ្នកតាមការស្នើ ។

Kreyole:
Depi ou mande, "CareLink" ap founi-ou sèvis entèpretasyon ak tradiksyon nan domenn pwosedi administratif.

Lao:
ຖ້າທ່ານຮ້ອງຂໍ, CareLink ຈະຈັດຕຽມບໍລິການນາຍພາສາແລະແປເອກະສານໃນເລື້ອງທີ່ກ່ຽວຂ້ອງກັບ ຂັ້ນຕອນການບໍລິຫານ ໃຫ້ກັບທ່ານ.

Russian:
По вашему требованию, компания CARELINK предоставит вам услуги устного и письменного переводчика в связи с прохождением административных процедур.

Simplified Chinese:
在要求时，CARELINK 会提供与行政程序有关的传译员和翻译服务。

Traditional Chinese:
在要求時，CARELINK 會提供與行政程序有關的傳譯員和翻譯服務。

Spanish:
Si lo solicita, CareLink le proporcionará servicios de interpretación y traducción relacionados con procedimientos administrativos.

1-866-352-9114

Telecommunications Device for the Deaf (TDD)

Call 1-800-868-5850.

Certificate of Insurance

THIS BOOKLET IS YOUR *CERTIFICATE* OF INSURANCE for health benefits underwritten by (“TIC”). TIC has entered into an agreement with Tufts Benefit Administrators (“TBA”) for TBA to administer health benefits. TBA also makes available a network of *Providers* described in this *Certificate*. Both TIC and Tufts Benefit Administrators (“TBA”) do business under the name of *Tufts Health Plan.* TBA and TIC have entered into an agreement with Connecticut General Life Insurance Company and its affiliates, International Rehabilitation Associates, Inc. and CIGNA Behavioral Health, Inc. (These companies are collectively referenced as “CIGNA.”). Under this agreement, CIGNA, on behalf of TIC, provides certain administrative services including participating provider network contracting and maintenance outside of Massachusetts and Rhode Island, medical management, and contracting and maintenance of a behavioral health provider network. Throughout this *Certificate*, your health insurance coverage provided in accordance with this agreement is referred to as *CareLink*.

Network Providers are hospitals, community-based physicians and other community-based health care professionals. They work in their own offices throughout the *Network Contracting Area*. *Tufts Health Plan* does not provide health care services to *Members*. *Network Providers* provide health care services to *Members*. These *Providers* are independent contractors. They are not the employees or agents of *Tufts Health Plan* for any purposes.

This *Certificate* describes the benefits, exclusions, conditions and limitations provided under the *Group Contract.* It applies to persons covered under the *Group Contract*. It replaces any *Certificate* previously issued to you. Read this *Certificate* for a complete description of benefits and an understanding of how the preferred provider plan works.

Introduction

Welcome to *Tufts Health Plan*. With *Tufts Health Plan*, each time you need health care services, you may choose to obtain your health care from either a *Network Provider* (*In-Network Level of Benefits)* or any *Non-Network Provider (Out-of-Network Level of Benefits).* Your choice will determine the level of benefits you receive for your health care services:

***In-Network Level of Benefits*:** If your care is provided by a *Network Provider*, you will be covered at the *In-Network Level of Benefits*.

[***IMPORTANT NOTE[S]:***

- [For *Outpatient* care: You may receive services from a *Primary Care Provider* (*“PCP”*). If this happens, your [*Copayment*] [*Coinsurance*] may be lower than for services from other *Providers*.]
- [For *Inpatient* care or *Day Surgery*: Your [*Copayment*] [*Coinsurance*] may be lower when you receive care at a *Community Hospital* than when you receive care at a *Tertiary Hospital.* See Appendix A for definitions of these facilities..]

For more information, see “Covered Services” in Chapter 3.]

See the “Benefit Overview” and “Plan and Benefit Information” sections and Chapter 3. These sections include more information on your coverage and costs for medical services under this plan.

***Out-of-Network Level of Benefits*:** If your care is provided by a *Non-Network Provider*, you will be covered at the *Out-of-Network Level of Benefits*.

[***Covered Services*** **Outside of the 50 United States**: *Emergency* care services you receive outside of the 50 United States qualify as *Covered Services*. In addition, *Urgent Care* services you receive while traveling outside of the 50 United States also qualify as *Covered Services.* Any other service, supply, or medication you receive outside of the 50 United States is not covered under this plan.]

For more information about these benefit levels and how to receive covered health care services, see Chapter 1. If you have any questions, call the Member Services Department.

READ THIS *CERTIFICATE* OF INSURANCE CAREFULLY.

Table of Contents

Table of Contents, continued

Chapter 3 -- *Covered Services*, continued

Table of Contents, continued

[FILING NOTE - PPO Option 1: This section describes an option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

[*COPAYMENTS*]
• **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):** • [Emergency room (per Emergency room visit).....[$0-$350]] • [In *Provider's* office (per office visit) .....[$0-$60]] [Note[s]: • [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]] • **[*Urgent Care* (*In-Network* and *Out-of-Network Level of Benefits*):]** • [*In-Network Level of Benefits*: [*Copayment* varies depending on location in which service is rendered (for example, *Emergency* room, urgent care center, or physician's office.] • [*Out-of-Network Level of Benefits* [*Copayment* varies depending on location in which service is rendered (for example, *Emergency* room, urgent care center, or physician's office] [then][*Deductible* and] *Coinsurance.]* • **Other *Covered Services* (*In-Network Level of Benefits* only):** [Office Visit (per visit) .....[$0-$60]] [Applies to *In-Network Office* Visits for: diagnostic cytological exams (Pap Smears), and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum)*; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.] *Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act. • [*Inpatient* Services (per admission).....[$0-$1,500]] • [*Day Surgery* (per admission) .....[$0-$1,500]]] **[Note**: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*] [or] [*Coinsurance*] at the *In-Network Level of Benefits.* Please see the "Benefit Overview" chart for more information.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS*, continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most Copayments] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network* Services Only)]

[*Deductible* (Individual)]

[This *Certificate of Insurance* has an Individual *Deductible* of [$0-$5,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits*.

[*Deductible* (Family)]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible*.]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when one enrolled *Member* in a family meets his or her [$0-$5,000] Individual *Deductible*; and one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Deductible* are applied toward the [$0-$25,000] Family *Deductible*.]

[Once the Family *Deductible* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] [*Contract Year*]. Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.]

[*OUT-OF-POCKET MAXIMUM*] [(*Out-of-Network* Services Only)]

[*Out-of-Pocket Maximum* (Individual)]

[This *Certificate of Insurance* has an individual *Out-of-Pocket Maximum* of [$0-$10,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits*. [Only the [*Deductible* and] *Coinsurance* count toward the *Out-of-Pocket Maximum*.]

[*Out-of-Pocket Maximum* (Family)]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum*.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when:

- one enrolled *Member* in a family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximum*s a collective amount equaling [$0-$50,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the [$0-$50,000] Family *Out-of-Pocket Maximum*.]

[Once the Family *Out-of-Pocket Maximum* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their [$0-$10,000] Individual *Out-of-Pocket Maximums* for the remainder of that [calendar year] [*Contract Year*].]

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf.**

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*]	[$0-$350] Emergency Room *Copayment*[*] [Covered in full] [*In-Network Coinsurance*]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [Observation services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]			
***Outpatient* Care**			
[*COVERED SERVICE*]	**[YOUR COST]**		**[PAGE]**
[Acupuncture] **[(PA)] [(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[3-2]
Allergy injections [**(PA)**]	[[$0-$60]*Copayment*] [Covered in full] [*Coinsurance]*	[*Deductible* and] *Coinsurance*.	[3-2]
Allergy testing [**(PA)**]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**

[**(PA)*** –*Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more.*	**Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional:* [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".	[*Deductible* and] *Coinsurance.*	[3-2]
[Cardiac rehabilitation [**(PA)**] **[(BL)]**]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-2]
Chemotherapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care See "Spinal manipulation"]			
[Chiropractic medicine] **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance.*	[3-2]
Diabetes services and supplies (For detailed information about how diabetes supplies are covered, please see "Diabetes services and supplies" in Chapter 3.)	[Diabetic test strips: [[$0-$75] *Copayment* applies] [Covered in full] [*Coinsurance*] Diabetes self-management education: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diabetes supplies covered as *Durable Medical Equipment*: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[*Deductible* and] *Coinsurance*.	[3-3]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(PA)] [*]**	**General imaging:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [[$0-$250] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [**MRI/MRA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance.*] **CT/CTA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] **PET:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.][*Coinsurance*.] [**Nuclear cardiology:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.]]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Deductible* and] [[10-50%]] *Coinsurance*.	[3-3]
Early intervention services for a Dependent Child	Covered in full.	Covered in full.	[3-3]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Family planning **[(PA)]** (procedures, services[, and contraceptives]) *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.]*]	**Office Visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Day Surgery*:** [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Immunizations	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Infertility services **(PA) [*] [(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are [covered in full] [subject to [$0-$1,500] *Copayment*] [subject to [0-20%] *Coinsurance*}]	*[Deductible* and] [0-20%] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** Laboratory tests associated with routine preventive care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	[*Deductible* and] *Coinsurance*.	[3-5]
Lyme disease	Covered in full	[*Deductible* and] *Coinsurance*.	[3-6]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Nutritional counseling **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-6]
Office visits to diagnose and treat illness or injury	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] **Office visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [*] ***Day Surgery***: [[$0-$1,500] *Day Surgery Copayment*] [Covered in full] [*Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	***Emergency* care in an Emergency Room:** [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*In-Network Coinsurance*] ***Emergency* care in a *Provider's* office:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] **All other services:** [*Deductible* and] *Coinsurance*.	[3-6]
Outpatient surgery in a *Provider's* office **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-7]
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[*Deductible* and] [*Coinsurance*.]	[3-8]
Preventive care for *Members* age 19 and under Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	Covered in full	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members* age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] All other preventive care services: Covered in full]	[*Deductible* and] *Coinsurance*.	[3-8]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Deductible* and] *Coinsurance*. Routine mammogram: [*Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive Screenings and Diagnostic Procedures & Exams - continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$1,500] *Day Surgery Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Radiation therapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]
[Short term] speech, physical and occupational therapy services [(PA)] [*] (BL)	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [*Deductible* and] *Coinsurance*. [Physical therapy:] [*Deductible* and] *Coinsurance*. [Occupational therapy:] [*Deductible* and] *Coinsurance*.	[3-9]
Smoking cessation counseling services	Covered in full.	[*Deductible* and] [*Coinsurance*.]	[3-9]
[Spinal manipulation] [**(BL)**]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-9]
[Urgent care in an urgent care center]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] [*Coinsurance*.]	[3-9]
[Vision care services] **[(PA)]**			
[Routine eye examination]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – Approval by an *Authorized Reviewer* may apply to these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Day Surgery			
Day Surgery	[[$0-$1,500] *Day Surgery Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] [*Coinsurance*.] [**Anesthesia**: [*Deductible* and] [[10%-40%] *Coinsurance*. **All other *Day Surgery* services**: [*Deductible* and] [[10-40% *Coinsurance*].]	[3-10]
***Inpatient* Care**			
Extended care services **(PA) [*]** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] [*Coinsurance*.]] [**Anesthesia**: [*Deductible* and] [[10-40%] *Coinsurance*. **All other hospital services**: [*Deductible* and] [10%-40%] *Coinsurance*.]	[3-11]
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-11]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Maternity Care			
Outpatient **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [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.]	[*Deductible* and] *Coinsurance*.	[3-11]
Inpatient	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-12]
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient* and Intermediate)**			
To contact *CareLink*, call 800-232-1164.			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*] –** [[$0-$60] Office Visit *Copayment* per visit.] [[0%-50%] *Coinsurance*].] [Individual session –] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [Group session – [[$0-$60] Office Visit *Copayment* per visit.]]Covered in full.]] [*Coinsurance*] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*] –** [[$0-$60] Office Visit*Copayment* per visit.] [[0%-50%] *Coinsurance*].] [Individual session -] [[$0-$60 Office Visit *Copayment*] [Covered in full.] [[0%-50%] *Coinsurance*].] [Group session -] [[$0-$60] Office Visit *Copayment*] [Covered in full.] [*Coinsurance*].]	[*Deductible* and] *Coinsurance*.	[3-13]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**

[(PA)* – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options. Page 10 of 14]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient* and Intermediate), continued**			
To contact *CareLink*, call 800-232-1164.			
Inpatient services **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
To contact *CareLink*, call 800-232-1164.			
Outpatient services [**(BL)**]	Substance Abuse Treatment Services: [Individual session -] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]. [Group session -] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*].	[*Deductible* and] *Coinsurance*.	[3-14]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Inpatient services **(PA)** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Intermediate care **[(PA)]** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Community Residential care **(PA) [(BL)]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services			
Ambulance services **(PA) [*]**			
Ground ambulance services	[Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Deductible* and then] [Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-15]
All other covered ambulance services	[Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-15]
[Diabetic monitoring strips]	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-15]
Durable Medical Equipment **(PA) [*]**	[Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] *Coinsurance*.	[3-16]
Hearing Aids **[(PA)] (BL)**	[Covered in full.] [We pay [50-90%]. You pay [10%-50%] *Coinsurance*.]	*[Deductible* and] [*Coinsurance*.] [Covered in full.]	[3-17]
Home health care **[(PA)] [*]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
[Hospice care services **[(PA)] [*]]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-18]
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-20]
New cancer therapies **[(PA)]**	***Outpatient***: [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-20]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] [*Coinsurance*.]	[3-20]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan*. Please see "How to File a Claim" in Chapter 6 for more information.]		[3-20]
[Private duty nursing [**(PA)]**]	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-20]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-20]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%] *Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-20]
Nonprescription enteral formulas **[(PA)] [*]**	[[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Deductible* and] [*Coinsurance*.]	[3-20]

[Prescription Drug Benefit]
[For information about your *Copayments* for covered prescription drugs, see the "Prescription Drug Benefit" section in Chapter 3.]
[Prescription drugs are not covered as part of this plan.]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 1: Option with Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, this autism spectrum disorders benefit only applies to groups of 51 or more*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [one evaluation and] [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

Infertility Services

Coverage is limited to [$100,000-unlimited] per *Member* per lifetime **(***In-Network* and *Out-of-Network Levels* combined). [Note: This limit applies to infertility services covered under the "Outpatient Care" benefit [and oral and injectable drug therapies used in the treatment of infertility and covered under the "Prescription Drug Benefit."]]

[FILING NOTE - PPO Option 1: This section describes an option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Mental Health *Outpatient* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30 -unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling

Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients

Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[Short-Term Speech, Physical and Occupational Therapy Services]

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[Spinal Manipulation]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days *for* Community Residence *services* (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services

Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*], whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is 30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 2: This section describes an option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

[*COPAYMENTS*]

- **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  - [Emergency Room (per Emergency room visit).....[$0-$350]]
  - [In *Provider's* office (per office visit) .....[$0-$60]]

  [Note[s]:
  - [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]
- ***Urgent Care* (*In-Network* and *Out-of-Network Levels of Benefits*):**
  - [*In-Network Level of Benefits* — [*Deductible* and then] [*Copayment. Copayment* varies depending on location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office.] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]
  - [*Out-of-Network Level of Benefits* — [*Copayment* varies depending on location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office. *Copayment*] [then] *[Deductible* and then*] [Coinsurance]]*
- **[Other] *Covered Services* (*In-Network Level of Benefits* only):**
  - [Office Visit (per visit).....[$0-$60]]

    [Applies to *In-Network Office* Visits for: diagnostic cytological examinations (Pap Smears), [certain disease and disorder screenings*,] and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam [and other vision care]; [family planning services;] [and] [routine] *Outpatient* maternity care (pre-natal and post-partum)**; [diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education].]

    [*includes disease and disorder screenings related to the following conditions: cancer; heart and vascular disease; infectious diseases; mental health conditions and substance abuse; metabolic, nutritional, and endocrine conditions ; musculoskeletal disorders; obstetric and gynecological conditions; pediatric conditions; and vision and hearing disorders. Please contact Member Services for more information. Also, please note that no Office Visit *Copayment* applies to disease and disorder preventive screenings that must be covered in full as required under the Affordable Care Act (ACA). For information on which screenings are covered in full under the ACA, please see our Web site at www.tuftshealthplan.com, or call Member Services.]

    **Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.
  - [*Inpatient* Services (per admission).....[$0-$1,500]]
  - [*Day Surgery* (per admission) .....[$0-$1,500]]

[Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged [an Office Visit *Copayment*] [or the *Deductible* and *Coinsurance*] when these services are provided in conjunction with an office visit. [In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment,*] [*Coinsurance*] [or] [a *Deductible*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview"chart for more information.]]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] [[0-4] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most *Copayments*] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*In-Network* and *Out-of-Network* combined)] ***FILING NOTE –*** *Used for non-HSA plans only*

[**Individual *Deductible***.....[$0-$5,000]]

[An Individual *Deductible* of [$0-$5,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services.*]

[**Family *Deductible***..... [$0-$25,000]]

[A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services*.]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5.000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*

[Once the Family *Deductible* has been met during a [c*alendar year] [Contract Year],* all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year]* . Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible.]*

[*DEDUCTIBLE*] [(*In-Network* and *Out-of-Network* combined)]

(FILING NOTE – *Used for HSA plans only. Deductible ranges below will be adjusted to comply with the IRS requirements for the applicable tax year.)*

[The *Deductible* is the amount you and the enrolled *Members* of your family (if applicable) must pay each year for certain *Covered Services* at both the *In-Network* and *Out-of-Network Levels of Benefits* before payments are made under this *Certificate*.

[The *Deductible* applies to all *Covered Services* at the *In-Network* and *Out-of-Network Levels of Benefits* except as listed below.]

[The amount of the *Deductible* which applies to you and the enrolled members of your family (if applicable) each [calendar year] [*Contract Year]* is:]

[Family Size	*Deductible* Amount
• One *Member*	[$1,200-$5,950] per person.
• Two *Members* or more	[$2,400-$11,900] per family.]

[The minimum *Deductible* dollar amount is adjusted each year to meet Internal Revenue Service requirements.]

[***Please note:** If you have two or more family members enrolled in the plan, and only one *Member* receives services in a [calendar year] [*Contract Year*], that*Member* must meet the full family *Deductible* ([$2,400-$6,000]) himself or herself before *Tufts Health Plan* will pay for any of his or her care in that year as *Covered Services*.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[Important Information About Your *Deductible*: ***FILING NOTE****: Used for non-HSA plans only.*

- The following are not subject to the *Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [*In-Network* Office Visits for: preventive care[*], routine cytological exams (Pap smears), preventive immunizations, and routine mammograms; [mental health and substance abuse;] routine ob/gyn exam; routine eye exam; other vision care[from an optometrist]; family planning services; *Outpatient* maternity care (pre-natal and post-partum)[**]; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] [early intervention services for a *Dependent Child*,] nutritional counseling; and health education.]

    [*Including diagnostic tests associated with preventive health care as described in Chapter 3.]

    [**This does not include diagnostic tests such as ultrasounds.]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology] [received at the *In-Network Level of Benefits*];]
  - [Laboratory tests [received at the *In-Network Level of Benefits*];]
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for services, supplies, or medications which are not *Covered Services*.
  - Any amount you pay for covered early intervention services.
- Once you meet your *Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance*.**]**

[Important Information About Your *Deductible:* ***FILING NOTE****: Used for HSA plans only.*

- The following are not subject to the *Deductible*:
  - *In-Network* Office Visits for: adult preventive care*, well-child exams, certain disease and disorder screenings**, routine cytological screenings (Pap smears), immunizations***, and routine mammograms; routine ob/gyn exams; routine eye exams; and routine *Outpatient* maternity care (pre-natal and post-partum).

    *Including diagnostic tests associated with preventive health care, as described under "Preventive Care for *Members* Age 19 and Under" and "Preventive Care for *Members* Age 20 and Older" in Chapter 3[, as well as other preventive services in accordance with the ACA].

    **includes disease and disorder screenings related to the following conditions: cancer; heart and vascular disease; infectious diseases; mental health conditions and substance abuse; metabolic, nutritional, and endocrine conditions ; musculoskeletal disorders; obstetric and gynecological conditions; pediatric conditions; and vision and hearing disorders[, as well as other screenings and counseling, in accordance with the ACA]. Please contact Member Services for more information.

    ***includes the following routine preventive immunizations:

    - For *Children* under age 18: Hepatitis B, DTP (diptheria, tetanus, pertussis), HiB (haemophilus influenza Type B), IPV (inactivated polio virus), meningococcal disease, varicella (chicken pox), pneumococcal influenza, hepatitis A, HPV (for female*Children* age 9 and older), and rotavirus vaccines.
    - For adults: TD (tetanus and diptheria), TDaP (tetanus, diphtheria, and pertussis), HPV (for adult females through age 26), varicella (chicken pox), influenza, hepatitis A, hepatitis B, meningococcal disease, and herpes zoster (shingles) vaccines.
  - Any amount you pay for services, supplies, or medications which are not *Covered Services*
- Any amounts you pay for prescription drugs are subject to the *Deductible*. For more information, see "Prescription Drug Benefit" in Chapter 3.
- Once you meet your *Deductible* in a [calendar year][*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayments* for *Covered Services* not subject to the *Deductible*; and
  - *Coinsurance*.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*OUT-OF-POCKET MAXIMUM*] [(*In-Network* and *Out-of-Network* combined)] ***FILING NOTE:*** *Used for Non-HSA plans only.*

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000]]

[An Individual *Out-of-Pocket Maximum* of [$0-$10,000] applies to each *Member* per [calendar year] *[Contract Year]* for *Covered Services.*]

[**Family *Out-of-Pocket Maximum***..... [$0-$50,000]]

[A Family *Out-of-Pocket Maximum* of [$0-$50,000] applies per [calendar year] *[Contract Year]* for all enrolled *Members* of a family for *Covered Services.*]

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

*[*The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *{Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

***OUT-OF-POCKET MAXIMUM [In-Network* and *Out-of-Network* combined)**

FILING NOTE – *Used for HSA plans only; Out-of-Pocket Maximum ranges below will be limited to comply with the IRS limits for the applicable tax year.*

[The amount of the *Out-of-Pocket Maximum* which applies to you and the enrolled members of your family (if applicable) each [calendar year] [*Contract Year*] is:

Family Size	*Out-of-Pocket Maximum Amount*
• One Member	[$0-$6,050] per person.
• Two Members or more	[$0-$12,100] per family.]

[The *Out-of-Pocket Maximum* is limited to the maximum dollar amount as defined each year by the Internal Revenue Service.]

[Important Information About Your *Out-of-Pocket Maximum*:

- Once you've satisfied your *Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - [Individual/Family *Deductibles*.]
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - [*Copayments* for *In-Network* Office Visits that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above.]
  - *Coinsurance*.
- The following cannot be used to meet the *Out-of-Pocket Maximum*, and you continue to pay for them after you have met your *Out-of-Pocket Maximum*:
  - [*Emergency* Care [*Copayments*][*Cost Sharing Amounts*].]
  - [*Copayments* for *In-Network* Office Visits [that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
  - At the *Out-of-Network Level of Benefits,* any amount you pay for costs above the *Reasonable Charge*.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[*Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and then] [$0-$350] Emergency Room *Copayment*[*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [Observation services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)] [(not subject to *Deductible*)]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)] [(not subject to *Deductible*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]			

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

***Outpatient* Care**			
COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
[Acupuncture] **[(PA)] [(BL)]**	[*Deductible and then*] [[$0-$60] Copayment] [Covered in full] [*Coinsurance*].	[*Deductible and then*] [[$0-$60] Copayment] [Covered in full] [*Coinsurance*].	[3-2]
Allergy injections **[(PA)]**	[*Deductible* and then] [[$0-$60]*Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance.*	[3-2]
Allergy testing **[(PA)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[[*Deductible* and then] *Coinsurance.]*	[3-2]
[Cardiac rehabilitation **[(PA)] [(BL)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-2]
Chemotherapy	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care - See "Spinal manipulation"]			
[Chiropractic medicine] **[(BL)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance.*	[3-2]
Diabetes services and supplies (For detailed information about how diabetes supplies are covered, please see "Diabetes services and supplies" in Chapter 3.)	[Diabetic test strips: [[*Deductible* and then] [$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes self-management education: [[*Deductible* and then] [$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes supplies covered as *Durable Medical Equipment*: [*Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] Diabetes supplies covered as medical supplies: [*Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[*Deductible* and] *Coinsurance*.	[3-3]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

(PA)* – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

***Outpatient* Care**			
COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(PA)] [*]**	**General imaging:** [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [**MRI/MRA:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] **CT/CTA:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance.]* **PET:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] [**Nuclear cardiology:** [*Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.]]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Deductible* and] [10%-50%] *Coinsurance*.	[3-3]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

***Outpatient* Care**			
COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Early intervention services for a *Dependent Child* [**(PA)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Deductible will only be applied to HSA plans under this Option 2.]*	[*Deductible* and then] Covered in full	[*Deductible* and then] Covered in full.	[3-3]
Family planning (procedures, services[, and contraceptives]) [**(PA)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.]*]*	**Office Visit:** [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [*Coinsurance*] [Covered in full] [(Family planning services [and contraceptives] not subject to *Deductible*)] ***Day Surgery*:** [*Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [*Coinsurance*] [Covered in full] [(subject to *Inpatient* and *Day Surgery Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis [**(PA)**]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing [**(PA)**]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Immunizations	**Routine preventive immunizations:** Covered in full**All other immunizations:** [*Deductible* and then] [[$0-$60 Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[*Deductible* and] *Coinsurance*.]	[3-4]
Infertility services **(PA) [*]**	[*Deductible* and then] [[$0-$60] Office Visit	[*Deductible* and] [0-20%]	[3-5]

[(BL)]	*Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are [covered in full] [subject to *Coinsurance*].	*Coinsurance*.	

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

***Outpatient* Care**			
COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Laboratory tests **(PA)** **Note:** In accordance with the ACA, laboratory tests performed as part of routine preventive care are covered in full at the *In-Network Level of Benefits.*	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance.*	[3-5]
Lead screenings	Covered in full	[*Deductible* and] *Coinsurance*.	[3-5]
Lyme disease	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[*Deductible* and] *Coinsurance*.]	[3-6]
Nutritional counseling **[(BL)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[*Deductible* and] *Coinsurance*.]	[3-6]
Office visits to diagnose and treat illness or injury	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	**Emergency Room:** [*Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] **Office Visit**: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [*] ***Day Surgery***: [*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	***Emergency* care in an Emergency Room:** [*Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*In-Network Coinsurance*] ***Emergency* care in a *Provider's* office:** [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] **All other services:** [*Deductible* and] *Coinsurance*.	[3-6]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Outpatient surgery in a *Provider's* office **[(PA)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-7]
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members* age 19 and under Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	Covered in full	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members* age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-50%]*Coinsurance*] [(not subject to *Deductible*)] All other preventive care services: Covered in full]	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Deductible* and] *Coinsurance*. Routine mammogram: [*Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	***In-Network* Level of Benefits**	***Out-of-Network* Level of Benefits**	
***Outpatient* Care,** continued			
Preventive Screenings and Diagnostic Procedures & Exams - continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[*Deductible* and then] [$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]
Radiation therapy	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[Short term] speech, physical and occupational therapy services **[(PA)] [*] [(BL)]**	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical Therapy:] [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational Therapy:] [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [*Deductible* and] *Coinsurance*. [Physical Therapy:] [*Deductible* and] *Coinsurance*. [Occupational Therapy:] [*Deductible* and] *Coinsurance*.	[3-9]
Smoking cessation counseling services	Covered in full.	[[*Deductible* and] *Coinsurance*.]	[3-9]
[Spinal manipulation] [**(BL)**]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-9]
[[Urgent care in an urgent care center]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Deductible* and] *Coinsurance*.]	[3-9]
[Vision care services] **[(PA)]**			
[Routine eye examination]	[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and] *Coinsurance*.	[3-9]
[Other] Vision care services	[**Care from an optometrist:]**[*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*][(not subject to *Deductible*)] **[Care from an ophthalmologist:** [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]	[*Deductible* and] *Coinsurance*.	[3-9]

Day Surgery			
Day Surgery [Note: Endoscopies and proctosigmoidoscopies are covered under this benefit.] ***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *The note in this benefit only to be used for HSA plans.*	[[*Deductible* and then] [$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Deductible* and] [10%-50%] *Coinsurance*. **All other *Day Surgery* services**: [*Deductible* and] [10%-50%] *Coinsurance*.]	[3-10]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Inpatient* Care**			
Extended care services **(PA) [*] [(BL)]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] [**Anesthesia:** [*Deductible* and] [10%-40%] *Coinsurance*. **All other hospital services:** [*Deductible* and] [10%-40%] *Coinsurance*.]	[3-11]
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and *Coinsurance*.]	[3-11]
Maternity Care ***FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *Both :routine" and "non-routine" sections will appear in this outpatient care maternity benefit for HSA plans only. Non-HSA plans will not differentiate between routine and non-routine care.*			
[Routine] *Outpatient* **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [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.]	[*Deductible* and] *Coinsurance*.	[3-11]
[Non-Routine *Outpatient*]	[[*Deductible* and then][$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and] *Coinsurance*.	[3-11]
Inpatient	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-12]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**			
[To contact *CareLink*, call 800-232-1164.			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*] –** [Individual session –] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [Group session – [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.]]Covered in full.]] [*Coinsurance*] [(not subject to *Deductible*)] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*] –** [Individual session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-50%] *Coinsurance*].] [Group session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-50%] *Coinsurance*.]]	[*Deductible* and] *Coinsurance*.	[3-13]
Inpatient services **(PA)** [*]	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact *CareLink*, call 800-232-1164.**			
Outpatient services [**(BL)**]	Substance Abuse Treatment Services: [Individual session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*Deductible* and then] [[$0-$60] Office Visit *Copayment*] per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Deductible* and] *Coinsurance*.	[3-14]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Inpatient services **(PA) [*]** [**(BL)**]	[[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Intermediate care **[(PA)]** [**(BL)**]	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Community Residential care **[(PA)] [[(BL)]]**	[*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services			
Ambulance services **(PA) [*]**			
Ground ambulance services	[*Deductible* and then] [Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Deductible* and then] [Covered in full] [*Coinsurance*] [**Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-15]
All other covered ambulance services	[Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-15]
[Diabetic monitoring strips]	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-15]
Durable Medical Equipment [**(PA)**]	[*Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] [10% - 50%] *Coinsurance*.	[3-16]
Hearing Aids **[(PA)] (BL)**	[*Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Deductible* and] [10%-50%] *Coinsurance*.] [Covered in full.]	[3-17]
Home health care **[(PA)] [*]**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
[Hospice care services **[(PA)] [*]]**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance]*.	[3-18]
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]]	[*Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-20]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
New cancer therapies **[(PA)]**	***Outpatient***: [*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-20]
Orthoses and Prosthetic devices **[(PA)]**	[*Deductible* and then] [Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Deductible* and] *Coinsurance*.]	[3-20]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan*. Please see "How to File a Claim" in Chapter 6 for more information.]		[3-20]
[Private duty nursing [**(PA)]**]	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-20]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.]	[3-20]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[*Deductible* and then] [[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%] *Coinsurance*]	[Covered in full.] [*Deductible* and] [*Coinsurance]*.	[3-20]
Nonprescription enteral formulas **[(PA)] [*]**	[*Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Deductible* and] *Coinsurance*.]	[3-20]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – Prior authorization is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, the autism spectrum disorder benefit only applies to groups of 51 or more.*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [one evaluation and] [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

Infertility Services

Coverage is limited to [$100,000-unlimited] per *Member* per lifetime **(***In-Network* and *Out-of-Network Levels* combined). [Note: This limit applies to infertility services covered under the "Outpatient Care" benefit [and oral and injectable drug therapies used in the treatment of infertility and covered under the "Prescription Drug Benefit."]]

[FILING NOTE - PPO Option 2: Option with (1) combined In-Network and Out-of-Network Deductible and (2) combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Mental Health *Outpatient* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling

Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients

Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Levels Network Levels* combined)

[Short-Term Speech, Physical and Occupational Therapy Services]

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[Spinal Manipulation]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days for *Community Residence* services (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services

Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*], whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-40%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

[*COPAYMENTS*]

• **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  • [Emergency room (per Emergency room visit).....[$0-$350]]
  • [In *Provider's* office (per office visit) .....[$0-$60]]
  [Note[s]:
  • [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]
 	
• **[*Urgent Care* (*In-Network* and *Out-of-Network Levels of Benefits*):**
  • [*In-Network Level of Benefits* [*In-Network Deductible* and then] [*Copayment. Copayment* varies depending on location in which services are rendered (for example, *Emergency* care, urgent care center, or physician's office).] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]
  • *[Out-of-Network Level of Benefits* [*Copayment. Copayment* varies depending on location in which services are rendered (for example, *Emergency* care, urgent care center, or physician's office).] [then] [*Out-of-Network Deductible* and] [*Coinsurance.]*
 	
• **[Other] *Covered Services* (*In-Network Level of Benefits* only):**
  • [Office Visit (per visit) .....[$0-$60]]
  [Applies to *In-Network Office* Visits for: diagnostic cytological exams (Pap smears), and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum)*; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.]
  *Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.
  • [*Inpatient* Services (per admission).....[$0-$1,500]]
  • [*Day Surgery* (per admission) .....[$0-$1,500]]
  [Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. Also, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*[[*Coinsurance*] [or] [a *Deductible*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview" chart for more information.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] [[0-4] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most Copayments] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000]] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*In-Network*)]

[**Individual *Deductible*** .....[$0-$5,000]]

[An Individual *Deductible* of [$0-$5,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services* received at the *In-Network Level of Benefits.*]

[**Family *Deductible***..... [$0-$25,000]]

[A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year] applies* for all enrolled *Members* of a family for *Covered Services* received at the *In-Network Level of Benefits.*]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*

[Once the Family *Deductible* has been met during a [calendar year] *[Contract Year],* all enrolled Members in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year]* . Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible.]*

[Important Information About Your *In-Network Deductible*:

- The following are not subject to the *In-Network Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [In-Network Office Visits for: preventive care[*]; routine cytological exams (Pap Smears), preventive immunizations, and routine mammograms; screening for colon or colorectal cancer; routine prostate and colorectal exams; [mental health and substance abuse;] routine ob/gyn exam; routine eye exam; other vision care[from an optometrist]; family planning services; *Outpatient* maternity care (pre-natal and post-partum)[**]; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] early intervention services for a *Dependent Child*, nutritional counseling; and health education.]
    [*Including diagnostic tests associated with preventive health care as described in Chapter 3.]
    [**This does not include diagnostic tests such as ultrasounds.]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology] [received at the *In-Network Level of Benefits*];]
  - [Laboratory tests [received at the *In-Network Level of Benefits*];]
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *In-Network Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance* [(for *Durable Medical Equipment* only)] .**]**

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network*)]

[**Individual *Deductible*** .....[$0-$8,000]

An Individual *Deductible* of [$0-$8,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services* received at the *Out-of-Network Level of Benefits.*]

[**Family *Deductible***..... [$0-$40,000]

A Family *Deductible* of [$0-$40,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services* received at the *Out-of-Network Level of Benefits.*]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when*:*

- one enrolled *Member* in family meets his or her [$0-$8,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$40,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$8,000] Individual *Deductible.]*

[Once the Family *Deductible* has been met during a [calendar year] *[Contract Year],* all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year]* . Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible.]*

[Important Information About Your *Out-of-Network Deductible*:

- The following are not subject to the *Out-of-Network Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology] [received at the *Out-of-Network Level of Benefits*];]
  - [Laboratory tests [received at the *Out-of-Network Level of Benefits*];]
  - Any amounts you pay for early intervention services for a *Dependent Child*.
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *In-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *Out-of-Network Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - *Coinsurance*.**]**

[*OUT-OF-POCKET MAXIMUM*] [(*In-Network* and *Out-of-Network* combined)]

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000]

An Individual *Out-of-Pocket Maximum* of [$0-$10,000] applies to each *Member* per [calendar year] *[Contract Year]* for *Covered Services.*]

[**Family *Out-of-Pocket Maximum***..... [$0-$50,000]

A Family *Out-of-Pocket Maximum* of [$0-$50,000] applies per [calendar year] *[Contract Year]* for all enrolled *Members* of a family for *Covered Services.*]

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

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

[Important Information About Your *Out-of-Pocket Maximum*:

- Once you've satisfied your *Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - Individual/Family *Deductibles*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance*.
- The following cannot be used to meet the *Out-of-Pocket Maximum*, and you continue to pay for them after you have met your *Out-of-Pocket Maximum*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [*Copayments* for *In-Network* Office Visits [that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for services, supplies, or medications that are not *Covered Services***.**
  - At the *Out-of-Network Level of Benefits,* any amount you pay for costs above the *Reasonable Charge*.]

]

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [Observation services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)] [(not subject to *Deductible*)]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)] [(not subject to *Deductible*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [**A *Day Surgery Copayment* may apply if *Day Surgery* services are received.**]			
***Outpatient* Care**			
[Acupuncture] **[(PA)] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
Allergy injections **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
Allergy testing **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*In-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Out-of-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-2]
[Cardiac rehabilitation **[(PA)] [(BL)]]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] [*Coinsurance]*.	[3-2]
Chemotherapy	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]

[Chiropractic care See “Spinal manipulation”]			
[Chiropractic medicine] **[(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance.*	[3-2]
~~Cytology examinations (Pap Smears)~~ **~~(BL)~~**	**~~Routine annual cytology screenings~~**~~: Covered in full~~ **~~Diagnostic cytology examinations~~**~~: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]~~	~~[*Out-of-Network Deductible* and] *Coinsurance*.~~	~~[3-2]~~

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[(BL) – Benefit Limit applies. See “Benefit Limit” section following this section and “*Covered Services*” in Chapter 3.]

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Diabetes services and supplies	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [Diabetic test strips: [[*In-Network Deductible* and then] [$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes self-management education: [[*In-Network Deductible* and then] [$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes supplies covered as *Durable Medical Equipment*: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] Diabetes supplies covered as medical supplies: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-3]
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(AR)] [*]**	**General imaging:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [In-Network *Deductible* and then] [[$0-$250] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **]** [**MRI/MRA:** [In-Network *Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] **CT/CTA:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] **PET:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] [**Nuclear cardiology:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.]]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.	[3-3]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Early intervention services for a *Dependent Child* **[(PA)]**	Covered in full.	Covered in full.	[3-3]
Family planning (procedures, services[, and contraceptives]) **[(PA)]** *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w)(3)(A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.]*]	**Office visit**: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] [(Family planning services [and contraceptives] not subject to *In-Network Deductible*)] ***Day Surgery*:** [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Immunizations	**Routine preventive immunizations:** Covered in full**All other immunizations:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Infertility services **(PA) [*] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are [covered in full] [subject to [0-20%] *Coinsurance*].]	[*Out-of-Network Deductible* and] [0-20%] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** Routine laboratory tests associated with preventive care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Lyme disease	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]
Nutritional counseling **[(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]
Office visits to diagnose and treat illness or injury	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] **Office visit**: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] ***Day Surgery***: [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	***Emergency* care in an Emergency Room:** [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*In-Network Coinsurance*] ***Emergency* care in a *Provider's* office:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] **All other services:** [*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Outpatient surgery in a *Provider's* office **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-7]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-8]
Preventive care for *Members* age 19 and under [Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.]*	Covered in full	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members*-age 20 and over [Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*]	[Covered in full] [Hearing screenings: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)] All other preventive care services: Covered in full]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Out-of-Network Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Out-of-Network Deductible* and] *Coinsurance*. Routine mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Preventive Screenings and Diagnostic Procedures & Exams, continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Radiation therapy	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Short term] speech, physical and occupational therapy services **[(PA)] [*] [(BL)]**	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*. [Physical Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*. [Occupational Therapy:] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
Smoking cessation counseling services	Covered in full.	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-9]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
[Spinal manipulation] [**(BL)**]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-9]
[*Urgent care* in an urgent care center]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[[$0-$60 *Copayment*] [then,,] [*Out-of-Network Deductible* and] *Coinsurance*.]	[3-9]
[Vision care services] [**(PA)]**			
[Routine eye examination]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	**[Care from an optometrist:]**[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[Care from an ophthalmologist:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
Day Surgery			
Day Surgery	[*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. **All other *Day Surgery* services:** [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.]	[3-10]
***Inpatient* Care**			
Extended care services **(PA) [*]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-10]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-10]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	*Out-of-Network Level of Benefits*	
***Inpatient* Care,** continued			
Hospital services (Acute care) **(PA)**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and] *Coinsurance*.] [**Anesthesia:** [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*. **All other hospital services:** [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*.]	[3-11]
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-11]
Maternity Care			
Outpatient **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits*, in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [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.]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-11]
Inpatient	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-12]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**			
***[*To contact *CareLink*, call 800-232-1164.]**			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*]** [Individual session –] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [Group session – [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)]] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*]** [Individual session -] [*In-Network Deductible* and then] [[$0-$60 Office Visit *Copayment* per visit] [Covered in full.] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full.] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-13]
Inpatient services **(PA) [*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]

[**(PA)** – *Prior authorization* is recommended for may apply to these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact *CareLink*, call 800-232-1164.]**			
Outpatient services [**(BL)**]	Substance Abuse Treatment Services: [Individual session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*].[(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)].	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Inpatient services **(PA) [*]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Intermediate care **[(PA)]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Community Residential care **[(PA)]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			

[**(PA)** – *Prior authorization* is recommended for these services on both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services			
Ambulance services **(PA) [*]**			
Ground ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Out-of--Network Deductible* and then] [Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-15]
All other covered ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-15]
[Diabetic monitoring strips]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of--Network Deductible* and] *Coinsurance*.]	[3-15]
Durable Medical Equipment **[(PA)]**	[*In-Network Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.	[*Out-of--Network Deductible* and] [10%-50%] *Coinsurance*.	[3-16]
Hearing Aids **[(PA)] (BL)**	[*In-Network Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Out-of-Network Deductible* and] [[10%-50%] *Coinsurance*.] [Covered in full.]	[3-17]
Home health care **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-18]
[Hospice care services **[(PA)] [*]]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of--Network Deductible* and] *Coinsurance*.	[3-18]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for may apply to these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services			
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-20]
New cancer therapies **[(PA)]**	***Outpatient***: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-20]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Out-of-Network Deductible* and]*Coinsurance*.]	[3-20]
Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan.* Please see "How to File a Claim" in Chapter 6 for more information.]		[3-20]
[Private duty nursing **[(PA)]]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] [*Coinsurance*.]	[3-20]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-20]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%]*Coinsurance*]	[Covered in full.] [*Out-of-Network Deductible* and] [*Coinsurance].*	[3-20]
Nonprescription enteral formulas **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-20]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, this autism spectrum disorders benefit only applies to groups of 51 or more.*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [one evaluation and] [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

Infertility Services

Coverage is limited to [$100,000-unlimited] per *Member* per lifetime **(***In-Network* and *Out-of-Network Levels* combined). [Note: This limit applies to infertility services covered under the "Outpatient Care" benefit [and oral and injectable drug therapies used in the treatment of infertility and covered under the "Prescription Drug Benefit."]]

[FILING NOTE - PPO Option 3: Option with (1) separate In-Network and Out-of-Network Deductibles and (2) a combined In-Network and Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Mental Health *Outpatient* Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling
Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or wigs for cancer or leukemia patients
Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[Spinal Manipulation]
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days of Inpatient substance abuse services (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services
Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*], whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]**
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10%-50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*.

[*COPAYMENTS*]

- **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  - [Emergency room (per Emergency room visit).....[$0-$350]]
  - [In *Provider's* office (per office visit) .....[$0-$60]]

  [Note[s]:
  - [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]

- **[*Urgent Care* (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  - [*In-Network Level of Benefits* .....[*In-Network Deductible* and then] [*Copayment. Copayment* varies depending on location in which services are rendered (for example, *Emergency* care, urgent care center, or physician's office).]
  - [*Out-of-Network Level of Benefits*[*Copayment* varies depending on location in which services are rendered (for example, *Emergency* care, urgent care center, or physician's office). *Copayment* per visit] [then,] [*Out-of-Network Deductible* and] [*Coinsurance*.]

- **[Other] *Covered Services* (*In-Network Level of Benefits* only):**
  - [Office Visit (per visit).....[$0-$60]]

    [Applies to *In-Network Office* Visits for: diagnostic cytological exams (Pap Smears), and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum); diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.]

    *Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.
  - [*Inpatient* Services (per admission).....[$0-$1,500]]
  - [*Day Surgery* (per admission) .....[$0-$1,500]]

  [Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*] [*Coinsurance*] [or] [a *Deductible*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview" chart for more information.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(In-Network Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] [[0-4] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most Copayments] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000]] [[0-4] Copayment] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(In-Network)]

[**Individual *Deductible*** .....[$0-$5,000]
An Individual *Deductible* of [$0-$5,000] per [calendar year] *[Contract Year]* applies to each *Member* for *Covered Services* received at the *In-Network Level of Benefits.*]

[**Family *Deductible***..... [$0-$25,000]
A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services* received at the *In-Network Level of Benefits.*]

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

[The Family Deductible is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*

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

[Important Information About Your In-Network *Deductible*:

- The following are not subject to the In-Network *Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [In-Network Office Visits for: preventive care[*]; routine cytological exams (Pap Smears), preventive immunizations, and routine mammograms; screening for colon and colorectal cancer; routine prostate and colorectal exams; [mental health and substance abuse;] routine ob/gyn exam; routine eye exam; other vision care[from an optometrist]; family planning services; *Outpatient* maternity care (pre-natal and post-partum)[**]; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] early intervention services for a *Dependent Child*, nutritional counseling; and health education.]
    [*Including diagnostic tests associated with preventive health care as described in Chapter 3.]
    [**This does not include diagnostic tests such as ultrasounds.]
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology] [received at the *In-Network Level of Benefits*];]
  - [Laboratory tests [received at the *In-Network Level of Benefits*];]
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your In-Network *Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - Office visit *Copayment* for *Covered Services* not subject to the *Deductible*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
  - *Coinsurance* [(for *Durable Medical Equipment* only)] .**]**

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network*)]

[**Individual *Deductible*** .....[$0-$5,000]

An Individual *Deductible* of [$0-$5,000] per [calendar year] [*Contract Year]* applies to each *Member* for *Covered Services* received at the *Out-of-Network Level of Benefits.*]

[**Family *Deductible***..... [$0-$25,000]

A Family *Deductible* of [$0-$25,000] per [calendar year] *[Contract Year]* applies for all enrolled *Members* of a family for *Covered Services* received at the *Out-of-Network Level of Benefits.*]

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

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$5,000] Individual *Deductible*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[The Family *Deductible* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible.]*

*[*Once the Family *Deductible* has been met during a [calendar year] *[Contract Year],* all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] *[Contract Year] .* Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible.]*

[Important Information About Your *Out-of-Network Deductible*:

- The following are not subject to the *Out-of-Network Deductible*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [Diagnostic imaging services, including [general imaging] [and] [MRI/MRA, CT/CTA, PET, and nuclear cardiology] [received at the *Out-of-Network Level of Benefits*];]
  - [Laboratory tests [received at the *Out-of-Network Level of Benefits*];]
  - Any amounts you pay for early intervention services for a *Dependent Child*,
  - [Any amounts you pay for prescription drugs. [Please note that a separate *Deductible* applies to your prescription drug coverage.] For more information, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *In-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
- Once you meet your *Out-of-Network Deductible* in a [calendar year] [*Contract Year*] for *Covered Services*, you pay only the following:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - *Coinsurance*.**]**

[*OUT-OF-POCKET MAXIMUM*] [(In-Network)]

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000]

An Individual *Out-of-Pocket Maximum* of [$0-$10,000] applies to each *Member* per [calendar year] *[Contract Year]* for *Covered Services* received at the *In-Network Level of Benefits.*]

[**Family *Out-of-Pocket Maximum*** ..... [$0-$50,000]

A Family *Out-of-Pocket Maximum* of [$0-$50,000] applies per [calendar year] *[Contract Year]* for all enrolled *Members* of a family for *Covered Services* received at the *In-Network Level of Benefits.*]

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

*[*The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[Important Information About Your In-Network *Out-of-Pocket Maximum*:

- Once you've satisfied your In-Network *Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - In-Network Individual/Family *Deductibles*.
  - [*Inpatient* Services *Copayment*.]
  - [*Day Surgery Copayment*.]
- The following cannot be used to meet the In-Network *Out-of-Pocket Maximum*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [*Copayments* for In-Network Office Visits [that are not subject to the *Deductible*. For a list of those services, see "*Deductible*" above].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*. **]**

[*OUT-OF-POCKET MAXIMUM] [(Out-of-Network*)]

[**Individual *Out-of-Pocket Maximum***..... [$0-$10,000] per [calendar year] [*Contract Year*]]

[Family *Out-of-Pocket Maximum*..... [$0-$50,000] per [calendar year] [*Contract Year*]]

[This Family *Out-of-Pocket Maximum* applies for all enrolled *Members* of a family.]

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

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when:

- one enrolled *Member* in family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximums* a collective amount equaling [$0-$50,000], in any combination.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] *[Contract Year]* when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum.]*

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

[Important Information About Your *Out-of-Network Out-of-Pocket Maximum*:

- Once you've satisfied your *Out-of-Network Out-of-Pocket Maximum* in a [calendar year] [*Contract Year*], you no longer pay for the following in that [calendar year] [*Contract Year*]:
  - *Out-of-Network* Individual/Family *Deductibles*.
  - Any amount you pay for *Covered Services* received at the *Out-of-Network Level of Benefits*.
- The following cannot be used to meet the *Out-of-Network Out-of-Pocket Maximum*:
  - [*Emergency* care [*Copayments*][*Cost Sharing Amounts*].]
  - [Any amounts you pay for prescription drugs. For more information about your prescription drug coverage, see "Prescription Drug Benefit" in Chapter 3.]
  - Any amount you pay for *Covered Services* received at the *In-Network Level of Benefits*.
  - Any amount you pay for services, supplies, or medications that are not *Covered Services*.
  - At the *Out-of-Network Level of Benefits,* any amount you pay for costs above the *Reasonable Charge*.**]**

]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

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).

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Emergency* Care**			
Treatment in an Emergency room	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*In-Network Deductible* and then] [[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*In-Network Coinsurance*] [(not subject to *Deductible*)]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [Observation services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]		
Treatment in a *Provider's* office	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [(waived if admitted as an *Inpatient* or for *Day Surgery*)]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)] [(not subject to *Deductible*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* Care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]			

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care**			
[Acupuncture] **[(PA)] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
Allergy injections **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist::] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*. [For services provided by an any other non-*Network Provider*:] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
Allergy testing **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[For services provided by an allergist or dermatologist::] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*. [For services provided by an any other non-*Network Provider*:] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
[Autism spectrum disorder – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*In-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*In-Network Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-2]
[Cardiac rehabilitation **[(PA)] [(BL)]]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] [*Coinsurance]*.	[3-2]
Chemotherapy	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care See "Spinal manipulation"]			

[Chiropractic medicine [**(BL)**]]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-2]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Diabetes services and supplies	[Diabetic test strips: [[*In-Network Deductible* and then] [$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes self-management education: [[*In-Network Deductible* and then] [$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diabetes supplies covered as *Durable Medical Equipment*: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] Diabetes supplies covered as medical supplies: [*In-Network Deductible* and then] [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [(not subject to *Deductible*)] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[Diabetes self-management education: [[$0-$60] Office Visit *Copayment*] [then,] *Out-of-Network Deductible* and] *Coinsurance*.] [All other covered diabetes services and supplies:] [*Out-of-Network Deductible* and] *Coinsurance*.]	[3-3]
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(PA)] [*]**	**General imaging:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment*] [Covered in full] [*Coinsurance*][(not subject to *Deductible*)] [**MRI/MRA:** [*In-Network Deductible* and then] [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*.] [(not subject to *Deductible*)] **CT/CTA:** [*In-Network Deductible* and then] [[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*.][(not subject to *Deductible*)] **PET:** [*In-Network Deductible* and then][[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*.][(not subject to *Deductible*)] [**Nuclear cardiology:** [*In-Network Deductible* and then] [[$0-$250] Office Visit Copayment per visit.] [Covered in full.] [*Coinsurance*.][(not subject to *Deductible)]*] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.	[3-3]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	*Out-of-Network Level of Benefits*	
***Outpatient* Care, continued**			
Early intervention services for a *Dependent Child* **[(PA)]**	Covered in full.	Covered in full.	[3-3]
Family planning (procedures, services[, and contraceptives]) **[(PA)]** *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w)(3)(A) and (B) or that does not fall under the federal safe harbor for contraceptive services.* **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.]*]	**Office visit**: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] [(Family planning services [and contraceptives] not subject to *In-Network Deductible*)] ***Day Surgery*:** [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
[House calls to diagnose and treat illness or injury]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.]	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing [(AR)]	[In-Network *Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Immunizations	Routine preventive immunizations: Covered in full. All other immunizations: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-4]
Infertility services **(PA) [*] [(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are [covered in full] [subject to *Coinsurance*].]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Laboratory tests **(PA)** **Note:** In accordance with the ACA, laboratory tests performed as part of routine preventive care are covered in full at the *In-Network Level of Benefits.*	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	*[Out-of-Network Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	[*Out-of-Network Deductible* and] [0-20%] *Coinsurance*.	[3-5]
Lyme disease	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	For services provided by an allergist or dermatologist::] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*. [For services provided by an any other non-*Network Provider*:] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]
Nutritional counseling **[(BL)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-6]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Office visits to diagnose and treat illness or injury	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	***Emergency* care in an Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*Coinsurance*] ***Emergency* care in a *Provider's* office:**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] **Office visit**: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] ***Day Surgery***: [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	***Emergency* care in an Emergency Room:** [[$0-$350] Emergency Room *Copayment*] [Covered in full] [*In-Network Coinsurance*] ***Emergency* care in a *Provider's* office:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] **All other services:** [*Out-of-Network Deductible* and] *Coinsurance*.	[3-6]
Outpatient surgery in a *Provider's* office **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-7]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-8]
Preventive care for *Members* age 19 and under Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	[Covered in full] [**Hearing screenings:** [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-50%] *Coinsurance*] [(not subject to *Deductible*)] **All other preventive care services:** Covered in full]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members* age 20 and over Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	Covered in full	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Preventive Screenings and Diagnostic Procedures & Exams			
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Out-of-Network Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Out-of-Network Deductible* and] *Coinsurance*. Routine mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Preventive Screenings and Diagnostic Procedures & Exams, continued			
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and proctosigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*In-Network Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)] Diagnostic cytology (pap smear) examination: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care, continued**			
Radiation therapy	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-8]
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Short term] speech,, physical and occupational therapy services **[(PA)] [*] [(BL)]**	[Speech Therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Physical Therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [Occupational Therapy:] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[Speech Therapy:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*. [Physical Therapy:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*. [Occupational Therapy:] [[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[**(PA)** – *Prior authorization* is recommended for these services on both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Outpatient* Care,** continued			
Smoking cessation counseling services	Covered in full.	[[$0-$60] Office Visit *Copayment*] [then,] [[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-9]
[Spinal manipulation] [**(BL)**]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Urgent care in an urgent care center]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Vision care services] **[(PA)]**			
[Routine eye examination]	[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	**[Care from an optometrist:]**[*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] **[Care from an ophthalmologist:]** [*In-Network Deductible* and then] [[$0-$60] Office Vist *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)]]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]
Day Surgery			
Day Surgery	[In-Network *Deductible* and then] [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*. **All other *Day Surgery* services**: [*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.]	[3-10]
***Inpatient* Care**			
Extended care services **(PA) [*]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-10]
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-10]

[**(PA)** – *Prior authorization* is recommended for these services on both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Inpatient* Care,** continued			
Hospital services (Acute care) **(PA)**	[In-Network *Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Out-of-Network Deductible* and]*Coinsurance*.] [**Anesthesia**: [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*. **All other hospital services:** [*Out-of-Network Deductible* and] [10%-40%] *Coinsurance*.]	[3-11]
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[In-Network *Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-11]
Maternity Care			
Outpatient **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[In-Network *Deductible* and then] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [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.]	[*Out-of-Network Deductible* and]*Coinsurance*.	[3-11]
Inpatient	[In-Network *Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-12]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact *CareLink*, call 800-232-1164.]**			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*]** [Individual session –] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] [Group session – [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [(not subject to *Deductible*)] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*]** [Individual session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment*] per visit] [Covered in full.] [[0%-50%]*Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60] *Copayment* per visit] [Covered in full] [[0%-50%] *Coinsurance*] [(not subject to *Deductible)*]	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-13]
Inpatient services **(PA) [*]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[AR)]**	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and]*Coinsurance*.	[3-14]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[**To contact *CareLink*, call 800-232-1164.]**			
Outpatient services [**(BL)**]	Substance Abuse Treatment Services: [Individual session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] [Group session -] [*In-Network Deductible* and then] [[$0-$60] Office Visit *Copayment* per visit.] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)].	[[$0-$60] Office Visit *Copayment*] [then,] [*Out-of-Network Deductible* and] *Coinsurance*.	[3-14]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Inpatient services **(PA) [*]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Intermediate care **[(PA)]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Community Residential care **[(PA)]** [**(BL)**]	[*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services			
Ambulance services **(PA) [*]**			
Ground ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[[*Out-of--Network Deductible* and then] [Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-15]
All other covered ambulance services **[(BL)]**	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-15]
[Diabetic monitoring strips]	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[$0-$60] Office Visit *Copayment*] [then,] [[Out-*of-Network Deductible* and] *Coinsurance*.]	[3-15]
Durable Medical Equipment **(PA) [*]**	[*In-Network Deductible* and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.	[*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.	[3-16]
Hearing Aids **[(PA)] (BL)**	[In-Network Deductible and then] [Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.	[*Out-of-Network Deductible* and] [10%-50%] *Coinsurance*.	[3-17]
Home health care **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-18]
[Hospice care services **[(PA)] [*][(BL)]]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-18]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
[Injectable, infused or inhaled Medications] **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-20]
New cancer therapies **[(PA)]**	***Outpatient***: [*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [*In-Network Deductible* and then] [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-20]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Out-of-Network Deductible* and] *Coinsurance*.]	[3-20]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan*. Please see "How to File a Claim" in Chapter 6 for more information.]		[3-20]
[Private duty nursing **[(PA)]]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] [*Coinsurance*].	[3-20]
Scalp hair prostheses or wigs for cancer or leukemia patients **[(BL)]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[*Out-of-Network Deductible* and] *Coinsurance*.	[3-20]
Special medical formulas			
Low protein foods **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment* per 30-day supply] [Covered in full] [[0%-50%]*Coinsurance*]	[Covered in full.] [*Out-of-Network Deductible* and] [*Coinsurance].*	[3-20]
Nonprescription enteral formulas **[(PA)] [*]**	[*In-Network Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Out-of-Network Deductible* and] [*Coinsurance*.]	[3-20]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[**(PA)** – *Prior authorization* is recommended for these services at both *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-50] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Ambulance Services]

[The maximum benefit payable in each [calendar year] [*Contract Year*] for covered sea, helicopter, and airplane ambulance transportation services (e.g., Medflight) is [$3,000-unlimited] (*In-Network* and *Out-of-Network Levels* combined). Please note that this limit does not apply to ground ambulance services covered under this plan.]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, this autism spectrum disorder benefit only applies to groups of 51 or more.*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic Medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [one evaluation and] [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

[Hematopoietic stem cell transplants, and human solid organ transplants]

[A lifetime maximum benefit of [$0-$10,000] applies per *Member* for transportation, accommodations and special expense costs related to covered transplants , when provided by a *Network Provider* and authorized by *Tufts Health Plan*.]

[Hospice Care Services]

[Covered up to [0-unlimited] visits per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined) for any combination of home visits and *Inpatient* facility visits.]

Infertility Services

Coverage is limited to [$100,000-unlimited] per *Member* per lifetime **(***In-Network* and *Out-of-Network Levels* combined). [Note: This limit applies to infertility services covered under the "Outpatient Care" benefit [and oral and injectable drug therapies used in the treatment of infertility and covered under the "Prescription Drug Benefit."]]

[FILING NOTE - PPO Option 4: This section describes an option with (1) separate In-Network and Out-of-Network Deductibles and (2) separate In-Network and Out-of-Network Out-of-Pocket Maximums. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Mental Health *Outpatient* Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30 -unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling
Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients
Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[Short-Term Speech, Physical and Occupational Therapy Services]
[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[Spinal Manipulation]
[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days for *Community Residence* services (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services
Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per [calendar year] [*Contract Year*] , whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services
The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview

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).

COINSURANCE
[*Coinsurance* (*In-Network Level of Benefits*): [Except as described in the *Covered Services* table below in this section, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* provided at the *In-Network Level of Benefits* by a *Network Provider*.] [The *Member* pays the remaining [0%-35%].**]** **[Important Note**: For *Outpatient* care, when you receive services from a *Primary Care Provider* (*"PCP"*), we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less). The *Member* pays the remaining [0%-35%].] For *Inpatient* care or *Day Surgery*, we pay [65%-100%] of the applicable Network fee schedule amount (or that same percentage of the *Reasonable Charge*, if less) for *Covered Services* received at a *Community Hospital*. See Appendix A for definitions of these facilities. For more information, please see "*Covered Services*" in Chapter 3.]
***Coinsurance* (*Out-of-Network Level of Benefits*):** Except as described in the *Covered Services* table below in this section, we pay [50%-90%] of the *Reasonable Charge* for all *Covered Services* provided [in the 50 United States] by a *Non-Network Provider*. The *Member* pays the remaining [10% -50%]. The *Member* is also responsible for any charges in excess of the *Reasonable Charge*. [*Important Note: *Covered Services* that are listed as "covered in full" or are subject to an Office Visit *Copayment* at the *In-Network Level of Benefits* in this Benefit Overview are covered at [50%-90%] of the *Reasonable Charge* when provided by a *Non-Network Provider*. The *Member* pays the remaining [10% -50%] and is also responsible for any charges in excess of the *Reasonable Charge*.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*COPAYMENTS*]

- **[*Emergency* care (*In-Network* and *Out-of-Network Levels of Benefits*):**
  - [Emergency room (per Emergency room visit).....[$0-$350]]
  - [In *Provider's* office (per office visit) ..... [$0-$60] [*Copayment* for care received from a *PCP.*
  - [$0-$75] *Copayment* for care received from any other *Provider*].]

  [Note[s]:
  - [An Emergency Room [*Copayment*][*Cost Sharing Amount*] 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.]]

- **[*Urgent Care* (*In-Network* and *Out-of-Network Levels of Benefits*):]**
  - [*In-Network Level of Benefits* [*Copayment* varies depending on type of *Provider* (*PCP* or specialist) and location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office).]]
  - [*Out-of-Network Level of Benefits* [*Copayment* varies depending on type of *Provider* (*PCP* or specialist) and location in which services are rendered (for example, *Emergency* room, urgent care center, or physician's office). *Copayment* [then,] [*Deductible* and] *Coinsurance*.]

- **Other *Covered Services* (*In-Network Level of Benefits* only):**

  [Office Visit (per visit) .....[$0-$60]]

  [Applies to *In-Network Office* Visits for: diagnostic cytological exams (Pap Smears), and diagnostic mammograms; diagnosis and treatment of illness or injury; [mental health and substance abuse;] routine eye exam and other vision care; family planning services; *Outpatient* maternity care (pre-natal and post-partum)*; diabetes self-management training and educational services; [spinal manipulation;] [chiropractic medicine;] [acupuncture;] nutritional counseling; and health education.]

  *Laboratory tests associated with routine *Outpatient* maternity care are covered in full, as required under the Affordable Care Act.

  - [*Inpatient* Services (per admission).....[$0-$1,500]]
  - [*Day Surgery* (per admission) .....[$0-$1,500]]

] [

  - [Lower Office Visit *Copayment*..... [[$0 - $60] *Copayment* per visit.] [Covered in full.]

    [Note: This *Copayment* applies to covered *Outpatient* care provided by a *PCP*, as well as for *Outpatient* [physical, occupational, or speech therapy services,] [spinal manipulation,] [chiropractic medicine;] [mental health and substance abuse services;] [cardiac rehabilitation services,] [, and] [routine eye care.]]

  - Higher Office Visit *Copayment*..... [[$0 - $75] *Copayment* per visit.] [Covered in full.]

    [Note: This *Copayment* applies to all covered *Outpatient* care subject to an Office Visit *Copayment,* except for care obtained from the *Providers* or for the services listed above under Lower Office Visit *Copayment*.]

  - *Inpatient* Services at a *Community Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]
  - *Inpatient* Services at a *Tertiary Hospital* ..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]
  - *Day Surgery* at a *Community Hospital*..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.]
  - *Day Surgery* at a *Tertiary Hospital*..... [[$0 - $1,500] *Copayment* per admission.] [Covered in full.] **]**

[Note: For certain *Outpatient* services listed as "covered in full" at the *In-Network Level of Benefits* in the table below, you may be charged an Office Visit *Copayment* when these services are provided in conjunction with an office visit. In addition, please note that in accordance with the Affordable Care Act (ACA), certain services, including women's preventive health services, are not subject to [a *Copayment*] [or] [*Coinsurance*] at the *In-Network Level of Benefits.* Please see the following "Benefit Overview" chart for more information.

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

***COPAYMENTS,* continued**

IMPORTANT NOTE – Preventive Care Services:

In accordance with the federal Affordable Care Act (ACA), this plan provides coverage for *Members* for preventive care services, immunizations, and vaccinations provided for in the guidelines for the following resources:

- services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women provided for in the comprehensive guidelines as supported by HRSA.

Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:

- The **preventive care services** described in the ACA guidelines above, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

[[*INPATIENT*] [AND] [*DAY SURGERY*] *COPAYMENT* MAXIMUM] [(*In-Network* Services Only)]

[

- [*Copayment* Maximum per *Member* [$0-$6,000] Copayments] per [calendar year] [*Contract Year*]]

[*Members* are responsible to pay [*Inpatient Copayments*] [*Day Surgery Copayments*] [*Inpatient* and/or *Day Surgery Copayments*] up to the [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum per person per [calendar year] [*Contract Year*].

The [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum [is the most money] [are the most *Copayments*] you will have to pay for [*Inpatient Covered Services*] [or] [*Day Surgery*] in a [calendar year] [*Contract Year*]. The [$0-$6,000] [[0-4] *Copayment*] [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum consists of [*Inpatient*] [and] [*Day Surgery*] *Copayments* only. It does not include [*Deductibles*,] *Coinsurance*, or other *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] [*Contract Year*].]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

[*DEDUCTIBLE*] [(*Out-of-Network* Services Only)]

[*Deductible* (Individual)]

[This *Certificate of Insurance* has an Individual *Deductible* of [$0-$5,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits,* other than early intervention services for a *Dependent Child*.

[*Deductible* (Family)]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$5,000] Individual *Deductible*.]

[The Family *Deductible* is satisfied in a [calendar year] [*Contract Year*] when one enrolled *Member* in a family meets his or her [$0-$5,000] Individual *Deductible*; and one or more additional enrolled *Members* in that family have paid toward their Individual *Deductibles* a collective amount equaling [$0-$25,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Deductible* are applied toward the [$0-$25,000] Family *Deductible*.]

[Once the Family *Deductible* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their Individual *Deductibles* for the remainder of that [calendar year] [*Contract Year*]. Also, please note that any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a *Contract Year* shall be carried forward to the next *Contract Year*'s *Deductible*.]

[*OUT-OF-POCKET MAXIMUM*] [(*Out-of-Network* Services Only)]

[*Out-of-Pocket Maximum* (Individual)]

[This *Certificate of Insurance* has an individual *Out-of-Pocket Maximum* of [$0-$10,000] per *Member* per [calendar year] [*Contract Year*] for all *Covered Services* provided at the *Out-of-Network Level of Benefits*. [Only [the *Deductible* and] *Coinsurance* count toward the *Out-of-Pocket Maximum*.]]

[*Out-of-Pocket Maximum* (Family)]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when [2-5] enrolled *Members* in a family each meet their [$0-$10,000] Individual *Out-of-Pocket Maximum*.]

[The Family *Out-of-Pocket Maximum* is satisfied in a [calendar year] [*Contract Year*] when:

- one enrolled *Member* in a family meets his or her [$0-$10,000] Individual *Out-of-Pocket Maximum*; and
- one or more additional enrolled *Members* in that family have paid toward their Individual *Out-of-Pocket Maximum*s a collective amount equaling [$0-$50,000], in any combination.]

[All amounts any enrolled *Members* in a family pay toward their Individual *Out-of-Pocket Maximums* are applied toward the [$0-$50,000] Family *Out-of-Pocket Maximum*.]

[Once the Family *Out-of-Pocket Maximum* has been met during a [calendar year] [*Contract Year*], all enrolled *Members* in a family will thereafter have satisfied their [$0-$10,000] Individual *Out-of-Pocket Maximums* for the remainder of that [calendar year] [*Contract Year*].]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

Important Note about your coverage under the Affordable Care Act ("ACA"): Under ACA, preventive care services, including women's preventive health care services as well as preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart below. For more information on the specific preventive care services covered in full, please see our Web site at **http://www.tuftshealthplan.com/employers/pdfs/preventive_services_listing.pdf**.

NOTE - You may need to pay a *Cost Sharing Amount* for diagnostic procedures (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart below.

PRE-EXISTING CONDITION LIMITATION
There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided By a *PCP*]	**[Care Provided by Any Other *Network Provider*]**		
	Coverage		**Coverage**	
***Emergency* Care**				
Treatment in an Emergency room	[[$0-$350] Emergency Room *Copayment*] [*] [Covered in full] [*Coinsurance*]		[$0-$350] Emergency Room *Copayment*[*] [Covered in full] [*In-Network Coinsurance*]	[3-2]
	[**Note**[**s**]:] [*Emergency Room *Copayment* waived if admitted as an *Inpatient* or for *Day Surgery*] [Observation services will [not] take an *Emergency* Room [*Copayment*][*Cost Sharing Amount*].]			
Treatment in a *Provider's* office	[Care provided by a *PCP:*] [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)] [Care from any other *Network Provider*: [[$0-$75] Office Visit *Copayment.*] [Covered in full.] [*Coinsurance*]] [(waived if admitted as an *Inpatient* or for *Day Surgery*)]		[[$0-$75] Office Visit *Copayment*] [Covered in full] [*In-Network Coinsurance*] [(waived if admitted as an *Inpatient* or for *Day Surgery*)]	[3-2]
A *Member* should call *Tufts Health Plan* within 48 hours after *Emergency* care is received. If you are admitted as an *Inpatient* after receiving *Emergency* care, we recommend that you or someone acting for you call *Tufts Health Plan* within 48 hours. [A *Day Surgery Copayment* may apply if *Day Surgery* services are received.]				

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

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).

***Outpatient* Care**				
COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided By Your *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**	**Coverage**	
[Acupuncture] **[(PA)] [(BL)]**	[[$0-$60] *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*.]	[[$0-$75] *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*.]	[*Deductible* and] [*Coinsurance*.]	[3-2]
Allergy injections **[(PA)]**	[[$0-$60]*Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
Allergy testing **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15 **[(PA)] [(BL)]]** ***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:*** *In accordance with RI General Laws 27.18-71, this benefit only applies to groups of 51 or more*	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $60] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	**[Applied behavioral analysis (ABA) services:** • When provided by a *Paraprofessional*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.] • When provided by a *Board Certified Behavior Analyst (BCBA)*: [*Deductible* and then] [[0%-35%] *Coinsurance*] [[$0 - $75] *Copayment* per visit.] [Covered in full.] **Therapeutic care:** Covered as described under "[Short-term] speech, physical and occupational therapy services".]	[*Deductible* and] [*Coinsurance*.]	[3-2]
[Cardiac rehabilitation **[(PA)]]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-2]

Chemotherapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-2]
[Chiropractic care See "Spinal manipulation"]				
[Chiropractic medicine] **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[*Deductible* and] *Coinsurance.*	[3-2]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – Approval by an *Authorized Reviewer* may apply to these services at the *In-Network Level of Benefits*.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Diabetes services and supplies	[Diabetic test strips: [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes self-management education: [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes supplies covered as *Durable Medical Equipment*: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[Diabetic test strips: [[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes self-management education: [[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*] Diabetes supplies covered as *Durable Medical Equipment*: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] Diabetes supplies covered as medical supplies: [Covered in full.] [We pay [50% - 90%]. You pay [10% - 50%] *Coinsurance*.] [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[Diabetic test strips: [*Deductible* and] *Coinsurance*. Diabetes self-management education: [*Deductible* and] *Coinsurance*. Diabetes supplies covered as *Durable Medical Equipment*: [*Deductible* and] *Coinsurance*. Diabetes supplies covered as medical supplies: [*Deductible* and] *Coinsurance*. [For information about your cost for diabetes supplies covered as prescription medication, please see the "Prescription Drug Benefit" in Chapter 3.]	[3-3]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Diagnostic imaging **[(PA)] [*]** • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET[and nuclear cardiology] **[(PA)] [*]**	**General imaging:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [[$0-$250] Office Visit Copayment] [Covered in full] [[0%-20%]*Coinsurance*] [**MRI/MRA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*] **CT/CTA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] **PET:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] [**Nuclear cardiology:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [0%-20%] *Coinsurance*.]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	**General imaging:** [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] **[MRI/MRA, CT/CTA, PET[and nuclear cardiology]:** [[$0-$250] Office Visit Copayment] [Covered in full] [[0%-20%]*Coinsurance*] [**MRI/MRA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*] **CT/CTA:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] **PET:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-20%] *Coinsurance*.] [**Nuclear cardiology:** [[$0-$250] Office Visit *Copayment* per visit.] [Covered in full.] [0%-20%] *Coinsurance*.]] [**Note**: Diagnostic imaging [except for general imaging] [related to a cancer diagnosis] will be covered in full [when the imaging is required as part of an active treatment plan for a cancer diagnosis].]	[*Deductible* and] [[10-50%]] *Coinsurance*.	[3-3]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Early intervention services for a *Dependent Child*	Covered in full.	Covered in full.	Covered in full.	[3-3]

[*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.]
[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Family planning **[(PA)]** (procedures, services[, and contraceptives]) ***[FILING NOTE* TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION*: Contraceptives and female sterilization services and procedures will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.*** **[Note:** Under the ACA, women's preventive health services, including contraceptives and female sterilization procedures, are covered in full.]*]*	**Office Visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Day Surgery*:** [[$0-$1,500] *Day Surgery Copayment* [*] per *Day Surgery* admission to a *Community Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* [and] [*Day Surgery*] *Copayment* Maximum)]	**Office Visit**: [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Day Surgery*:** [[$0-$1,500] *Day Surgery Copayment* [*] per *Day Surgery* admission to a *Tertiary Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-4]
Hemodialysis **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Human leukocyte antigen testing or histocompatibility locus antigen testing **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]
Immunizations	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	**Routine preventive immunizations:** Covered in full. **All other immunizations:** [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-4]

Infertility services **(PA) [*] [(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are covered in full] [subject to *Coinsurance*}.	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [Note: Approved Assisted Reproductive Technology services are covered in full] [subject to *Coinsurance*}.	[*Deductible* and] *Coinsurance*.	[3-5]

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

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Laboratory tests **(PA)** **Note:** In accordance with the ACA, laboratory tests performed as part of routine preventive care are covered in full at the *In-Network Level of Benefits.*	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	*[Deductible* and] *Coinsurance*.	[3-5]
Lead screenings	Covered in full	Covered in full	[*Deductible* and] *Coinsurance*.	[3-5]
Lyme disease	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-6]
Nutritional counseling **[(BL)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-6]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Office visits to diagnose and treat illness or injury	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-6]
Oral health services **(PA) [*]**	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] **Office visit**: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [*] ***Day Surgery***: [[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Community Hospital* [Covered in full] [[0%-20%] *Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	**Emergency Room:**: [[$0-$350] Emergency Room *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] **Office visit**: [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [*] ***Day Surgery***: [[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Community Hospital* [Covered in full] [[0%-20%] *Coinsurance*] [*] [(*subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	***Emergency* care in an Emergency Room:** [[$0-$350] Emergency Room *Copayment*] [Covered in full] [[0%-20%] *Coinsurance]* ***Emergency* care in a *Provider's* office:** [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%[*Coinsurance.* **All other services:** [*Deductible* and] *Coinsurance*.	[3-6]
	[*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.]			
Outpatient surgery in a *Provider's* office **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-7]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***	**PAGE**
	Coverage	**Coverage**	
***Outpatient* Care,** continued			
[Pediatric dental for *Members* under age 12] **[(PA)]**	[Covered in full]	[[*Deductible* and] *Coinsurance*.]	[3-8]

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Preventive care for *Members* age 19 and under **Note:** Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*	Covered in full	Covered in full	[*Deductible* and] *Coinsurance*.	[3-8]
Preventive care for *Members* age 20 and over **Note:** Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*	[Covered in full] [Hearing screenings: [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] All other preventive care services: Covered in full]	[Covered in full] [Hearing screenings: [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] All other preventive care services: Covered in full]	[*Deductible* and] *Coinsurance*.	[3-8]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Preventive Screenings and Diagnostic Procedures & Exams				
Preventive Screenings (for example, colonoscopy and sigmoidoscopy screenings)	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: Covered in full. Routine annual cytology (pap smear) screening: Covered in full. Routine mammogram: Covered in full. Routine prostate and colorectal exam: Covered in full.	Screening for colon or colorectal cancer in the absence of symptoms, with or without surgical intervention: [*Out-of-Network Deductible* and] *Coinsurance*. Routine annual cytology (pap smear) screening: [*Out-of-Network Deductible* and] *Coinsurance*. Routine mammogram: [*Out-of-Network Deductible* and] *Coinsurance*. Routine prostate and colorectal exam: [*Out-of-Network Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Preventive Screenings and Diagnostic Procedures & Exams - continued				
Diagnostic Procedures & Exams (for example, diagnostic colonoscopy, endoscopy, and procto-sigmoidoscopy procedures)	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [[$0-$60] Office Visit *Copayment**] [Covered in full] [*Coinsurance*] [(not subject to *Deductible*)] Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [[$0-$1,500] *Day Surgery Copayment* per *Day Surgery* admission] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] Diagnostic cytology (pap smear) examination: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic mammogram: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*] Diagnostic prostate and colorectal exam: [[$0-$60] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]	Diagnostic colon or colorectal **procedure only** (for example, endoscopies or colonoscopies associated with symptoms): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic colon or colorectal **procedure accompanied by treatment/surgery** (for example, polyp removal): [*Deductible* and] [10%-50%] *Coinsurance*. Diagnostic cytology (pap smear) examination: [*Deductible* and] *Coinsurance*. Diagnostic mammogram: [*Deductible* and] *Coinsurance*. Diagnostic prostate and colorectal exam: [*Deductible* and] *Coinsurance*.	[3-9]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***		**PAGE**
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Radiation therapy	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-8]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
***Outpatient* Care,** continued				
Respiratory therapy or pulmonary rehabilitation services **[(PA)]**	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]
[Short term] speech, physical and occupational therapy services **[(PA)] [*] (BL)**	[Speech therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [Physical therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*] [Occupational therapy:] [[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[Speech therapy:] [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance]* [Physical therapy:] [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance]* [Occupational therapy:] [[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[Speech therapy:] [*Deductible* and] *Coinsurance*. [Physical therapy:] [*Deductible* and] *Coinsurance*. [Occupational therapy:] [*Deductible* and] *Coinsurance*.	[3-9]
Smoking cessation counseling services	Covered in full.	Covered in full.	[*Deductible* and] *Coinsurance*.	[3-9]
[Spinal manipulation] [**(BL)**]	[[$0-$60] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-9]
[*Urgent care* in an urgent care center]	[[$0-$60] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full.] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [then,] [[*Deductible* and] [*Coinsurance*.]	[3-9]
[Vision care services] **[(PA)]**				
[Routine eye examination]	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%] *Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]
[Other] vision care services	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-9]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided at a *Community Hospital*]	**[Care Provided at a *Tertiary Hospital*]**		
	[Coverage]	**[Coverage]**	**Coverage**	
Day Surgery				
Day Surgery	[[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Community Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Day Surgery Copayment*] [*] per *Day Surgery* admission to a *Tertiary Hospital*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient* and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] [**Anesthesia**: [*Deductible* and] [10%-40%] *Coinsurance*. **All other *Day Surgery* services**: [*Deductible* and] [10-40% *Coinsurance*].]	[3-10]
	[*This *Copayment* also applies for *Covered Day Surgery* services at a free-standing surgical center.]			

***Inpatient* Care**			
COVERED SERVICE	***In-Network Level of Benefits***	***Out-of-Network Level of Benefits***	**PAGE**
	Coverage	**Coverage**	
Extended care services **(PA) [*]** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided at a Community Hospital]	**[Care Provided at a Tertiary Hospital]**		
	Coverage	**Coverage**		
***Inpatient* Care, continued**				
Hematopoietic stem cell transplants, and human solid organ transplants **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-10]
Hospital services (Acute care) **(PA)**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.] **[Anesthesia**: [*Deductible* and] [10-40%] *Coinsurance*. **All other hospital services**: [*Deductible* and] [10%-40%] *Coinsurance*.]	[3-11]
Reconstructive surgery and procedures and mastectomy surgeries **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-11]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided by a *PCP*]	**[Care Provided By Any Other *Network Provider*]**		
	Coverage	**Coverage**		
Maternity Care				
Outpatient **Note:** Routine laboratory tests associated with maternity care are covered in full at the *In-Network Level of Benefits,* in accordance with the ACA.	[[$0-$60] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [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.]	[[$0-$75] Office Visit *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [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.]	[*Deductible* and] *Coinsurance*.	[3-11]

COVERED SERVICE	***In-Network Level of Benefits***		***Out-of-Network Level of Benefits***	**PAGE**
	[Care Provided at a Community Hospital]	**[Care Provided at a Tertiary Hospital]**		
	Coverage	**Coverage**		
Maternity Care				
Inpatient	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [[0%-20%]*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-12]

[(PA) – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.**]**
[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]
[(BL) – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient* and Intermediate)**			
[To contact *CareLink*, call 800-232-1164.]			
Outpatient services **[(PA)]** [**(BL)**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*	**[Visits 1-30 in a [calendar year] [*Contract Year*]** [Individual session –] [[$0-$75] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] [Group session – [[$0-$75] Office Visit *Copayment* per visit.] [Covered in full.] [*Coinsurance*] **[Visits [31-unlimited] in a [calendar year] [*Contract Year*]** [Individual session -] [[$0-$75 Office Visit *Copayment* per visit] [Covered in full.] [[0%-50%] *Coinsurance*].] [Group session -] [[$0-$75] Office Visit *Copayment* per visit.] [Covered in full.] [[0%-50%] *Coinsurance*.]	*Deductible* and *Coinsurance*.	[3-13]
Inpatient services **(PA) [*]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]
Intermediate care **[(PA)]**	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-14]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	**YOUR COST**		**PAGE**
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient*, and Intermediate)**			
[To contact *CareLink*, call 800-232-1164.]			
Outpatient services [**(BL)**]	Substance Abuse Treatment Services: [Individual session -] [[$0-$75] Office Visit *Copayment*] [Covered in full] [*Coinsurance*]. [Group session -] [[$0-$75] Office Visit *Copayment*] [Covered in full] [*Coinsurance*].	[*Deductible* and] *Coinsurance*.	[3-14]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Inpatient services **(PA)** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Intermediate care **[(PA)]** [**(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			
Community Residential care **(PA) [(BL)**]	[[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[*Deductible* and] *Coinsurance*.	[3-15]
***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*			

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	*Out-of-Network Level of Benefits*	
Other Health Services			
Ambulance services **(PA) [*]**			
Ground ambulance services	[Covered in full] [*Coinsurance*, up to a maximum of $50 per trip] [[$0-$50] *Copayment* per trip]	[Covered in full] [*Coinsurance*] **[Note:** Ground ambulance services received from non-*Network Providers* [licensed to operate in Rhode Island] are covered at the *In-Network Level of Benefits.]*	[3-15]
All other covered ambulance services	[*In-Network Deductible* and then] [Covered in full] [*Coinsurance*]	[[*Deductible* and then] [Covered in full] [*Coinsurance*]	[3-15]
[Diabetic monitoring strips]	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-15]
Durable Medical Equipment **(PA) [*]**	[Covered in full] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] *Coinsurance*.	[3-16]
Hearing Aids **(PA) (BL)**	[Covered in full.] [We pay [50%-90%]. You pay [10%-50%] *Coinsurance*.]	[*Deductible* and] [*Coinsurance*.] [Covered in full.]	[3-17]
Home health care **[(PA)] [*]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-18]
[Hospice care services **[(PA)] [*]]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*.]	[3-18]
[Injectable, infused or inhaled medications] **[(PA)] [*]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[[*Deductible* and] *Coinsurance*.]	[3-18]
Medical supplies **[(PA)]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-20]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Overview, continued

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

COVERED SERVICE	YOUR COST		PAGE
	In-Network Level of Benefits	***Out-of-Network Level of Benefits***	
Other Health Services, continued			
New cancer therapies **[(PA)]**	***Outpatient***: [Annual *Deductible* and then] [[$0-$60] *Copayment*] [Covered in full] [*Coinsurance*] ***Inpatient***: [[$0-$1,500] *Inpatient* Services *Copayment*] [Covered in full] [*Coinsurance*] [(subject to [*Inpatient*] [and] [*Day Surgery*] *Copayment* Maximum)]	[[*Deductible* and] *Coinsurance*.	[3-20]
Orthoses and prosthetic devices **[(PA)]**	[Covered in full.] [We pay [50-90%]. You pay [10%-50%] *Coinsurance*.]	[[*Deductible* and] *Coinsurance*.]	[3-20]
[Prescription infant formulas]	[You pay all costs up front. Covered prescription infant formulas will be reimbursed 100% by *Tufts Health Plan.* Please see "How to File a Claim" in Chapter 6 for more information.]		[3-20]
Private duty nursing **[(PA)]]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] [*Coinsurance*].	[3-20]
Scalp hair prostheses or wigs for cancer or leukemia patients [**(BL)**]	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[*Deductible* and] *Coinsurance*.	[3-20]
[Special medical formulas]			
[Low protein foods **[(PA)] [*]**	[[$0-$75] *Copayment* per 30-day supply] [Covered in full] [[0%-50%]*Coinsurance*]	[Covered in full.] [*Deductible* and] [*Coinsurance*.]	[3-20]
[Nonprescription enteral formulas **[(PA)] [*]]**	[[$0-$75] *Copayment*] [Covered in full] [*Coinsurance*]	[Covered in full.] [[*Deductible* and] *Coinsurance*.]	[3-20]

[Prescription Drug Benefit]

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

[Prescription drugs are not covered as part of this plan.]

[**(PA)** – *Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits*.]

[**(PA)*** – *Prior authorization* is recommended for these services at the *In-Network Level of Benefits*.]

[**(BL)** – Benefit Limit applies. See "Benefit Limit" section following this section and "*Covered Services*" in Chapter 3.]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Contract and Benefit Information

Benefit Limits

[Acupuncture] -

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family. (*In-Network* and *Out-of-Network Levels* combined)] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-20] visits per person. (*In-Network* and *Out-of-Network Levels* combined)]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15]

[The maximum benefit payable for applied behavioral analysis services for autism spectrum disorders is [$32,000-unlimited] in each [calendar year] [*Contract Year*].]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, this autism spectrum disorder benefit only applies to groups of 51 or more*

[Cardiac Rehabilitation Services]

[Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

[Chiropractic medicine]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [one evaluation and] [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

Extended Care Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [100-unlimited] days [in a skilled nursing facility. The maximum benefit payable in each [calendar year] [*Contract Year*] is any combination of [60-unlimited] days in a rehabilitation hospital or chronic hospital] (*In-Network* and *Out-of-Network Levels* combined).

Hearing Aids

Coverage is limited to:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined);
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid (*In-Network* and *Out-of-Network Levels* combined).

Infertility Services

Coverage is limited to [$100,000-unlimited] per *Member* per lifetime **(***In-Network* and *Out-of-Network Levels* combined). [Note: This limit applies to infertility services covered under the "Outpatient Care" benefit [and oral and injectable drug therapies used in the treatment of infertility and covered under the "Prescription Drug Benefit."]]

[FILING NOTE - PPO Option 5: This section describes a differential copayment option with an Out-of-Network Deductible and an Out-of-Network Out-of-Pocket Maximum. This option may be integrated into any of the other PPO Options.]

Benefit Limits, continued

[Mental Health *Outpatient* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited visits] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Nutritional Counseling

Covered up to a maximum benefit of [3-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined).

Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients

Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)

[Short-Term Speech, Physical and Occupational Therapy Services]

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year.* (*In-Network* and *Out-of-Network Levels* combined)] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*. (*In-Network* and *Out-of-Network Levels* combined)] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]]

[Spinal Manipulation]

[The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per person or [10-unlimited visits] [$300-$5,000] (*In-Network* and *Out-of-Network Levels* combined) per family.]

[Substance Abuse *Community Residential* Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days *for Community Residence services* (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Inpatient* Detoxification Services

Inpatient detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per calendar year, whichever occurs first.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

[Substance Abuse *Outpatient* Treatment Services

The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] hours (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

Chapter 1

How Your Preferred Provider Plan Works

Eligibility for Benefits

You can obtain health care services from either a *Network Provider* (*In-Network Level of Benefits*); or a *Non-Network Provider* (*Out-of-Network Level of Benefits*). Your choice will determine the level of benefits you receive for your health care services. We cover only the services and supplies described as *Covered Services* in Chapter 3.

Important Note[s]:

- [There are no pre-existing condition limitations under this plan. You are eligible to use your benefits as of your *Effective Date*.] [There is a pre-existing condition limitation under this plan. Please see Chapter 7 for more information.]
- [You may be a *Member* living outside of Rhode Island. If so, your coverage may also include benefits required by the laws of your state. For more information, call Member Services.]

In-Network Level of Benefits

You may receive care from a *Network Provider*. If so, you are covered at the *In-Network Level of Benefits*.

You pay [*Coinsurance*] [a *Copayment*] for certain *Covered Services* you receive at the *In-Network Level of Benefits*. For more information about your *Member* costs for medical services, see "Benefit Overview".

[**IMPORTANT NOTE – [*COPAYMENTS*] [*COINSURANCE*] AT THE *IN-NETWORK LEVEL OF BENEFITS*:**

***Outpatient* care**: You may receive *Outpatient* services from a *PCP*. If so, your [Office Visit *Copayment*] [*Coinsurance*] may be lower than for services from other *Providers*. The lower *Copayment* also applies to: physical, occupational, or speech therapy services; spinal manipulation; and routine eye care.]

[*Inpatient* care [or *Day Surgery*]: You may receive *Inpatient* care [or *Day Surgery*] at a *Community Hospital*. If so, your [*Copayment]* [*Coinsurance*] may be lower than when you receive care at a *Tertiary Hospital*.]

For more information, see "*Covered Services*" in Chapter 3.]

When a *Network Provider* provides your care, you do not have to submit any claim forms. The *Network Provider* will submit the claim forms to us for you.

In-Network Level of Benefits, continued

Selecting a *Provider*

In order to receive coverage at the *In-Network Level of Benefits*, you must receive care from a *Network Provider*. *Network Providers* are listed in the *Directory of Health Care Providers*. Choose a *Provider* who is in a location near you.

Note:
[Under certain circumstances required by law, if your *Provider* is not in the *Tufts Health Plan* network, you will be covered for a short period of time for services provided by your physician. A Member Specialist can give you more information. See "Continuity of Care" later in this chapter.]

No *Precertification* by You

When your *Inpatient* procedure is provided by a *Network Provider*, you do not have to *Preregister* the procedure. Your *Network Provider* will *Preregister* the procedure for you.

Canceling Appointments

If you have to cancel an appointment with any *Network Provider*, give him or her at least 24 hours notice. The *Network Provider* may charge you for missed appointments not canceled in advance. If so, you will have to pay the charges. We will not pay for missed appointments that you did not cancel in advance.

Changes to *Provider* network

CareLink offers *Members* access to an extensive network of physicians, hospitals, and other *Providers.* They are located throughout the *Network Contracting Area*. *Network Providers* may change during the year.

This can happen for many reasons. Examples include: a *Provider's* retirement; moving out of the *Network Contracting Area*; or failure to continue to meet credentialing standards. Also, note that *Providers* are independent contractors. They may leave the network if they do not reach agreement on a network contract.

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

Out-of-Network Level of Benefits

Out-of-Network Level of Benefits

You may get care from a *Non-Network Provider.* If so, your coverage will be at the *Out-of-Network Level of Benefits*. [A *Deductible*] [An *Out-of-Network Deductible*] and *Coinsurance* may apply for this care.] For more information, see "Benefit Overview".

You must submit a claim form for care received from a *Non-Network Provider*. For more information, see Chapter 6.

Covered Services Not Available from a *Network Provider*

Some *Covered Service* may not be available from a *Network Provider*. If so, with our approval, you may go to a *Non-Network Provider* and receive *Covered Services* at the *In-Network Level of Benefits* up to the *Reasonable Charge*.

Out-of-Network Level of Benefits, continued

[*Covered Services* Outside of the 50 United States
Emergency care services you receive outside of the 50 United States are *Covered Services*. *Urgent Care* services you receive while traveling outside of the 50 United States also qualify as *Covered Services*. However, any other service, supply, or medication you receive outside of the 50 United States is not covered.]

[Continuity of Care

If you are an existing *Member*

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

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

If you are enrolling as a new *Member*

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

- you are undergoing a course of treatment. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* for up to 30 days from your *Effective Date*;
- you are in your second or third trimester of pregnancy. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *Provider* through your first postpartum visit; or
- you are terminally ill. In this instance, you may continue to see your *Provider* and receive *Covered Services* at the *In-Network Level of Benefits* from that *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 us.**]**

Inpatient Mental Health and Substance Abuse Services

In-Network Level of Benefits: You may need *Inpatient* or intermediate mental health or substance abuse services. If you wish to be covered for these services at the *In-Network Level of Benefits*, you must receive them from a *Network Provider*. [These services are covered at [*Copayment*] [*Coinsurance*] Level 1.] There is no need to contact us first. Simply call or go directly to any *Network Provider*. Identify yourself as a *Tufts Health Plan Member*. The *Network Provider i*s responsible for providing all *Inpatient/*intermediate mental health and substance abuse services. [You are not responsible for *Precertifying* your admission at a *Network Provider*.]

Out-of-Network Level of Benefits: You may want to receive *Inpatient* mental health or *Inpatient* substance abuse services from a *Non-Network Provider*. If so, your coverage will be at the *Out-of-Network Level of Benefits*. [You will pay [a *Deductible* and] *Coinsurance*.] *Prior authorization* is recommended for *Inpatient* [or intermediate] mental health or substance abuse services at the *Out-of-Network Level of Benefits*. Call [*CareLink* at 800-232-1164] for more information.

Emergency Admission to a Non-*Network Provider*

In an *Emergency,* you may be admitted to a Non-*Network Provider*. In this case, you will be covered at the *In-Network Level of Benefits*. Once it is determined that transfer to a *Network Provider* is medically appropriate, you will be transferred to a *Network Provider*. If you want to remain at the [Non-*Network Provider* and refuse to be transferred, then you will be covered at the *Out-of-Network Level of Benefits*.]

Emergency Care

To Receive *Emergency* care

If you have an *Emergency*, seek care at the nearest *Emergency* facility. If needed, call 911 for emergency medical assistance. 911 services may not be available in your area. In this event, call the local number for emergency medical services.

Outpatient Emergency care

You may receive *Emergency* services and not admitted as an *Inpatient*. If this happens, you will be covered at the *In-Network Level of Benefits*. You will pay a [*Copayment*] [*Cost Sharing Amount*] for each Emergency room visit.

You may receive *Emergency Covered Services* from a *Non-Network Provider*. If this happens, *Tufts Health Plan* will pay up to the *Reasonable Charge*. [You pay the applicable [*Copayment*][*Cost Sharing Amount*].]

Inpatient Emergency care

You may receive *Emergency* services and be admitted as an *Inpatient*. If this happens, you or someone acting for you should notify us as soon as reasonably possible.

If you are admitted as an *Inpatient* to a hospital that is a *Non-Network Provider* after receiving *Emergency* care, an *Inpatient Copayment* will apply.

Financial Arrangements between *Tufts Health Plan* and *Network Providers*

Methods of payment to *Network Providers*

Our goal in paying *Providers* is to encourage preventive care and active illness management of illnesses. We strive to be sure that our financial reimbursement system: (1) encourages appropriate access to care; and (2) rewards *Providers* for providing high quality care to our *Members*. We use a variety of mutually agreed upon methods to compensate *Network Providers* [with whom we contract].

The *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 that can be both harmful and costly to *Members*.

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

Member Identification Card

Introduction

CareLink gives each Member a member identification card (Member ID card).

Reporting errors

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

Identifying yourself as a *CareLink Member*

Your Member ID card is important; it identifies you as a *CareLink Member*. Please: (1) carry your Member ID card at all times; (2) have your Member ID card with you for medical, hospital and other appointments and; (3) show your card to any *Provider* before you receive health care services. When you receive services, tell the staff that you are a *CareLink Member*.

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, call a *CareLink* Member Specialist.

Utilization Review

Utilization review

The purpose of the *CareLink* utilization review program is to control health care costs. It does this by evaluating whether health care services provided to *Members* are: (1) *Medically Necessary;* and (2) provided in the most appropriate and efficient manner. [This program sometimes includes prospective, concurrent, and retrospective review of health care services.]

[We use **prospective review** to determine if proposed treatment is *Medically Necessary*. This review happens before that treatment begins. It is also called "Pre-Service Review".

We use **concurrent review** to: (1) monitor the course of treatment as it occurs; and (2) to determine when that treatment is no longer *Medically Necessary*.

We use **retrospective review** to evaluate care after it is provided.Sometimes, we use retrospective review to more accurately decide if a *Member's* health care services are appropriate. It is also called "Post-Service Review".]

[TIMEFRAMES FOR TUFTS HEALTH PLAN TO REVIEW YOUR COVERAGE REQUEST

Type of Review:	Timeframe for Determinations:[*]
Prospective (Pre-Service) Review.	Urgent: [Within 72 hours of receipt of the request.] [Within 72 hours of receiving all necessary information.] Non-urgent:: [Within 15 business days of receipt of the request.] [Within 15 business days of receiving all necessary information.]
Concurrent Review.	[Prior to the end of the current certified period.] [Urgent: Within 24 hours of receipt of the request.]
Retrospective (Post-Service) Review.	[Within 30 days of receipt of the request.] [Within 30 business days of receipt of a request for payment with all supporting information.]

]

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

We may deny your coverage request. If this happens, you have the right to file an appeal. See Chapter 6 for information on how to file an appeal.

Coverage determinations are made under this *CareLink* plan. You and your *Provider* make all treatment decisions.

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

- [Mental health or substance abuse utilization review decisions – 800-232-1164;]
- All other utilization review decisions - 1-866-352-9114.

Utilization Review, continued

Specialty case management

Some *Members* with Severe Illnesses or Injuries may warrant case management intervention under a specialty case management program. Under this program, we: (1) encourage the use of the most appropriate and cost-effective treatment; and (2) support the *Member's* treatment and progress.

We may contact the *Member* and his or her *Network Provider*. We may do this to discuss a treatment plan and establish short and long term goals. A 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 Network 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*;
- cancer;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- serious heart or lung disease;
- certain neurological diseases;
- severe traumatic injury.

[Individual case management (ICM)]

[In certain circumstances, *CareLink* may approve 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, *CareLink* may approve coverage for alternative services and supplies that do not otherwise qualify as *Covered Services* for that *Member*. This will occur only if *Tufts Health Plan* determines, in its sole discretion, that all of the following conditions are satisfied:

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

CareLink may approve an ICM plan. If this happens, *CareLink* will also indicate the *Covered Service* that the ICM plan will replace. The benefit available for the ICM plan will be limited to the benefit that the *Member* would have received for the *Covered Service*.

Tufts Health Plan will periodically monitor the appropriateness of the alternative services and supplies provided to the *Member*. *CareLink* may decide, at any time, that these services and supplies fail to satisfy any of the conditions described above. In this event, *CareLink* may modify or terminate coverage for the services or supplies provided pursuant to the ICM plan.]

[Preadmission Certification and Continued Stay Review

What is Preadmission Certification and Continued Stay Review (PAC/CSR)?

Preadmission Certification/Continued Stay Review is a program designed to help you and your *Dependents* choose the most appropriate facility for your medical care.. It will also help you to avoid unnecessary or excessively long *Inpatient* hospital admissions. As part of the *Precertification* process, *CareLink* will determine an appropriate length for your *Inpatient* hospital admission. Your *Provider* will handle PAC/CSR when you use a *Network Provider.* You may choose to use a non-*Network Provider*. If so, we recommend that you have your Inpatient hospital admission *Precertified*. A *Review Organization* performs PAC and CSR for *CareLink* through a utilization review program.

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

This section describes Pre-Admission Certification (PAC) and Continued Stay Review (CSR). These terms refer to the process used to certify the *Medical Necessity* and length of an *Inpatient* hospital admission. This process is used when a *Member* requires treatment in a Hospital:

- as a registered bed patient;
- for partial hospitalization for mental health or substance abuse treatment;
- for mental health or substance abuse residential treatment services.

We recommend that you or your *Dependent* contact the *Review Organization* to request PAC:

- prior to any non-*Emergency* treatment in a hospital, as described above;
- in the case of an *Emergency* admission;
- for an admission due to pregnancy, or
- prior to the end of the certified length of stay, for continued hospital confinement.

Changes to *Precertification* Information

Precertification is valid only for the diagnosis, procedure, admission date and medical facility specified at the time of *Precertification*. We recommend that you provide notification of any delays, changes or cancellations of your proposed admission. You may choose to use a *Network Provider*. If so, your *Provider* must obtain a separate *Precertification* for a new admission date, readmission, hospitalization, transfer or surgery for conditions other than those designated during the initial *Precertification*.

]

Chapter 2

Eligibility, Enrollment, & Continuing Eligibility

Eligibility

Subscribers

[You are eligible to enroll as a *Subscriber* when you are in the class of eligible employees established by the *Group*.]

[You are [eligible as a *Subscriber* only if you are an employee of a *Group*] [a *Subscriber* only if you are eligible to be a *Subscriber* under your *Group*] and you:

- meet your *Group's* and *Tufts Health Plan's* eligibility rules; and
- maintain primary residence in the *Network Contracting Area*; and
- live in the *Network Contracting Area* for at least 9 months in each period of 12 months*.

*Note: The 12-month period begins with the first month you do not live in the *Network Contracting Area*.]

Dependents

[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 *Certificate*; and
- meets your *Group's* and *Tufts Health Plan's* eligibility rules.]

[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 *Certificate*; and
- meets your *Group's* and *Tufts Health Plan's* eligibility rules; and
- maintains primary residence in the *Network Contracting Area**; and
- lives in the *Network Contracting Area* for at least 9 months in each period of 12 months*.

*Notes:

- The 12-month period begins with the first month you do not live in the *Network Contracting Area*.
- In some cases, *Dependents* who live outside of the *Network Contracting Area* can be eligible for coverage under this plan. See "If you live outside of the *Network Contracting Area*" below for more information.
- *Children* are not required to maintain primary residence in the *Network Contracting Area.* However, care outside of the *Network Contracting Area* is only covered at the *Out-of-Network Level of Benefits.*]

If you live outside of the *Network Contracting Area*

If you live outside of the *Network Contracting Area*, you can be covered only if:

- you are a *Child;* or
- you are a *Dependent* subject to a Qualified Medical Child Support Order (QMCSO); or
- you are a divorced *Spouse* that *Tufts Health Plan* must cover.

Eligibility, continued

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: (1) during the annual *Open Enrollment Period;* or (2) within 30 days of the date you or your *Dependent* is first eligible for this coverage.

Note: You may fail to enroll for this coverage when first eligible. If this happens, 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
- and you have acquired a *Dependent* through marriage, birth, adoption, or placement for adoption.

In these cases, you or your eligible *Dependent* may 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 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

We may accept your application and receive the needed *Premium*. When this happens, coverage starts on the date your *Group* chooses. Enrolled *Dependents'* coverage starts when the *Subscriber's* coverage starts, or at a later date if the *Dependent* becomes eligible after the *Subscriber* became eligible for coverage. A *Dependent's* coverage cannot start before the *Subscriber's* coverage starts.

You or your enrolled *Dependent* may be an *Inpatient* on your *Effective Date*. If so, 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* not currently enrolled in *Tufts Health Plan* only:

- during your *Open Enrollment Period*; or
  - within 30 days after any of the following events:
  - a change in your marital status;
  - the birth of a *Child*;
  - the adoption of a *Child* as of the earlier of the date the *Child* is placed with you for the purpose of adoption or the date you file a petition to adopt the *Child*;
  - a court orders you to cover a *Child* through a qualified medical child support order;
  - a *Dependent* loses other health care coverage involuntarily;
  - [a *Dependent* moves into the *Network Contracting Area*;] or
  - if your *Group* has an IRS qualified cafeteria plan, any other qualifying event under that plan.

How to add *Dependents*

You may have *Family Coverage*. If so, fill out a membership application form listing the *Dependents*. Give this form to your *Group* during your *Open Enrollment Period*. Or, give your *Group* the form within 30 days after the date of an event listed above, under "When *Dependents* may be added".

You may not have *Family Coverage*. If so, ask your *Group* to change your *Individual Coverage* to *Family Coverage*. Then follow the above procedure.

Effective Date of *Dependents'* coverage

We may accept your application to add *Dependents*. If so, 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.

Availability of benefits after enrollment

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

Note: We will only pay for *Covered Services* provided on or after your *Effective Date*.

Newborn *Children* and *Adoptive Children*

Importance of enrolling newborn *Children* and *Adoptive Children.*

Newborn *Child*: You must notify *Tufts Health Plan* of the birth of a newborn *Child* and pay the required *Premium* within 31 days after the date of birth. Otherwise, that *Child* will not be covered beyond such 31-day period. No coverage is provided for a newborn *Child* who remains hospitalized beyond that 31-day period and has not been enrolled in this plan.

***Adoptive Child*:** You must enroll your *Adoptive Child* within 31 days after the *Child* has been adopted or placed for adoption with you. This is required 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*.

Continuing Eligibility for *Dependents*

When coverage ends
Dependent coverage for a *Child* ends on the *Child's* 26th birthday.

> Note: This age limit does not apply to a *Child* who qualifies as a *Disabled Dependent at any age*

Coverage after termination
When a *Child* loses coverage under this *Certificate,* he or she may be eligible for federal or state continuation. He or she may also be able to enroll in *Individual Coverage*. See Chapter 5 for more information.

Disabled Dependents

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* disability.

Coverage after termination
The former *Disabled Dependent* may be eligible to enroll in *Individual Coverage.* See Chapter 5 for more information.

Continuing Eligibility for *Dependents,* continued

Rule for former *Spouses* (Also see Chapter 5)

If you and your *Spouse* divorce, your former *Spouse* may continue coverage as a *Dependent* under your *Family Coverage* in accordance with Rhode Island law if the order for continued coverage is included in the judgment when entered.

Note: Coverage for your divorced *Spouse* ends:

- when either you or your divorced *Spouse* remarry;
- until such time as provided by the judgment for divorce; or
- when your divorced *Spouse* becomes eligible for coverage in a comparable plan through his or her own employment.

How to continue coverage for former *Spouses*

To continue coverage for a former *Spouse*, call a Member Specialist within 30 days after the divorce decree is issued. Do this to tell us about your divorce. Send us proof of your divorce when asked.

[*Domestic Partners*]

You have elected coverage of *Domestic Partners*. In order to enroll a *Domestic Partner*, the *Subscriber* must provide the *Group*:

- proof of common residence for [[0-12] prior consecutive months]. This proof may include a driver's license, canceled rent check, utility bill, lease, or mortgage; and
- a completed and signed enrollment statement certifying that the relationship between the *Subscriber* and the *Domestic Partner* satisfies the criteria described in Appendix A.

[A *Subscriber* may have only one Domestic Partner at a time. If a *Domestic Partner's* coverage ends, the *Subscriber* may not enroll another Domestic Partner until the later of:

- [0-12] consecutive months] following the termination of the former *Domestic Partner's* coverage; or
- the date the relationship between the *Subscriber* and the new *Domestic Partner* satisfies that criteria.]

[The *Covered Services* available to a *Spouse* are available to a *Domestic Partner*. The *Covered Services* available to a *Child* are available to the child of a *Domestic Partner*.]

Keeping *Tufts Health Plan's* records current

You must notify us of any changes that affect your 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 *Network Contracting Area* or temporarily residing out of the *Network Contracting Area* for more than 90 consecutive days;]
- address changes; and
- changes in an enrolled *Dependent's* status as a *Child* or *Disabled Dependent*.

We have forms to report these changes. The forms are available from your *Group* or Member Services.

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 *CareLink's Medical Necessity* Guidelines in effect at the time the services or supplies are provided. This information is available on our Web site at **www.tuftshealthplan.com**. You can also call *CareLink* Member Services.]
- [obtained within the 50 United States. The only exceptions to this rule are *Emergency* care services or *Urgent Care* services while traveling, which are *Covered Services* when provided outside of the 50 United States; and]
- provided to treat an injury, illness or pregnancy, except for preventive care.

Important Notes:

- A *Covered Service* is one which is described in this chapter. We will only pay claims which are for *Covered Services*.
- *Prior authorization* is recommended for certain services. We will only cover a service listed in this *Certificate* if *CareLink* or its designee determines that the care is *Medically Necessary*. For services you receive at the *In-Network Level of Benefits*, your *Network Provider* is responsible for obtaining *prior authorization*. For services you receive from a *Non-Network Provider*, we recommend that you obtain *prior authorization* by contacting *CareLink*. Please contact [Member Services, or, for mental health and substance abuse services] *CareLink* at 1-800-232-1164 for more information. *Covered Services* for which we suggest *prior authorization* include a "(PA)" notation in the "Benefit Overview" section of this document.

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 services that qualify as *Covered Services*.

Notes:

- For information about your costs for the *Covered Services* listed below (for example, *Copayments*, *Coinsurance*, *Deductibles* [and] [*Out-of-Pocket Maximums*]), see the "Benefit Overview" section earlier in this document.
- Please note that your coverage level under this plan at the *In-Network Level of Benefits* will be different for **preventive services** and **diagnostic services**:
- **Preventive care services** described in the ACA guidelines, including women's preventive health services and preventive screening procedures (for example, screening colonoscopies and sigmoidoscopies) and preventive mammograms, are covered in full at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.
- You may need to pay a *Cost Sharing Amount* for **diagnostic procedures** (including diagnostic colonoscopies, endoscopies and proctosigmoidoscopies) and diagnostic mammograms. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.
- Information about the day, dollar, and visit limits under this plan is listed in "Benefit Limits" section. This information also appears in certain *Covered Services* listed below.
- [For *Outpatient* care: You may receive services from a *PCP*. If so, your [*Copayment*] [*Coinsurance*] may be lower than for services from other *Providers*.]
- [For *Inpatient* care or *Day Surgery*: You may receive care at a *Community Hospital.* If so, your [*Copayment*] [*Coinsurance*] may be lower when you receive care at a *Community Hospital* than when you receive care at a *Tertiary Hospital* (See Appendix A for definitions of these facilities.).]

***Emergency* Care**

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

[Notes:

- [The Emergency Room [*Copayment*][*Cost Sharing Amount*] is waived if the Emergency room visit results in immediate hospitalization [or *Day Surgery*].]
- You may receive *Emergency Covered Services* from a *Non-Network Provider*. In this case, *Tufts Health Plan* will pay up to the *Reasonable Charge*. [You pay the applicable [*Copayment*][*Cost Sharing Amount*].]
- [You may register in an Emergency room but leave that facility without receiving care. If this happens, an Emergency Room [*Copayment*][*Cost Sharing Amount*] may apply.]
- [You may receive *Day Surgery* services. If this happens, a *Day Surgery Copayment* may apply.] [[The Annual *Deductible* and then] [A [$0-$1,500] *Copayment* per admission] may apply [in addition to *Coinsurance*] if *Day Surgery* services are received.]

***Outpatient* care**

[Acupuncture services]

[Note[s]: [The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$2,500] per person or [$0-$5,000] per family (*In-Network* and *Out-of-Network Levels* combined).] [The maximum benefit payable in each [calendar year] [*Contract Year*] is [one initial examination and] [0-50] visits per person. (*In-Network* and *Out-of-Network Levels* combined)] [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

<u>*Outpatient* care - continued</u>

Allergy testing

Allergy testing (including antigens) and treatment, and allergy injections. [<u>*Prior authorization* is recommended for these services. See page 3-1 for more information.</u>]

[Autism spectrum disorders – diagnosis and treatment for *Children* under age 15

(*Prior authorization* is recommended for these services at both the *In-Network* and *Out-of-Network Levels of Benefits.* See page 3-1 for more information.)

Coverage is provided, in accordance with Rhode Island law, for the diagnosis and treatment of autism spectrum disorders for *Children* under age 15. 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*:

- applied behavioral analysis services (ABA)*, supervised by a *Board-Certified Behavior Analyst (BCBA)* who is a licensed health care clinician. [These services are covered up to [$32,000-unlimited] per [calendar year] [*Contract Year*].] For more information about these services, call the *Tufts Health Plan* Mental Health Department at 1-800-208-9565.
- Therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, or physical therapists), covered under your "[Short-term] speech, physical and occupational therapy services" benefit, described later in this chapter.

*For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modification, using behavioral stimuli and consequences, to product socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.]

***FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION:** In accordance with RI General Laws 27.18-71, this autism spectrum disorder benefit only applies to groups of 51 or more.*

Cardiac rehabilitation services

- *Outpatient* treatment of documented 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.

<u>Note[s]</u>

- We do <u>not</u> cover the program phase that maintains rehabilitated cardiovascular health.
- [<u>*Prior authorization* is recommended for these services. See page 3-1 for more information.</u>]
- [Covered up to [10-unlimited] visits per *Contract Year* (*In-Network* and *Out-of-Network Levels* combined).]

Chemotherapy

[Chiropractic care

See "Spinal manipulation."]

[Chiropractic medicine]

[Includes coverage for *Medically Necessary* visits for the purpose of chiropractic treatment or diagnosis, regardless of the place of service. *Members* are covered for up to three of the following modalities per visit: application of hot or cold pack; mechanical traction; electrical stimulation; ultrasound; myofascial release; diathermy.]

<u>*Outpatient* care - continued</u>

Diabetes services and supplies

In accordance with Rhode Island General Law § 27-18-38, coverage is provided for the following services and supplies for the treatment of insulin treated diabetes, non-insulin treated diabetes, or gestational diabetes, when *Medically Necessary* and prescribed by a *Provider*:

- blood glucose monitors and blood glucose monitors for the legally blind (covered as "Durable Medical Equipment: - see page XX);
- test strips for glucose monitors and/or visual reading [(covered under your "Prescription Drug Benefit" – see page XX)] [covered as "Other Health Services" – see page XX)];
- insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar [(covered under your "Prescription Drug Benefit" – see page XX)] [covered as "Other Health Services" – see page XX)];
- insulin pumps and related supplies and insulin infusion devices (covered as "Medical Supplies" – see page XX);
- therapeutic/molded shoes for the prevention of amputation (covered as "Durable Medical Equipment" - see page XX); and
- diabetes self-management education, including medical nutrition therapy.

Upon the approval of the United States Food and Drug Administration, new or improved diabetes equipment and supplies will be covered when *Medically Necessary* and prescribed by a *Provider*.
*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Coverage for test strips, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar will be provided as part of the "Diabetes services and supplies" listed above for plans that **include** prescription drug coverage. For plans that **exclude** prescription drug coverage, those items will be covered under the "Prescription Drug Benefit" found later in this chapter.]*

Diagnostic imaging

This includes general imaging (such as x-rays and ultrasounds). This also includes MRI/MRA, CT/CTA, and PET tests [and nuclear cardiology].

[Important Note: *Prior authorization* is recommended for [all diagnostic imaging] [MRI/MRA, CT/CTA, and PET tests] [and nuclear cardiology]. See page 3-1 for more information.]

Outpatient care - continued

Early intervention services

Services provided by early intervention programs that meet standards established by the Rhode Island Department of Human Services. *Medically Necessary* early intervention services include, but are not limited to: evaluation and case management; nursing care; occupational therapy; physical therapy; speech and language therapy; nutrition; service plan development and review; and assistive technology services and devices.

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

[Note: *Prior authorization* is recommended for these services. See page 3-1 for more information.]

Family planning

[Coverage is provided for *Outpatient* contraceptive services. This includes consultations, procedures and medical services. These services must be related to the use of all contraceptive methods approved by the United States Food and Drug Administration.]

- **[Procedures**
  - [sterilization][; and
  - [pregnancy terminations, when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest].
- **[Services**
  - medical examinations;
  - consultations;
  - birth control counseling;
  - genetic counseling.]
- **[Contraceptives**
  - cervical caps;
  - implantable contraceptives (e.g., Implanon® (etonorgestrel), levonorgestrel implants;
  - Intrauterine devices (IUDs);
  - Depo-Provera or its generic equivalent;
  - any other *Medically Necessary* contraceptive device approved by the United States Food and Drug Administration[*].

[*Notes:

- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]
- We cover certain contraceptives under a Prescription Drug Benefit. Those contraceptives include oral contraceptives and diaphragms, under your Prescription Drug Benefit. If those contraceptives are covered under that benefit, they are not covered here. **]**

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Contraceptives and female sterilization procedures and services will be covered in full for at the In-Network Level of Benefits all new groups or upon a group's renewal on or after 8/1/12 for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services.]*

Outpatient care – continued

Hemodialysis

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

[*Prior authorization* is recommended for these services. See page 3-1 for more information.]

[House calls to diagnose and treat illness or injury]

[A licensed physician must provide this care.]

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. Testing must be performed at a facility accredited by the American Association of Blood Banks or its successors. Includes costs of testing for A, B or DR antigens. [Limited to one testing per lifetime.]

[*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Immunizations

[Infertility services

In accordance with Rhode Island General Law § 27-18-30, coverage is provided for *Medically Necessary* diagnosis and treatment of infertility . We only cover these services for a woman who is:

- [between the ages of 25 and 42;]

  *[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** This text would only be removed for plan designs which do not apply an age range to this infertility coverage.]*

- married, in accordance to the laws of the state in which she resides;
- unable to conceive or sustain a pregnancy during a period of one year; and
- a presumably healthy individual.

Notes:

- Oral and injectable drug therapies may be used to treat infertility. These therapies are considered *Covered Services* for *Members* covered by a Prescription Drug Benefit. Your plan may include prescription drug coverage. If so, see the "Prescription Drug Benefit" section in this chapter for information about drug therapy benefit levels for those drug therapies.
- These infertility services are covered at the benefit level shown in the "Benefit Overview" section. Also, these services are subject to the maximum benefit listed in the "Benefit Limits" section. Your plan may include prescription drug coverage. If so, those drug therapies are also subject to that maximum benefit.

<u>*Outpatient* care - continued</u>

Laboratory tests

These include, but are not limited to:, blood tests; urinalysis, throat cultures; glycosolated hemoglobin (A1c) tests; genetic testing; and urinary protein/microalbumin and lipid profiles. (**<u>Important</u>**: *Prior authorization* is recommended for some laboratory tests (e.g., genetic testing). [See page 3-1 for more information. Also, please note that, in accordance with the ACA, laboratory tests associated with routine preventive care are covered in full at the *In-Network Level of Benefits.*])

Lead screenings

Includes lead screening related services, and diagnostic evaluations for lead poisoning in accordance with Rhode Island law.

Lyme Disease

Medically Necessary diagnostic testing and, to the extent not covered under a Prescription Drug Benefit, long-term antibiotic treatment of chronic Lyme disease. Treatment for Lyme disease otherwise eligible for coverage under this benefit will not be denied solely because such treatment may be characterized as unproven, *Experimental or Investigative.*

Nutritional counseling

Office visits to diagnose and treat illness or injury

- *Medically Necessary* evaluations and related health care services for acute or *Emergency* gynecological conditions.
- Office visits for evaluations and consultations.

  [<u>Note</u>: Coverage for diagnostic laboratory tests and x-rays associated with these office visits is described in the “Diagnostic imaging” and “Diagnostic tests and laboratory services” benefits.]

***Outpatient* care - continued**

Oral health services

The following oral services are covered. If you want to make sure that a planned service is a *Covered Service,* call Member Services.

- *Emergency* care

  X-rays and *Emergency* oral surgery in a *Provider's* office or emergency room. This care must be done 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

  Important Note: *Prior authorization* is recommended for all Non-*Emergency* oral health services performed in an *Inpatient* or *Day Surgery* setting.

  - **[**Hospital, physician, and surgical charges for the following conditions:
    - Surgical treatment of skeletal jaw deformities; or
    - Surgical treatment for Temporomandibular Joint Disorder (TMJ).
  - In certain specific instances, the costs of *Inpatient* services and *Day Surgery* for certain additional oral health services are covered. For these services (see 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. (An example of this is hemophilia.), AND
    - the *Member* requires these services in order to maintain his/her health (Also, the services are not cosmetic or *Experimental.*).

IF you meet the above criteria and require these services…	**THEN you are covered for:**
Surgical removal of impacted teeth when embedded in bone.	Hospital, physician, and surgical charges.
Surgical removal of unerupted teeth when embedded in bone.	Hospital, physician, and surgical charges.
Extraction of seven or more permanent teeth during one visit.	Hospital, physician, and surgical charges.
Any other non-covered dental procedure that meets the above criteria.	Hospital charges only.

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

Outpatient care **- continued**

Oral health services, continued

[

IF you require these services…	THEN you are covered for:
Surgical removal of impacted or unerupted teeth when embedded in bone.	Hospital, physician, and surgical charges.
Extraction of seven or more permanent teeth during one visit.	Hospital, physician, and surgical charges.
Surgical treatment of skeletal jaw deformities.	Hospital, physician, and surgical charges.
Surgical repair related to Temporomandibular Joint Disorder.	Hospital, physician, and surgical charges.

Note: *Prior authorization* is recommended for certain oral health services.]

- Coverage for hospital charges **only** may be provided. This is the case when a *Member* requires treatment in an *Inpatient* or *Day Surgery* setting for oral health services not described in this benefit. The *Member* must meet the following criteria. Otherwise, hospital services will not be covered:
  - the *Member* cannot safely and effectively receive oral health services in an office setting. This must be due to a specific and serious nondental organic impairment (An example of this is hemophilia.), AND
  - the *Member* requires these services in order to maintain their health (Also, the services are not cosmetic or *Experimental.*).]

Outpatient **surgery in a *Provider's* office** [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

[[Pediatric dental care for Members under age 12]

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

Important: You must choose a dentist for your *Dependent Child.* Choose one from the preferred dental provider directory. For more information, call Delta Dental [of Massachusetts] [at 617-886-1234 or 800-872-0500]. [*Prior authorization* is recommended for these services. See page 3-1 for more information.]]

Outpatient care - continued

Preventive care for *Members* through age 19

Coverage is provided for pediatric preventive care for a *Child* from birth to age 19, in accordance with the guidelines established by the American Academy of Pediatrics and as required by Rhode Island General Laws Section § 27-38.1

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam is subject to a *Cost Sharing Amount.*

Preventive care for *Members* age 20 and over

- routine physical examinations. These include appropriate immunizations and lab tests as recommended by a *Provider*;
- routine annual gynecological exam. This includes any follow-up obstetric or gynecological care we decide is *Medically Necessary* based on that exam;
- hearing examinations and screenings.

Note: Any follow-up care determined to be *Medically Necessary* as a result of a routine physical exam or a routine annual gynecological exam is subject to a *Cost Sharing Amount.*

Outpatient **care - continued**

Preventive Screenings and Diagnostic Procedures & Exams

IMPORTANT NOTE: Your coverage level under this plan at the *In-Network Level of Benefits* will be different for these **preventive screenings** (covered in full) versus **diagnostic services** (subject to *Member Cost Sharing)*. For more information, see "Preventive Screenings" and "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

Coverage is provided for the following Preventive Screenings (with no *PCP* referrals required):

Note: These routine screenings and exams are covered in full under this plan at the *In-Network Level of Benefits*. For more information, see "Preventive Screenings"" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

- Preventive screenings for colon and colorectal cancer.

  Examples include colonoscopy and sigmoidoscopy screenings.

- Routine annual cytology (Pap Smear) examinations.

  Coverage for routine pap smears is provided in accordance with guidelines established by the American Cancer Society. This includes coverage for one annual screening for women age 18 and older.

- Routine mammograms, in accordance with guidelines established by the American Cancer Society.
- Routine prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines.

Coverage is provided for the following Diagnostic Procedures & Exams:

Note: These diagnostic procedures and exams may be subject to *Member Cost Sharing* under this plan. For more information, see "Diagnostic Procedures & Exams" in the Benefit Overview chart at the beginning of this *Evidence of Coverage*.

- Diagnostic colon or colorectal procedures. (*Prior authorization* is recommended for these services. See page 3-1 for more information.)

  Examples include diagnostic colonoscopy, endoscopy and proctosigmoidoscopy procedures.

- Diagnostic cytology (Pap Smear) examinations.

  Coverage for diagnostic pap smears is provided in accordance with guidelines established by the American Cancer Society.

- Diagnostic mammograms, in accordance with guidelines established by the American Cancer Society.
- Diagnostic prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines.

Outpatient **care - continued**

Radiation therapy

Respiratory therapy or pulmonary rehabilitation services [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

[Short term] speech, physical and occupational therapy services

[These services are covered only when provided to restore function lost or impaired as the result of an accidental injury or illness [and the *Member's* condition is subject to significant improvement within a period of [0-90] days from the initial treatment. That improvement needs to be a direct result of these therapies.]]

- Massage therapy may be covered as a treatment modality. This is the case when done 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.

[Short term speech therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term physical therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term occupational therapy services covered up to [20-unlimited] visits per *Contract Year*.] [Short term speech, physical and occupational therapy services are covered up to a combined maximum of [20-unlimited] visits per *Contract Year*.]] *(In-Network* and *Out-of-Network Levels* combined).

[Important Note[s]:

- [This benefit limit does not apply to [short-term] speech, physical or occupational therapy provided in conjunction with a *Provider's* approved home health care plan.]
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.].]

Outpatient care - continued

Smoking cessation counseling sessions

Coverage is provided for individual, group, and telephonic smoking cessation counseling services that:

- are provided in accordance with current guidelines established by the United States Department of Health and Human Services; and
- meet the requirements of the Rhode Island Department of the Health Insurance Commissioner Regulation 14.

[Note: Coverage is also provided for prescription and over-the-counter smoking cessation agents. For more information, see the "What is Covered" provision within the "Prescription Drug Benefit" later in this chapter.]

[Spinal manipulation

Manual manipulation of the spine.

Note: The maximum benefit payable in each [calendar year] [*Contract Year*] is [10-unlimited visits] [$300-$5,000] per person or [10-unlimited visits] [$300-$5,000] per family.] (*In-Network* and *Out-of-Network Levels* combined). Spinal manipulation services are not covered for *Members* age 12 and under.]

[*Urgent Care* in an urgent care center]

Vision care services [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

- Coverage* is provided for services and supplies for the treatment of visual impairments, such as: regular eye exams; prescription eyewear; contact lenses; refractive laser eye surgery; and optometric vision therapy.]

  [*Note: The maximum benefit payable in each [calendar year] [*Contract Year*] is [$0-$350] per person and [$0-$750] per family. This limitation does not apply to contact lenses. It also does not apply to eyeglasses (one pair per prescription change) to replace the natural lens of the eye or following cataract surgery. For more information, see "*Durable Medical Equipment*".]

- [Routine eye examination: Coverage is provided for one routine eye examination [every [zero-twenty-four] months] [per [calendar year] [*Contract Year*]] [every other [calendar year] [*Contract Year*]] (*In-Network* and *Out-of-Network Levels* combined).]

  Note: You must receive routine eye examinations from a *Provider* in the EyeMed Vision Care network in order to be covered at the *In-Network Level of Benefits*. Go to **www.tuftshealthplan.com** or contact Member Services for more information.

- [Other vision care services: Coverage is provided for eye examinations and necessary treatment of a medical condition.]

Day Surgery

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.
- You must be shown on the facility's census as an *Outpatient*.

[Note: Endoscopies and proctosigmoidoscopies are covered under this benefit.]

FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: *The Note in this benefit will only be used for HSA plans.*

***Inpatient* care**

Extended care services

Extended care services are *Skilled* nursing, rehabilitation or chronic disease hospital services. These services are provided in a Medicare-certified:

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

Notes:

- **Extended care services are covered up to [100-unlimited] days [in a skilled nursing facility. Extended care services in a rehabilitation hospital or chronic hospital are covered up to any combination of [60-unlimited] days per [calendar year] [*Contract Year*] These limits apply at the *In-Network* and *Out-of-Network Levels* combined..**
- *Custodial Care* is not covered.
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Hematopoietic stem cell transplants and human solid organ transplants

[*Prior authorization* is recommended for these services.]

Hematopoietic stem cell transplants and human solid organ transplants which are generally accepted in the medical community for *Members* who are the stem cell or solid organ recipients. When the recipient is a *Member*, the following services related to the procurement of the stem cells or solid organ from the donor are covered, but only to the extent that such services are not covered by any other plan of health benefits or health care coverage:

- evaluation and preparation of the donor; and
- surgical intervention and recovery services related 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. *Prior authorization* is recommended for additional donor search expenses for unrelated donors.
- We cover a *Member's* human leukocyte antigen (HLA) testing. See "*Outpatient* care" for more information.
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]
- [A lifetime maximum benefit of [$0-$10,000] applies per *Member* for transportation, accommodations and special expense costs related to covered transplants, when provided by a *Network Provider* and authorized by *Tufts Health Plan*.]

Hospital services (Acute care)

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

**Prior authorization* is recommended for these services. See page 3-1 for more information.

Reconstructive surgery and procedures and mastectomy surgeries

- services required to relieve pain or to restore a bodily function impaired as a result of: a congenital defect; birth abnormality; traumatic injury or covered surgical procedure;
- the following services in connection with mastectomy:
  - surgical procedures known as a mastectomy;
  - axilary node dissection;
  - 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).

  Inpatient care in hospital for mastectomies is covered for:
  - a minimum of 48 hours following a surgical procedure known as a mastectomy; and
  - a minimum of 24 hours following an axilary node dissection.

  Any decision to shorten this minimum coverage shall be made by the attending physician in consultation with and upon agreement by the *Member. [*If the *Member* agrees to an early discharge,] coverage shall also include a minimum of one home visit conducted by a physician or registered nurse.

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

Removal of a breast implant. This is covered when:

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

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

Notes:

- Cosmetic surgery is not covered.
- [Except as described above in connection with a mastectomy, *prior authorization* is recommended for these services. See page 3-1 for more information.]

Maternity care

Maternity care (*Outpatient*) [- Routine and Non-Routine Care]

FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION: *Bracketed text in the title of this benefit will only be used for HSA plans.*

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

[Note: *Providers* may collect *Copayments* in a variety of ways for this coverage. (For example, the *Provider* may collect your *Copayment* at the time of your first visit, at the end of your pregnancy or in installments. Check with your *Provider*. Also, please note that in accordance with the ACA, laboratory tests associated with routine maternity care are covered in full at the *In-Network Level of Benefits.*]

Maternity care, continued

Maternity care (*Inpatient*)

- hospital and delivery services; and
- 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. The newborn *Child's* coverage consists of coverage of injury or sickness. This coverage includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, as well as routine well-baby care services.

Any decision to shorten these minimum coverages will be made by the attending health care provider. (This may be the attending obstetrician, pediatrician, family practitioner, general practitioner, or certified nurse midwife attending the mother and newborn *Child.*) In addition, the decision must be made in consultation with the mother.

Coverage of the newly-born *Child* will continue for 31 days after birth. For coverage to continue beyond this 31-day period, you must enroll the *Child* as described under "Newborn *Children* and *Adoptive Children*".

Note[s]:

- [In case of an early discharge,] *Covered Services* will include: one home visit by a registered nurse, physician, or certified nurse midwife; and additional *Medically Necessary* home visits, when provided by a licensed health care provider. *Covered Services* will include, but not be limited to: parent education, assistance, and training in breast or bottle feeding; and the performance of any necessary and appropriate clinical tests.
- [These *Covered Services* will be available to a mother and her newborn *Child* whether or not there is an early discharge. (This means: (1) a hospital discharge less than 48 hours following a vaginal delivery; or (2) 96 hours following a caesarean delivery.)]

***Mental Disorder* Services for Mental Health Care (*Outpatient*, *Inpatient*, and Intermediate)**

***Outpatient* mental health care services**

Services to diagnose and treat *Mental Disorders* . This includes individual, group and family therapies.

Note: Psychopharmacological services and neuropsychological assessment services are covered as *Outpatient* medical care. This is described earlier in this chapter.

Important Note[s]:

- [Outpatient mental health care services are covered up to **[30 -unlimited visits] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined)**.] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION**: The benefit limits for mental health care services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*
- [*Prior authorization* is recommended for psychological testing and neuropsychological assessment services. See page 3-1 for more information.]

***Inpatient* and intermediate mental health care services**

- *Inpatient* mental health services for *Mental Disorders* in a general hospital, a mental health hospital, or a substance abuse facility.

  Important Notes:
  - *Inpatient* mental health services must be obtained at a *Network Provider* in order to be covered at the *In-Network Level of Benefits*. See "*Inpatient* Mental Health and Substance Abuse Services" for more information.
  - *Prior authorization* is recommended for *Inpatient* mental health services. See page 3-1 for more information.

- Intermediate mental health care services. These services are more intensive than traditional *Outpatient* mental health care services. They are less intensive than 24-hour hospitalization. Some examples of Covered intermediate mental health care services are:
  - [level III community-based detoxification;]
  - [crisis stabilization;]
  - intensive *Outpatient* programs;
  - day treatment/partial hospital programs; and
  - [acute residential treatment* (longer term residential treatment is not covered).]

  Important Notes:
  - No visit limit applies to *Inpatient* or intermediate mental health care services.
  - Intermediate mental health care services must be obtained at a *Network Provider* to be covered at the *In-Network Level of Benefits*. See "*Inpatient* Mental Health and Substance Abuse Services" for more information. [*Prior authorization* is recommended for intermediate mental health services See page 3-1 for more information.]

***Mental Disorder* Services for Substance Abuse (*Outpatient*, *Inpatient* and Intermediate)**

(Note: Treatment for the abuse of tobacco or caffeine is not covered under these substance abuse services benefits.)

***Outpatient* substance abuse services**

Outpatient substance abuse treatment services.

[Note: Outpatient Substance Abuse Treatment Services are covered for [30-unlimited] hours per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined).] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:*** *The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*

***Inpatient* and Intermediate Substance Abuse Services**

- *Inpatient* substance abuse detoxification and treatment services in a general hospital, substance abuse facility, or *Community Residence*.
- Intermediate substance abuse services. These services are more intensive than traditional *Outpatient* substance abuse services. They are but less intensive than 24-hour hospitalization. Some examples of Covered intermediate substance abuse services are day treatment/partial hospital programs and intensive *Outpatient* programs.

Notes:

- [**No visit limit applies to *Inpatient* substance abuse treatment or intermediate substance abuse services. *Inpatient* detoxification services are limited to [5-unlimited] detoxification occurrences per calendar year, or [30-unlimited] days per calendar year, whichever occurs first (*In-Network* and *Out-of-Network Levels* combined).The maximum benefit payable in each [calendar year] [*Contract Year*] is [30-unlimited] days of *Community Residential* care services (*In-Network* and *Out-of-Network Levels* combined).**] ***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION****: The benefit limits for substance abuse services will be omitted for all groups of 50 or more, in accordance with H.R. 1424, Div. C, Title V, Subtitle B.]*
- *Inpatient* substance abuse services must be obtained at a *Network Provider* in order to be covered at the *In-Network Level of Benefits*. See "*Inpatient* Mental Health and Substance Abuse Services" for more information. [*Prior authorization* is recommended for *Inpatient* substance abuse services. See page 3-1 for more information.]
- Intermediate substance abuse services must be obtained at a *Network Provider* in order to receive benefits at the *In-Network Level of Benefits*. See "I*npatient* Mental Health and Substance Abuse Services" in Chapter 1 for more information. [*Prior authorization* is recommended for intermediate mental health services See page 3-1 for more information.]

Other health services

Ambulance services

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

**Prior authorization* is recommended for these services See page 3-1 for more information.]

Important Note[s]:

- You may be treated by Emergency Medical Technicians (EMTs) or other ambulance staff. At that time, you may refuse to be transported to the hospital or other medical facility. In this case, you will be responsible for the costs of this treatment.
- [Covered sea, helicopter, and airplane ambulance transportation services (for example, Medflight) is covered up to [$3,000-unlimited] per [calendar year][*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined). This limit does not apply to the ground ambulance services we cover.]

[Diabetic monitoring strips]

[The following diabetic monitoring strips for home use. These strips must be ordered by a *Provider*, in writing, to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes:

- blood glucose monitoring strips;
- urine glucose strips; and
- ketone strips.]

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;
- 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 *Tufts Health Plan* determines this.

Tufts Health Plan may decide that equipment is: (1) non-medical in nature; and (2) used primarily for non-medical purposes. (This may occur (even though that equipment may have some limited medical use.) In this case, the equipment will not be considered *Durable Medical Equipment*. It will not be covered under this benefit.

(Note: *Prior authorization* is recommended for certain *Durable Medical Equipment.* See page 3-1 for more information.]

Important Note: You may need to pay towards the cost of the *Durable Medical Equipment* we cover. Your *Durable Medical Equipment* benefit may be subject to a *Deductible* or *Coinsurance.* See the "Benefit Overview" and "Benefit Limits" sections.

These are examples of covered and non-covered items. They are for illustration only. Call a Member Specialist to see if we cover a certain piece of equipment.

- **Examples of covered items. (This list is not all-inclusive.):**
  - contact lenses or eyeglass lenses (One pair per prescription change is covered.) to replace the natural lens of the eye or following cataract surgery. [Note: Eyeglass frames are covered up to a maximum of $69 per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels of Benefits* combined) They must be provided in association with these lenses.];
  - gradient stockings (Up to three pairs per calendar year are covered.);
  - [insulin pumps;]
  - oral appliances for the treatment of sleep apnea;
  - prosthetic devices, except for arms, legs or breasts*;
    *Note: Breast prostheses and prosthetic arms and legs (in whole or in part) are covered under the "Orthoses and prosthetic devices" benefit.
  - [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: See "Scalp hair prostheses or wigs for cancer or leukemia patients".);]
  - [power/motorized wheelchairs;]
  - therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease;

We will decide whether to purchase or rent the equipment for you. At the *In-Network Level of Benefits*, this equipment must be purchased or rented from a *Durable Medical Equipment* provider that has an agreement with us to provide such equipment. (continued on next page)

- **Examples of non-covered items. (This list is not all-inclusive.):**
  - 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 trays, and bed wedges;
  - car seats;
  - car/van modifications;
  - comfort or convenience devices;
  - dentures;
  - ear plugs;
  - fixtures to real property. Examples are ceiling lifts, elevators, ramps, stair lifts or stair climbers;
  - exercise equipment and saunas;
  - orthoses and prosthetic devices (see "Orthoses and prosthetic devices" for information about these *Covered Services*);
  - 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, see "Prosthetic devices". [;and
  - scooters].

Hearing Aids [(*Prior authorization* is recommended for these devices. See page 3-1 for more information.**)**

Coverage is provided for:

- one hearing aid per ear every three (3) years for *Members* up to age 19. Coverage is provided up to [$1,500-unlimited] for each individual hearing aid;
- one hearing aid per ear every three (3) years for *Members* age 19 and older. Coverage is provided up to [$700-unlimited] for each individual hearing aid.

Other Health Services – continued

Home health care

This is as a *Medically Necessary* program to: (1) reduce the length of a hospital stay; or (2) delay or eliminate an otherwise *Medically Necessary* hospital admission. Coverage includes:

- home visits by a *Provider*;
- skilled [intermittent] nursing care;
- [*Medically Necessary* private duty nursing care. A certified home health care agency must provide this care.];
- physical therapy;
- speech therapy;
- occupational therapy;
- medical/psychiatric social work;
- nutritional consultation;
- prescription drugs and medication;
- medical and surgical supplies (Examples include dressings, bandages and casts.);
- laboratory tests, x-rays, and E.K.G. and E.E.G. evaluations;
- the use of *Durable Medical Equipment;* and
- the services of a part-time home health aide.

[Note[s]:

- Home health care services for speech, physical and occupational therapies may follow an injury or illness. If this occurs, the services are only covered to the extent provided to restore function lost or impaired. This is described under “Short term speech, physical and occupational therapy services.”. However, those home health care services are [not] subject to: (1) the [0-90]-day period for significant improvement requirement] [or; (2) the visit limits] listed under “Short term speech, physical and occupational therapy services”.
- [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

[Hospice care services [*Prior authorization* is recommended for these services. See page 3-1 for more information.]]

We will cover the following services for *Members* who are terminally ill. (This means 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 (This includes bereavement counseling services for the *Member's* family. This applies for up to one year after 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.]

[Note: Covered up to [0-unlimited] visits per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined) for any combination of home visits and *Inpatient* facility visits.]

[Injectable, infused or inhaled medications

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

Notes:

- *Prior authorization* and quantity limits may apply.
- There are designated home infusion *Providers* for a select number of specialized pharmacy products and drug administration services. These *Providers* offer clinical management of drug therapies, nursing support, and care coordination to *Members* with acute and chronic conditions. Medications offered by these *Providers* include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, immune deficiency and enzyme replacement therapy. Call Member Services or see our Web site for more information on these medications and *Providers.*
- Coverage includes the components required to administer these medications. This includes, but is not limited to, *Durable Medical Equipment*, supplies, pharmacy compounding, and delivery of drugs and supplies.
- Medications 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 *CareLink* Member Services. Or, check our Web site at **www.tuftshealthplan.com**.]

Other Health Services - continued

Medical supplies

We cover the cost of certain types of medical supplies, including:

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

Note[s]: Contact a Member Specialist with coverage questions. [*Prior authorization* is recommended for these services. See page 3-1 for more information.]

New cancer therapies

Coverage is provided for new cancer therapies (both *Inpatient* and *Outpatient*) still under investigation as required by Rhode Island General Laws Section § 27-18-36.

[*Prior authorization* is recommended for these services. See page 3-1 for more information.]

Orthoses and prosthetic devices

We cover the cost of orthoses and prosthetic devices (This includes repairs.), as required by Rhode Island law. This includes breast prostheses*, as required by federal law. Coverage is provided for the most appropriate model that adequately meets the *Member's* needs. His or her treating *Provider* determines this. [(*Prior authorization* is recommended for these services.*)]

[*Important Note: Breast prostheses provided in connection with a mastectomy are not subject to any *prior authorization*. See page 3-1 for more information.**]**

[Prescription infant formulas]

[Infant formulas are covered when *Medically Necessary.* The formulas must be prescribed for infants and children up to age 2.

Contact Member Services for more information.]

[Private duty nursing]

[We cover private duty nursing services. It must be *Medically Necessary.* Also, it needs to be ordered by a physician and performed by a certified home health care agency. Private duty nursing services are covered when the patient requires continuous skilled nursing observation and intervention.]

[Note: *Prior authorization* is recommended for these services. See page 3-1 for more information.]

Scalp hair prostheses or wigs for cancer or leukemia patients

Coverage is provided for scalp hair prostheses or wigs worn for hair loss suffered as a result of the treatment of any form of cancer. (See "*Durable Medical Equipment*" earlier in this chapter.)

Note: Covered up to a maximum benefit of [$350-unlimited] per [calendar year] [*Contract Year*] (*In-Network* and *Out-of-Network Levels* combined).

[Special medical formulas

Includes nonprescription enteral formulas and low protein foods. A *Provider* must prescribe the formular or food for these treatments:]

Low protein foods:

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

[Note: *Prior authorization* is recommended for these formulas. See page 3-1 for more information.]

Nonprescription enteral formulas:

- For home use for treatment of malabsorption caused by: Crohn's disease; ulcerative colitis; gastroesophageal reflux; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids.

[*Prior authorization* is recommended for these formulas. See page 3-1 for more information.]

[Prescription Drug Benefit

Introduction

This section describes the prescription drug benefit. These topics are included here. They explain your prescription drug coverage:

- How Prescription Drugs Are Covered;
- Prescription Drug Coverage Table;
- What is Covered;
- What is Not Covered;
- [*CareLink* Pharmacy Management Programs;]
- Filling Your Prescription. **]**

[How prescription drugs are covered

Prescription drugs may be considered *Covered Services*. This occurs only if they comply with the *Tufts Health Plan Pharmacy Management Programs* section below and are:

- listed below under *What is Covered*;
- provided to treat an injury, illness, or pregnancy; and
- *Medically Necessary*.

We have a current list of covered drugs. See our Web site at **www.tuftshealthplan.com**. You can also call a Member Specialist.

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

- [Tier-0 drugs [are covered in full] [have the lowest *Cost Sharing Amount*].]
- Tier-1 drugs have the [lowest] [lower] level *Cost Sharing Amount*; many generic drugs are on Tier-1.
- Tier-2 drugs have the [middle] [higher] level *Cost Sharing Amount*.
- [Tier-3 drugs have the [higher] [highest] level *Cost Sharing Amount*.]
- [[Tier-4] [Special Designated Pharmacy Program] drugs have the highest *Cost Sharing Amount*.]

[Note: Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law are covered in full. [However, if a generic equivalent is available, non-generic oral contraceptives, diaphragms and hormonal contraceptives are subject to the applicable Tier *Copayment.]]*

FILING NOTE: *As of 8/1/12, contraceptives and sterilization services will be covered in full at the In-Network Level of Benefits for all new groups or upon a group's renewal on or after that date for all non-grandfathered groups except upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C.(w) (3) (A) and (B) or that does not fall under the federal safe harbor for contraceptive services..*

PRESCRIPTION DRUG COVERAGE TABLE

INFERTILITY MEDICATIONS

[0-20%] *Coinsurance**]], for up to a 30-day supply [(This is subject to the [prescription drug deductible] below.].

*Notes:

- *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.
- [Coverage for infertility is limited to [$100,000-unlimited] per *Member* per lifetime (This maximum is for *In-Network* and *Out-of-Network Levels* combined.). This limit applies to both: (1) infertility services covered under the "*Outpatient* Care" benefit; and (2) oral and injectable drug therapies used to treat infertility and covered under this "Prescription Drug Benefit."]

[DIABETES EQUIPMENT/SUPPLIES [(subject to the [prescription drug deductible] described below]

Retail Pharmacy

When obtained through a *Tufts Health Plan* Designated Retail Pharmacy:

- [Blood glucose meters: [$0-$50] *Copayment.]*
- [Test strips: [$0-$25] *Copayment* for generic test strips (for up to a 30-day supply); [$0-$25] *Copayment* for preferred brand name test strips (up to a 30-day supply); [$0-$50] for non-preferred brand name test strips (up to a 30-day supply).]
- [Lancets, lancet devices, and miscellaneous supplies (including alcohol swabs and calibration fluids): [$0-$25] *Copayment* for generic lancets, lancet devices and miscellaneous supplies (up to a 30-day supply); [$0-$50] *Copayment* for preferred brand name lancets, lancet devices, and miscellaneous supplies (up to a 30-day supply).]

When not obtained through a *Tufts Health Plan* Designated Retail Pharmacy:

- Blood glucose meters, test strips, lancets, lancet devices, and miscellaneous supplies (including alcohol swabs and calibration fluids): [$0-$50] *Copayment* then [0-20%] *Coinsurance* (up to a 30-day supply).

Mail Order

When obtained through a *Tufts Health Plan* Designated Mail Services Pharmacy:

- Blood glucose meters: [$0-$25] *Copayment.*
- Test strips: [$0-$25] *Copayment* for generic test strips (for up to a 90-day supply); [$0-$25] *Copayment* for preferred brand name test strips (up to a 90-day supply); [$0-$50] for non-preferred brand name test strips (up to a 90-day supply).
- Lancets, lancet devices, and miscellaneous supplies (including alcohol swabs and calibration fluids): [$0-$25] *Copayment* for generic lancets, lancet devices and miscellaneous supplies (up to a 90-day supply); [$0-$25] for preferred brand name lancets, lancet devices, and miscellaneous supplies (up to a 90-day supply).

When not obtained through a *Tufts Health Plan* Designated Mail Services Pharmacy: There is no coverage for any diabetes equipment or supplies when obtained through a mail services pharmacy that is not *Tufts Health Plan* Designated Mail Services Pharmacy. **]**

[CANCER DRUGS [(subject to the [prescription drug deductible] described below]

Anti-neoplastic (chemotherapy) drugs used for cancer treatment are covered in full when purchased through a retail pharmacy. There is no coverage for anti-neoplastic (chemotherapy) drugs when purchased through a mail order pharmacy.

Note: Some chemotherapy drugs are not covered under this pharmacy benefit and are instead covered under the "Injectable medications" benefit earlier in this chapter. Call Member Services for more information. **]**

Prescription Drug Benefit - continued

PRESCRIPTION DRUG COVERAGE TABLE – continued

ALL OTHER MEDICATIONS

DRUGS OBTAINED AT A RETAIL PHARMACY:

- Coverage When Drugs **Are Obtained** Through a *Tufts Health Plan* Designated Retail Pharmacy:

  Covered prescription drugs (This includes both acute and maintenance drugs.) You must obtain these drugs directly from a *Tufts Health Plan* designated retail pharmacy.

[Tier-0 drugs:	**Tier-1 drugs:**	**Tier-2 drugs:**	**Tier-3 drugs:**
[[[$0-$50] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$50] ,] for a 1-30 day supply	[[[$0-$50] *Copayment*] [[10-50%] *Coinsurance**] [, up to a maximum of [$0-$50],] for a 1-30 day supply	[[[$0-$75] *Copayment]* [[10-50%] *Coinsurance**] [, up to a maximum of [$0-$75],] for a 1-30 day supply	[[[$0-$150] *Copayment]* [[10-60%] *Coinsurance**]] [, up to a maximum of [[$0-$150],] for a 1-30 day supply.
[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 31-60 day supply]	[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 31-60 day supply]	[[[$0-$300]*Copayment*] [[10-60%] *Coinsurance**]] [, up to a maximum of [$0-$300],] or a 31-60 day supply]
[[[$0-$150]*Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 61-90 day supply]	[[[$0-$150] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 61-90 day supply]	[[[$0-$225] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$225],] for a 61-90 day supply]	[[[$0-$450] *Copayment*] [[10-60%] *Coinsurance**]] [, up to a maximum of [$0-$450],] for a 61-90 day supply]

[(subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] described below)]

- Coverage When Drugs **Are Not Obtained** Through a *Tufts Health Plan* Designated Retail Pharmacy:

  You may choose to obtain a covered prescription drug at a retail pharmacy which is **not** a *Tufts Health Plan* designated pharmacy. If so, you pay [a [$0-$50] *Copayment*] [, and then] [20%-50%] *Coinsurance* for that drug.

  [(This is subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] described below.)]

[DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY:

- Coverage When Drugs **Are Obtained** Through a *Tufts Health Plan* Designated Mail Services Pharmacy:

  Most maintenance medications, when mailed to you through a *Tufts Health Plan* designated mail services pharmacy.

[Tier-0 drugs:	**Tier-1 drugs:**	**Tier-2 drugs:**	**[Tier-3 drugs:**
[[[$0-$100] *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 1-[30-9]0 day supply]	[[[$0-$100 *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$100],] for a 1-[30-90]-day supply]	[[[$0-$150 *Copayment*] [[10-50%] *Coinsurance**]] [, up to a maximum of [$0-$150],] for a 1-[30-90]- day supply]	[[[$0-$450 *Copayment*] [[10-60%] *Coinsurance**]] [, up to a maximum of [$0-$450],] for a 1-[30-90] day supply]

[(This is subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] described below.)]

- Coverage When Drugs **Are Not Obtained** Through a *Tufts Health Plan* Designated Mail Services Pharmacy:

  If you choose to obtain a covered prescription drug through a mail services pharmacy which is **not** a *Tufts Health Plan* designated pharmacy, you pay 20% *Coinsurance* for that drug.

  [(This is subject to the [prescription drug deductible] [and] [[calendar year] [*Contract Year*] maximum benefit] described below.)]

*Note: *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.

PRESCRIPTION DRUG COVERAGE TABLE – continued

[DRUGS OBTAINED THROUGH THE SPECIAL DESIGNATED PHARMACY PROGRAM**

The following drugs must be obtained through a special designated pharmacy: medications used in the treatment of infertility; multiple sclerosis; hemophilia; hepatitis C; growth hormone deficiency; rheumatoid arthritis; and cancers treated with oral medications, when obtained from special designated pharmacies.

[Tier-4 drugs:]

[[[$0-$125] *Copayment*] [[10-70%] *Coinsurance**]], [, up to a maximum of [$0-$300],] for up to a 30-day supply.

[(This is subject to the [prescription drug deductible] [and] [the[calendar year] [*Contract Year*] maximum benefit] below.)]

*Note: *Coinsurance* is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates that we receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.

For more information, see "*Tufts Health Plan* Pharmacy Management Programs". **]

***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** If implemented, this Special Designated Pharmacy Program will not be limited to mail order.]*

[Prescription drug deductible]

[A [$0-$600] prescription drug deductible applies to [prescription drugs on Tiers 2 and 3 for] each *Member* per [calendar year] [*Contract Year*]. This is the amount you must first pay for covered prescription drugs [obtained at a [*Tufts Health Plan* designated] retail pharmacy] [obtained through a [*Tufts Health Plan* designated] mail order pharmacy] [on Tiers 2 and 3] before we will pay for any covered [retail] [mail order] prescription drugs.] [Upon initially joining *Tufts Health Plan*, any deductible amount you paid for covered [retail] [mail order] prescription drugs under another health plan during the current calendar year may be used to satisfy your prescription drug deductible for that year.]

[Note: This prescription drug deductible does **not** apply to [generic drugs, regardless of their tier] [prescription drugs on Tier 1] [prescription and over-the-counter smoking cessation agents.]

[Any combination of enrolled *Members* of a covered family may satisfy the [$0-$1,800] family prescription drug deductible during a [calendar year] [*Contract Year*]. In this case, the remainder of the covered *Members* of that family will not need to satisfy an individual prescription drug deductible for the rest of that [calendar year] [*Contract Year*].]

[Any deductible amount you pay for covered [retail] [mail order] prescription drugs [on Tiers 2 and 3] under this plan in the last [0-12] months of a [calendar year] [*Contract Year*] may be used to satisfy your prescription drug deductible during the following year.]

[The deductible is calculated based on our contracted rate when the prescription is filled. It does not reflect any rebates that we may receive at a later date. Rebates, if any, are reflected in your *Group's Premium*.]

Prescription Drug Benefit – continued

[***Deductible***]

[Prescription drugs are subject to the *Deductible*. For more information, see the "Benefit Overview" section.]

Note[s]:

- You may fill your prescription in a state that allows you to request a brand-name drug even though your *Provider* authorizes the generic equivalent. In this case, you will pay the applicable Tier *Cost Sharing Amount.* You will also pay the difference in cost between the brand-name drug and the generic drug.
- [You always pay the applicable *Cost Sharing Amount.* This is the case, even if the cost of the drug is less than the *Cost Sharing Amount*.]

]

[Generic Incentive Program]

[Your *Provider* may prescribe a brand-name drug that has a generic equivale. nt This can happen in Massachusetts and many other states. In this case, you will receive the generic drug and pay the applicable Tier *Copayment*. Wherever you fill your prescription, your *Provider* may request that you receive a covered brand-name drug only. In this case, you will pay the *Copayment* for the generic drug. You must also pay the difference between the cost of the generic drug and the cost of the covered brand-name drug. In many cases, there may be a significant difference in price between the brand-name drug and the generic drug. This may result in a significant difference in what you need to pay.]

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Text in "What is Covered" and "What is Not Covered" provisions in this "Prescription Drug Benefit" will include coverage for oral contraceptives and diaphragms for groups with prescription drug **except** upon request that such coverage be removed from an employer that is a church or qualified church-controlled organization, as those terms are defined in 26 U.S.C. section 3121**[**(w)(3)(A) and (B).**]**]*

[Prescription Drug Benefit - continued

What is covered

We cover the following under this Prescription Drug Benefit:

- Prescribed drugs that by law require a prescription and are not listed under *What is Not Covered* (See "Important Notes" below.).
- [Test strips for glucose monitors and/or visual aid reading, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar levels.]

*[**FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** Coverage for test strips, insulin, syringes, injection aids, cartridges for the legally blind, and oral agents for controlling blood sugar will be provided as part of the "Prescription Drug Benefit" listed above for plans that **include** prescription drug coverage. For plans that **exclude** prescription drug coverage, those items will be covered under the "Diabetes services and supplies" in the "Outpatient Care" section earlier in this chapter.]*

- 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 (e.g., patches, rings) that by law require a prescription. See "Family planning" above for information about other covered contraceptive drugs and devices.]
- Fluoride for *Children*.
- [Injectables and biological serum included in the list of covered drugs on our Web site. For more information, call Member Services. Also, see our Web site at **www.tuftshealthplan.com**.]
- Prefilled sodium chloride for inhalation (This is covered both by prescription and over-the-counter.).
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer 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. These are only covered 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. Also, see our Web site at **www.tuftshealthplan.com**.]
- Prescription and over-the-counter smoking cessation agents. These must be recommended and prescribed by a *Provider.*

[Note: Certain prescription drug products may be subject to one of the *CareLink Pharmacy Management Programs* described below.]

]

What is not covered

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

- Drugs that by law do not require a prescription (unless listed as covered in the *What is Covered* section above).
- Drugs not listed on the "Tufts Health Plan Prescription Drug List". See the list at **www.tuftshealthplan.com.** Also, you can call Member Services for more information.
- Vitamins and dietary supplements (except prescription prenatal vitamins and fluoride for *Children*[and supplements for the treatment of mitochondrial disease]).
- Medications for the treatment of idiopathic short stature.
- Topical and oral fluorides for adults.
- Cervical caps, IUDs, implantable contraceptives (Implanon® (etonorgestrel), levonorgestrel implants, Depo-Provera or its generic equivalent [(These are covered under your *Outpatient* care benefit earlier in this Chapter.)] [oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription].
- 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" above.
- **[**Prescriptions written by *Providers* who do not participate in *Tufts Health Plan.* These drugs are excluded, except in cases of authorized referral or *Emergency* care.]
- [Prescriptions filled at pharmacies other than *Tufts Health Plan* designated pharmacies, except for *Emergency* care.]
- 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*.
- [Drugs dispensed in an amount or dosage that exceeds our established quantity limitations.]
- 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 [is not] [may not be] covered. Also, the entire class of prescription medications may not be covered. For more information, call Member Services. You can also check our Web site at **www.tuftshealthplan.com**. Note: This restriction on prescription drugs does not apply to prescription and over-the-counter smoking cessation agents.
- Prescription medications when packaged with non-prescription products.
- Oral non-sedating antihistamines.

Prescription Drug Benefit - continued

[*CareLink* Pharmacy Management Programs]

[In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, *CareLink* has developed these Pharmacy Management Programs:]

[[Quantity Limitations Program]:

CareLink limits the quantity of selected medications *Members* can receive in a given time period. We do this for cost, safety and/or clinical reasons.]

[Prior Authorization Program:

CareLink restricts the coverage of certain drug products. These are drugs with a narrow indication for usage, may have safety concerns and/or are extremely expensive. We require the prescribing *Provider* to obtain prior approval from *CareLink* for such drugs.]

Step Therapy PA Program

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

[Special Designated Pharmacy Program:

CareLink has designated special pharmacies to supply a select number of medications . This includes medications used to treat 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. They are staffed with clinicians to provide support services to *Members*. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time. [Medications are delivered directly to the *Member's* home via mail. This is NOT part of the mail order pharmacy benefit.] Extended day supplies and *Copayment* savings do not apply to these special designated drugs.]

***[FILING NOTE TO RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION:** If implemented, this Special Designated Pharmacy Program will not be limited to mail order.]*

Non-Covered Drugs:

Tufts Health Plan covers over 4,500 drugs. However, a small number of drugs (less than 1%) are not covered. This is because there are safe, effective and more affordable alternatives available. Drugs may not be covered for safety reasons, if they are new on the market, if they become available over-the-counter, or if a generic version of a drug becomes available. For more information about these non-covered drugs, call Member Services or go to **www.tuftshealthplan.com**. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) . They are widely used and accepted in the medical community to treat the same conditions as the medications that are not covered. For up-to-date information on these non-covered drugs and their suggested alternatives, please call *Member Services,* or see the web site at www.tuftshealthplan.com.

Prescription Drug Benefit - continued

[*CareLink* Pharmacy Management Programs, continued**]**

[New-To-Market Drug Evaluation Process:

CareLink'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. This is usually within 6 months of the drug product's availability.]

[IMPORTANT NOTES:

- [Your *Provider* may feel it is *Medically Necessary* for you to take medications that are restricted under any of the *CareLink Pharmacy Management Programs* described above. In this case, he or she may submit a request for coverage. *CareLink* will approve the request if it meets our guidelines for coverage. For more information, call Member Services.]
- 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, a brand drug's patent may expire. In this case, we may [move] [change the drug's status by either (a) moving] the brand drug from Tier - 2 to Tier – 3 [or (b) no longer covering the brand drug] when a generic alternative becomes available. Many generic drugs are available on Tier - 1.
- You may have questions about your prescription drug benefit. You may want to know the tier of a particular drug. [You might like to know if your medication is part of a Pharmacy Management Program] For these issues, check our Web site at **www.tuftshealthplan.com.** You can also call *CareLink* Member Services at 1-866-352-9114.

Prescription Drug Benefit - continued

Filling your prescription

Where to fill prescriptions:

You can fill your prescriptions at any pharmacy. You must fill your prescriptions at a *CareLink* designated pharmacy in order to receive coverage at the *In-Network Level of Benefits*. *CareLink* designated pharmacies include:

- [for the majority of prescriptions,] many of the pharmacies in Massachusetts and Rhode Island. They also include additional pharmacies nationwide; [and]
- [for a select number of drug products, a small number of special designated pharmacy providers. (See "*CareLink* Pharmacy Management Programs" above.)] You may have questions about where to fill your prescription. If so, call Member Services.]

How to fill prescriptions:

- When you fill a prescription, provide your Member ID to any *CareLink* designated pharmacy and pay your *Cost Sharing Amount*.
- The cost of your prescription may be less than your *Copayment.* In this case, you [must pay for the actual cost of the prescription] [must pay that *Copayment*].
- If you have any problems using this benefit, call *CareLink* Member Services.

Important: If you fill a prescription at a non-*CareLink* designated pharmacy, call *CareLink* Member Services. They will explain how to submit your prescription drug claims for reimbursement.

[Filling Prescriptions for Maintenance Medications:

You may need to take a *maintenance* medication. If so, we offer you two choices for filling your prescription:

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

[Note: See the "Preventive Medication Benefit" at the front of this document for more information.]

*These drugs may not be available to you through a *CareLink* 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 [;or]
- 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 from Benefits

Tufts Health Plan 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 that is not essential to treat an injury, illness, or pregnancy, except for preventive care services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting.
- A service, supply, or medication that is primarily for your, or another person's, personal comfort or convenience.
- [A service, supply, or medication that is obtained outside of the 50 United States. The only exceptions to this rule are for *Emergency* care services or *Urgent Care* services while traveling, which qualify as *Covered Services* when provided outside of the 50 United States.]
- *Custodial Care*.
- Services related to non-*Covered Services.* This does not apply to complications related to pregnancy terminations.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

  This exclusion does not apply to:
  - treatment of chronic Lyme disease;
  - new cancer therapies, as described earlier in this chapter [; or
  - off-label uses of prescription drugs for the treatment of cancer, if you have a Prescription Drug Benefit]

  which meet the requirements of Rhode Island law.

  A treatment may be *Experimental or Investigative.* In this case, we will not pay for any related treatments provided to the *Member* for the purpose of furnishing the *Experimental or Investigative* treatment.
- Drugs, medicines, materials or supplies for use outside the hospital or any other facility, except as described earlier in this chapter. Medications and other products which can be purchased over-the-counter except those listed as covered earlier in this chapter.
- The following exclusions apply to services provided by the relatives of a *Member*:
  - Services provided by a relative who is not a *Provider* are not covered;
  - Services provided by an immediate family member (by blood or marriage), even if the relative is a *Provider*, are not covered.
  - If you are a *Provider*, you cannot provide or authorize services for yourself or a member of your immediate family (by blood or marriage).
- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are an employer, an insurance company, a school, or a court.
- Services for which you are not legally obligated to pay. Services for which no charge would be made if you had no health plan.
- Care for conditions for which benefits are available under workers' compensation or other government programs other than Medicaid.

Exclusions from Benefits, continued

- 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 see if your Provider charges such a fee.
- Charges incurred when the Member, for his or her convenience, chooses to remain an Inpatient beyond the discharge hour.
- Facility charges or related services if the procedure being performed is not a Covered Service, except as provided under "Oral health services" earlier in this chapter.
- [Preventive dental care [, except as provided under "Pediatric dental care for Members under age 12" earlier in this chapter];_ [periodontal treatment;] [orthodontia, even when it is an adjunct to other surgical or medical procedures;] [dental supplies;] [dentures;] [restorative services including, but not limited to, crowns, fillings, root canals, and bondings;] [skeletal jaw surgery, except as provided under "Oral health services" earlier in this chapter;] [alteration of teeth;] [care related to deciduous (baby) teeth;] [splints and oral appliances (except for sleep apnea, as described earlier in this chapter), including those for TMJ disorders.] TMJ disorder-related therapies, including TMJ appliances, occlusal adjustment, or TMJ appliance-related therapies, are not covered.]
- [Surgical removal or extraction of teeth, except as provided under "Oral health services" earlier in this chapter.]
- Cosmetic (This means 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.
- [Contraceptives] [and] [contraceptive services].
- Costs associated with home births; costs associated with the services provided by a doula.
- Circumcision performed in any setting other than a hospital, *Day Surgery,* or a *Provider's* office.
- Infertility services for *Members* who do not meet the definition of Infertility as described in the "Outpatient Care" section earlier in this chapter; *Experimental* infertility procedures; the costs of surrogacy*; [sterilization;] reversal of voluntary sterilization; long-term (longer than 90 days) [sperm or] embryo cryopreservation unless the Member is in active infertility treatment; costs associated with donor recruitment and compensation; Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization [; infertility services for male *Members*;] [; and donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.]

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

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

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

  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 authorization* is recommended for these services.

Exclusions from Benefits, continued

- Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the *Member* is the sole recipient of the donor's eggs. *Prior authorization* is recommended for these services.
- [Pregnancy terminations, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest.]
- [Preimplantation genetic testing and related procedures performed on gametes or embryos.]
- Treatments, medications, procedures, services and supplies related to: medical or surgical procedures for sexual reassignment; reversal of voluntary sterilization; or over-the-counter contraceptive agents.
- 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" (This is 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;] [chiropractic medicine;] [spinal manipulation services for *Members* age 12 and under;] *Inpatient* and *Outpatient* weight-loss programs and clinics; [nutritional counseling, except as described earlier in this chapter;] relaxation therapies; massage therapies, except as described under "Short-term speech, 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. All services, procedures, labs and supplements associated with this type of medicine.
- Any service, supply, or procedure performed in a non-conventional setting (This includes, but is 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* applies);
  - Intravenous immunoglobulin for treatment of severe immune disorders, certain neurological conditions, infectious conditions, and bleeding disorders (*Prior authorization* is recommended for these services.).
- Devices and procedures intended to reduce snoring. These include, but are not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards.

Exclusions from Benefits, continued

- Examinations, evaluations or services for educational purposes or developmental purposes. This includes 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 not caused by an underlying medical illness or condition.

- [Eyeglasses, lenses or frames, except as described under "Durable Medical Equipment" earlier in this chapter; [refractive eye surgery (including radial keratotomy) for conditions which can be corrected by means other than surgery]. [Routine eye exams.] Except as described earlier in this chapter, we will not pay for contact lenses or contact lens fittings.]
- Methadone maintenance or methadone treatment [related to substance abuse].
- [Private duty nursing (block or non-intermittent nursing)[, except as described under “Home health care” earlier in this chapter.]
- Routine foot care. Examples include: 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; or other non-orthotic support devices for the feet.

  Note: This exclusion does not apply to routine foot care for Members diagnosed with diabetes.
- Transportation, including , but not limited to, transportation by chair car, wheelchair van, or taxi, except as described in “Ambulance services” in this chapter.
- Lodging related to receiving any medical service[, except as described under “Hematopoietic stem cell transplants and human organ transplants” earlier in this chapter] .
- [Bariatric surgery.]
- [The prescription drug, RU-486, or its therapeutic equivalent.]
- [Telephone consultations.]
- [Supervision of maintenance therapy for chronic disease which is not aggravated by surgery and would not ordinarily require hospitalization; rehabilitation for maintenance purposes.]
- [Sleep studies performed in the home.]
- [Bone marrow blood supply MRIs.]
- [Non-cadaveric small bowel transplants.]

Chapter 4
When Coverage Ends

Reasons coverage ends

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

- you lose eligibility because you no longer meet your *Group's* or *Tufts Health Plan's* eligibility rules;
- [you are a *Subscriber* or a *Spouse* and you move out of the *Network Contracting Area**;]
- you choose to drop coverage;
- you commit an act of physical or verbal abuse unrelated to your physical or mental condition which poses a threat to any *Provider*, any *Tufts Health Plan Member*, *Tufts Health Plan* or any *Tufts Health Plan* employee;
- you commit an act of misrepresentation or fraud; or
- your *Group Contract* with us ends. (For more information, see "Termination of a *Group Contract*" later in this chapter.)

*Note: *Children* are not required to maintain primary residence in the *Network Contracting Area.* In addition, there are a few other exceptions in which *Dependents* are still eligible for coverage even if they live outside of the *Network Contracting Area*. However, care outside of the *Network Contracting Area* is only covered at the *Out-of-Network Level of Benefits.* See "If you live outside of the *Network Contracting Area*" in Chapter 2 for more information.

Benefits after termination

If you are totally disabled when your coverage ends, you may be able to continue your coverage as described in "Extension of Benefits" later in this chapter. Otherwise, we will <u>not</u> 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 converted plans

Once your coverage ends, you may be eligible to continue your coverage with your *Group*. Or, you may be able to enroll in a converted coverage plan. 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.

<u>Important Note</u>: Your coverage will terminate retroactively. This is done back to the date you are no longer eligible for coverage.

When a *Member* is No Longer Eligible, continued

If you move out of the *Network Contracting Area*

If you are a *Subscriber* or *Spouse* and you move out of the *Network Contracting Area*, coverage ends on the date you move*. *Children* are not required to maintain primary residence in the *Network Contracting Area*. However, care outside of the *Network Contracting Area* is only covered at the *Out-of-Network Level of Benefits.*

Before you move, tell your *Group* or call a Member Specialist before you move to notify us of your move. You may have kept a residence in the *Network Contracting Area* but been out of the *Network Contracting Area* for more than 90 days. If this happens, coverage ends 90 days after the date you left the *Network Contracting Area*.

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

*Note: There are a few other exceptions in which *Dependents* are still eligible for coverage even if they live outside of the *Network Contracting Area*. See "If you live outside of the *Network Contracting Area*" in Chapter 2 for more information.

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. See Chapter 2, "Continuing Eligibility for *Dependents*", for more information.

You choose to drop coverage

Coverage ends if you decide you no longer want coverage and you meet any qualifying event your *Group* requires. To end your coverage, notify your *Group*. You must do this 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

We 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

We may terminate your coverage for misrepresentation or fraud during the first two years of coverage under this plan. If your coverage is terminated for misrepresentation or fraud, we may not allow you to re-enroll for coverage with us under any other plan (such as an individual plan 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:

- alse 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 we terminate your coverage for misrepresentation or fraud, your coverage will end as of a later date chosen by us. During the first two years of coverage, we reserve the right to revoke coverage and deny payment of claims retroactive to your *Effective Date* for any false or misleading information on your application.

Payment of claims

We will pay for all *Covered Services* you received between:

- your *Effective Date*; and
- your termination date, as chosen by us. We retroactively terminate your coverage back to a date no earlier than your *Effective Date*.

We may 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 us back; or
- not pay for those services. In this case, you will have to pay the *Provider* for the services.

The *Premium* may be more than is needed to pay for *Covered Services* you received after your termination date. In this case, we will refund the excess to your *Group*.

Despite the above provisions related to *Member* termination for misrepresentation or fraud:

- the validity of the *Group Contract* will not be contested, except for non-payment of *Premiums*, after the *Group Contract* has been in force for two years from its date of issue; or
- no statement made for the purpose of effecting insurance coverage with respect to a *Member* under this *Group Contract* shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits thereunder after that *Member's* insurance under this *Group Contract* has been in force for a period of two years during his or her lifetime, nor unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to him or her.

Termination of a *Group Contract*

End of *Tufts Health Plan's* and *Group's* relationship

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.

*Note: In accordance with the provisions of the *Group Contract,* the *Group* is entitled to a one-month grace period for the payment of any *Premium* due, except for the first month's *Premium*. During that one-month grace period, the *Group Contract* will continue to stay in force. However, upon termination of the *Group Contract*, the *Group* will be responsible for the payment of Premium, prorated based on the actual date of the termination. That termination date will be at the end of the grace period, unless the *Group* notifies us of an earlier termination date.

Extension of Benefits

If you are totally disabled on the date the *Group Contract* ends, you will continue to receive *Covered Services* for 12 months.

The following conditions apply:

- the *Covered Services* must be:
  - *Medically Necessary*,
  - provided while the total disability lasts, and
  - directly related to the condition that caused the *Member* to be totally disabled on that date; and
- all of the terms, conditions, and limitations of coverage under the *Group Contract* will apply during the extension of benefits.

The extension of benefits will end on the earliest of:

- the date the total disability ends;
- the date you become eligible for coverage under another plan; or
- 12 months after your extended benefits began.

Transfer to Other Group Health Plans

Conditions for transfer

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 *Network Contracting 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.

Obtaining a Certificate of Creditable Coverage

Certificates of Creditable Coverage are mailed to each Subscriber and/or *Dependent* upon termination. This is done in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting us. Call the Member Services Department at 1-866-352-9114.

Chapter 5

Continuation of *Group Contract* Coverage and Conversion Privilege

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 Group 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.

FEDERAL COBRA - DURATION OF COVERAGE		
Qualifying Event(s)	**Qualified Beneficiaries**	**Maximum Period of Coverage**
• Termination of *Subscriber's* employment for any reason other than gross misconduct. • Reduction in the *Subscriber's* work hours.	*Subscriber*, *Spouse*, and *Dependent Children*	18 months*
Subscriber's divorce, legal separation, entitlement to Medicare, or death.	*Spouse* and *Dependent Children*	36 months
Subscriber's or *Spouse's* enrolled *Dependent* ceases to be a *Dependent Child*.	*Dependent Child*	36 months
*__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 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.

Rhode Island Continuation Coverage

If your employment is terminated because of involuntary layoff or death, or as a result of the workplace ceasing to exist, or the permanent reduction in size of the workforce, the benefits under this *Group Contract* may be continued as provided under Rhode Island General Laws, Chapter 27-19.1. The period of this continuation will be for up to eighteen (18) months from your termination date. The continuation period cannot exceed the shorter of:

- the period that represents the period of your continuous employment preceding termination with your *Group;* or
- the time from your termination date until the date that you or any other covered *Member* under your plan becomes employed by another employer and eligible for benefits under another group plan.

Note: We must receive the applicable *Premium* in order to continue coverage under this provision.

Rhode Island Conversion Privilege

You may be entitled to enroll in a separate health benefit contract ("converted contract") if your coverage under this *Group Contract*:

- has been terminated for any reason other than discontinuance of the *Group Contract* in its entirety or with respect to an insured class; and
- you have been continuously covered under the *Group Contract* (and under any employer contract providing similar benefits which it had replaced) for at least three (3) months immediately prior to termination.

  Notes:

  - You will not be entitled to coverage under a converted contract if your coverage under the *Group Contract* ended because (1) you failed to pay any required contribution or (2) any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days.
  - You must submit written application for the converted contract and pay us the first required contribution no later than thirty-one (31) days after such termination.

For more information about converted contracts, call Member Services.

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

Chapter 6

How to File a Claim and *Member* Satisfaction

How to File a Claim

Network Providers

You may get care from a *Network Provider*. If so, you do not have to submit claim forms. The *Network Provider* will submit claim forms to *CareLink* for you. *CareLink* will make payment directly to the *Network Provider*.

Non-*Network Providers*

You may get care from a *Non-Network Provider*. Is so, it may be necessary to file a claim form. Claim forms are available from the *Group* or *CareLink* (see "To Get Claim Forms" and "Time Limit for Providing Claim Forms" below).

Hospital Admission or *Day Surgery*

You may get care from a hospital that is a *Non-Network Provider*. In this case, have the hospital complete a claim form. The hospital should submit the claim form directly to *CareLink*. If you are responsible for any part of the hospital bill, *CareLink* will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the Non-*Network Hospital*.

Outpatient Medical Expenses

When you receive care from a *Non-Network Provider*, you are responsible for completing claim forms. (Check with the *Non-Network Provider* to see if he or she will submit the claim directly to *CareLink*. If not, you must submit the claim form directly to *CareLink*.)

If you sign the appropriate section on the claim form, *CareLink* will make payment directly to the *Non-Network Provider*. If you are responsible for any portion of the bill, *CareLink* will send you an explanation of benefits statement. The explanation of benefits will tell you how much you owe the *Non-Network Provider*.

If you do not sign the appropriate section on the claim form, *CareLink* will make payment directly to you. If you have not already paid, you will be responsible for paying the *Non-Network Provider* for the services you received. If you are responsible for any part of the bill, *CareLink* will send you an explanation of benefits statement. The explanation of benefits statement will tell you how much you owe the *Non-Network Provider*.

To Get Claim Forms

You can get claim forms from the *Group*. Or, you can call *CareLink* Member Services.

Where to Forward Medical Claim Forms

Send completed claim forms to:

[*Tufts Health Plan*
Claims Department
P.O. Box 9185
Watertown, MA 02471-9185]

You should submit separate claim forms for each family member.

How to File a Claim, continued

Pharmacy Expenses

You may obtain a prescription at a non-designated or out of network pharmacy. If so, you must pay for the prescription up front. Then, submit a claim for reimbursement. You can get a pharmacy claim forms by calling *CareLink* Member Services. Or, see our Web site at **www.tuftshealthplan.com**.

Time Limit for Providing Claim Forms

We will provide the *Member* making a claim, or to the *Group* for delivery to such person, the claim forms we furnish for filing proof of loss for *Covered Services* obtained at the *Out-of-Network Level of Benefits*. If we do not provide such forms within 15 days after we received notice of any claim under the *Group Contract*, the *Member* making that claim will be deemed to have met the requirements under that *Group Contract* for proof of loss, upon submitting to us within the time fixed in the *Group Contract* for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Member Satisfaction Process

CareLink has a multi-level Member Satisfaction process including:

- Internal Inquiry;
- *Member* Grievance Process;
- Two levels of Internal *Member* Appeals; and
- External Review by an External Appeals designated by the Rhode Island Department of Health.

Mail all grievances and appeals to us:

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

You can also call us at 1-866-352-9114.

Internal Inquiry:

Call a *CareLink* Member Specialist to discuss concerns you have about your health care coverage. We will make every effort to resolve your concerns. You may choose to file a grievance or appeal. If you do this, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Member Grievance Process

A grievance is a formal complaint about actions taken by *CareLink* or a *Network 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 us as soon as possible to explain your concern. Grievances may be filed either verbally or in writing. You may choose to file a grievance verbally. If you do this, call a *CareLink* Member Specialist. This person 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. Then, send it to the address at the beginning of this section. Your explanation should include:

- your name and address;
- your *CareLink* Member ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and *Provider* names; and
- any supporting documentation.

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

Administrative Grievances

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

Administrative Grievance Timeline

- You may file your grievance verbally or in writing. If you do this, we will notify you by mail. We will do this within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That notification will provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.
- We will review your grievance and will send you a letter regarding the outcome. As allowed by law, we will send that 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. This will be done by mutual written agreement between you or your authorized representative and *CareLink*.

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. You may have concerns about your medical care. If so, you should discuss them directly with your *Provider*. You may not be satisfied with your *Provider's* response or not want to address your concerns directly with your *Provider*. If so, you may contact *CareLink* Member Services to file a clinical grievance.

You may file your grievance verbally or in writing. If so, we will notify you by mail, within five (5) business days after receiving your grievance, that your verbal grievance or letter has been received. That letter will include with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your grievance.

CareLink will review your grievance and will notify you in writing regarding the outcome. As allowed by law, we will send that letter within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days. This may occur if we need additional time to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

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 *CareLink* 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 coordinate a review of all of the information submitted upon appeal. That review will consider your benefits as detailed in this *Certificate.* You are entitled to two (2) levels of internal review.

It is important that you contact *CareLink* as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage, claim payment, or first level appeal denial to file an internal appeal. Appeals may be filed either verbally or in writing. You may file a verbal appeal. To do this, call a *CareLink* Member Specialist. That person will document your concern and forward it to an Appeals and Grievances Analyst in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing. Then, send it to the address listed earlier in this section. Your explanation should include:

- your name and address;
- your *CareLink* Member ID number;
- a detailed description of your concern. This includes relevant dates, any applicable medical information, and Provider names; and
- any supporting documentation.

Appeals Timeline

- You may file your appeal verbally or in writing. If you do this, we will notify you in writing, within three (3) business days after receiving your letter, that your letter has been received. Our letter will include the name, address, and number of the Appeals and Grievances Analyst coordinating the review of your appeal.
- *CareLink* will review your appeal, make a decision, and send you a decision letter within fifteen (15) calendar days of receipt.
- The time limits in this process may be extended by mutual verbal or written agreement between you or your authorized representative and *CareLink*. The extension can be for up to 15 calendar days.

We may be waiting for medical records that are necessary for the review of your appeal. If we have not received them, we may need this extension. The Appeals and Grievances Analyst handling your case will notify you in advance if an extension may be needed. The notification will include the specific information required to complete the review.

When Medical Records are Necessary

Your appeal may require the review of medical records. In this event, we will send you a form. You must sign that form to authorize your *Providers* to release to *CareLink* medical information relevant to your appeal. You must sign and return the form before *CareLink* can begin the review process. If you do not sign and return the form to us within fifteen (15) calendar days of the date you filed your appeal, *CareLink* may issue a response to your request without reviewing the medical records. You will have access to any medical information and records relevant to your appeal in the possession and control of *CareLink*.

Who Reviews Appeals?

First level appeals of a medical necessity determination will be reviewed by a licensed practitioner:

- with the same licensure status or a licensed physician or a licensed dentist; and
- who did not participate in any of the prior decisions on the case.

Second level appeals will be reviewed by a licensed practitioner in the same or similar specialty as typically treats the medical condition, procedure or treatment under review.

A designated reviewer will review appeals involving non-*Covered Services*.

Appeal Response Letters

The letter you receive from *CareLink* will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding an adverse appeal determination (a decision based on medical necessity) will include: the specific information upon which the adverse appeal determination was based; *CareLink*'sunderstanding 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; the title and credentials of the individual who reviewed the case; notification of the steps requested the next level of internal appeal or an external review by an External Appeals Agency, designated by the Rhode Island Department of Health, as appropriate; and the availability of translation services and consumer assistance programs.

Also, a first level adverse appeal determination letter will notify you that should you file a second level appeal, you have the right to: (1) inspect the appeal review file; and (2) add information prior to our reaching a final decision. Finally, a second level adverse appeal determination letter will include:

- fee information for filing an external review; and
- a statement that if *CareLink's* decision is overturned by the external appeals agency, you will be reimbursed by *CareLink* within sixty (60) days of the date you are notified of the overturn for your share of the appeal fee.

Expedited Appeals

CareLink recognizes that there are circumstances that require a quicker turnaround than the fifteen (15) calendar days allotted for the standard Appeals Process. *CareLink* 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. Additionally, *CareLink* will expedite your appeal if a medical professional determines it involves emergent health care services (defined as services provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g., severe pain) where the absence of immediate medical attention could be reasonably expected to result in placing your health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part). If your request meets the criteria for an expedited review, you may also file a request for a simultaneous external appeal.

If you feel your request meets the criteria cited above, you or your attending *Provider* should contact *CareLink* Member Services. Under these circumstances, you will be notified of *CareLink's* decision on the earlier of:

- within two (2) business days of receipt of all information necessary to complete the review; or
- seventy-two (72) hours after the review is initiated.

External Review

CareLink provides for an independent external review by an external appeal agency for final adverse determinations These are decisions based on medical necessity. The Rhode Island Department of Health has designated an external appeal agency who performs independent reviews of final adverse medical necessity decisions. The external review agency is not connected in any way with *CareLink.* Note that appeals for coverage of services excluded from coverage under your plan are not eligible for external review.

To initiate this external appeal, you must send a letter to *CareLink* within four months of the receipt of your second level adverse determination letter. In that letter, you must include any additional information that you would like the external review agency to consider.

Within five (5) days of receipt of your written request, *CareLink* will forward the complete review file, including the criteria utilized in rendering its decision to the external appeal agency. The external appeal agency shall provide notice to you and your *Provider* of record of the outcome of the external appeal.

The external review shall be based on the following:

- the review criteria used by *CareLink* to make the internal appeal determination;
- the medical necessity for the care, treatment or service for which coverage was denied; and
- the appropriateness of the service delivery for which coverage was denied.

The decision of the external appeals agency is binding. However, any person who is aggrieved by a final decision of the external appeals agency is entitled to judicial review in a court of competent jurisdiction.

If the external appeals agency overturns *CareLink's* appeal decision, we will send you a written notice within five (5) business days of receipt of the written decision from the appeal agency. This notice will:

- include an acknowledgement of the decision of the agency;
- advise of any 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 appeal.

Bills from *Providers*

Occasionally, you may receive a bill from a *Non-Network Provider* for *Covered Services*. Before paying the bill, contact the *CareLink* Member Services Department.

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

- A completed, signed Member Reimbursement Medical Claim Form. You can obtain this from our Web site. You can also get one by contacting our Member Services Department; and
- the documents required for proof of service and payment. Those documents are listed on the Member Reimbursement Medical Claim Form.

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

Note: You must contact *CareLink* regarding your bill(s) or send your bill(s) to *CareLink* within 90 days from the date of service, or as soon as reasonably possible. If you do not, the bill cannot be considered for payment, unless you are legally incapacitated. In no event, except in cases of legal incapacitation, can bills be considered for payment after a period of 1 year.

If you receive *Covered Services* from a *Non-Network Provider*, we will pay up to the *Reasonable Charge* for the services within 60 days of receiving a completed Member Reimbursement Medical Claim Form and all required supporting documents.

IMPORTANT NOTE:
We will directly reimburse you for *Covered Services* you receive from most *Non-Network Providers* within our *Network Contracting Area.* Some examples of these types of *Non-Network Providers* include:

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

You will be responsible to pay the *Non-Network Provider* for those *Covered Services.*
For more information, call Member Services or check our Web site at **www.tuftshealthplan.com.**

We reserve the right to be reimbursed by the *Member* for payments made due to *CareLink's* error.

[Notice to Michigan Residents

Tufts Health Plan will promptly process a complete and proper claim for *Covered Services* made by a *Member.* However, in the event there are delays in processing claims, the *Member* shall have no greater rights to interest or other remedies against *Tufts Health Plan's* third party administrator, Tufts Benefit Administrators, Inc., than as otherwise afforded to him or her by law.]

Limitation on Actions

You cannot bring an action at law or in equity to recover on this *Group Contract* prior to the expiration of sixty (60) days after a claim has been filed in accordance with the requirements stated under "How to File a Claim" earlier in this chapter. You cannot bring such action at all unless you bring it within three (3) years from the expiration of the time within which a claim must be filed as listed under "Bills from Providers" earlier in this chapter.

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 (a "Third Party"). "Third Party" means any person or company that is, or could be, responsible for the costs of injuries or illness to you. This includes such costs to any *Dependent* covered under this plan.

Tufts Health Plan may cover health care costs for which a Third Party is responsible. In this case, we may require that Third Party to repay us the full cost of all such benefits provided by this plan. Our rights of recovery apply to any recoveries made by you or on your behalf from any source. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance company on behalf of the Third Party;
- any payments or rewards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and
- any other payments from a source intended to compensate you for Third Party injuries.

We have the right to recover those costs in your name. We can do this with or without your consent, directly from that person or company. Our right has priority, except as otherwise provided by law. We can recover against the total amount of any recovery, regardless of whether all or part of the recovery is for medical expenses or the recovery is less than the amount needed to reimburse you fully for the illness or injury.

Med Pay

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

Tufts Health Plan's right of reimbursement

This provision applies in addition to the rights described above. You may recover money by suit, settlement, or otherwise. If this happens, you are required to reimburse us for the cost of health care services, supplies, medications, and expenses for which we paid or will pay. This right of reimbursement attaches when we have provided health care benefits for expenses where a Third Party is responsible and you have recovered any amounts from any sources. This includes, but is not limited to:

- payments made by a Third Party;
- payments made by any insurance companion on behalf of the Third Party;
- any payments or awards under an uninsured or underinsured motorist coverage policy;
- any disability award or settlement;
- medical payments coverage under any automobile policy;
- premises or homeowners' medical payments coverage;
- premises or homeowners' insurance coverage; and

- any other payments from a source intended to compensate you where a Third Party is responsible.

We have the right to be reimbursed up to the amount of any payment received by you. This is 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 compensate you fully for the illness or injury.

Member **cooperation**

You further agree:

- to notify us promptly and in writing when notice is given to any Third Party or representative of a Third Party of the intention to investigate or pursue a claim to recover damages or obtain compensation;
- to cooperate with us and provide us and with requested information;
- to do whatever is necessary to secure our rights of subrogation and reimbursement under this plan;
- to assign us any benefits you may be entitled to receive from a Third Party. Your assignment is up to the cost of health care services and supplies, and expenses, that we paid or will pay for your illness or injury;
- to give us a first priority lien on any recovery, settlement, or judgment or other source of compensation which may be had by any Third Party. You agree to do this to the extent of the full cost of all benefits associated with Third Party responsibility;
- to do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by the plan;
- to serve as a constructive trustee for the benefit of this plan over any settelemtn or recovery funds received as a result of Third Party responsibility;
- that we may recover the full cost of all benefits provided by this plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise;
- that no court costs or attorney fees may be deducted from our recovery;
- that we are not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party without our prior express written consent; and
- that in the event you or your representative fails to cooperate with *Tufts Health Plan,* you shall be responsible for all benefits provided by this plan in addition to costs and attorney's fees incurred by *Tufts Health Plan* in obtaining repayment.

Workers' compensation
Employers provide workers' compensation insurance for their employees. Employer do this 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. We will not provide coverage for any injury or illness for which it determines that the *Member* is entitled to benefits pursuant to: (1) any workers' compensation statute or equivalent employer liability; or (2) indemnification law. This is the case whether or not the employer has obtained workers' compensation coverage as required by law.

We may pay for the costs of health care services or medications for any work-related illness or injury. If we do this, we have 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 us for any work-related illness or injury, contact the Liability and Recovery Department at 1-888-880-8699, x. 1098.

Subrogation, continued

Subrogation Agent
We may contract with a third party to administer subrogation recoveries. In such case, that subcontractor will act as our agent.

Constructive Trust
By accepting benefits from *Tufts Health Plan*, 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. This is the case whether the payment of such benefits is made to you directly or made on your behalf, for example to a.*Provider.* Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to *Tufts Health Plan.*

Coordination of This *Group Contract's* Benefits with Other Benefits

Applicabililty
A. This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of "This Plan" are determined before or after those of another plan. The benefits of "This Plan":

(1) shall not be reduced when, under the order of benefit determination rules, "This Plan" determines its benefits before another plan; but

(2) may be reduced when, under the order of benefits determinationrules, another plan determines its benefits first. The above reduction is described in the "Effect on the Benefits of "This Plan" " section below.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Definitions

A. "Plan" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

   (1) Group insurance or group-type coverage whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   (2) Coverage under a governmental plan, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the *Group Contract* that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether "This Plan" is a Primary Plan or Secondary Plan as to another plan covering the person. When "This Plan" is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When "This Plan" is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, "This Plan" may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under "This Plan", or any part of a year before the date this COB provision or a similar provision takes effect.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Order of Benefit Determination Rules

A. General. When there is a basis for a claim under "This Plan" and another plan, "This Plan" is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of "This Plan"; and

(2) Both those rules and "This Plan"'s rules, in Subsection B below, require that "This Plan"'s benefits be determined before those of the other plan.

B. Rules. "This Plan" determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph B(3) below, when "This Plan" and another plan cover the same child as a dependent of different person, called "parents:"

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered the parents longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has the rule based upon the gender of the patient, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

(3) Dependent Child/Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(4) Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above in Paragraph B(2) of this section.

(5) Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (5) is ignored.

(6) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

Effect on the Benefits of "This Plan"

A. When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules" section above, "This Plan" is a Secondary Plan as to one or more other plans. In that event the benefits of "This Plan" may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in "This Plan"'s Benefits. The benefits of "This Plan" will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expenses under "This Plan" in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of "This Plan" will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of "This Plan" are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of "This Plan".

Coordination of This *Group Contract's* Benefits with Other Benefits, continued

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. *Tufts Health Plan* has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. *Tufts Health Plan* need not tell, or get the consent of, any person to do this. Each person claiming benefits under "This Plan" must give *Tufts Health Plan* any facts it needs to pay the claim.

Facility of Payment

A payment made under another plan may include an amount which should have been paid under "This Plan". If it does, *Tufts Health Plan* may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under "This Plan". *Tufts Health Plan* will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by *Tufts Health Plan* is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;

B. Insurance companies; or

C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

For more information

Contact the Liability and Recovery Department at 1-888-880-8699, x.1098. You can also call a *CareLink* Member Specialist. That person can transfer your call to the Liability and Recovery Department.

Medicare Eligibility

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

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*. This notice explains how we use and disclose your medical information. If you have questions or would like another copy of our *Notice of Privacy Practices*, 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 and *Providers*

Tufts Health Plan arranges health care services. We do not provide health care services. We have agreements with *Providers* practicing in their private offices throughout the *Network Contracting Area*. These *Providers* are independent. They are not *Tufts Health Plan* employees, agents or representatives. *Providers* are not authorized to change this *Certificate* or assume or create any obligation for *Tufts Health Plan*.

We are not liable for acts, omissions, representations or other conduct of any *Provider*.

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, we will make a good faith effort to arrange for the provision of services. In doing so, we will take into account the impact of the event and the availability of *Network Providers*

Group Contract

Acceptance of the terms of the *Group Contract*

By signing and returning the membership application form, you: (1) apply for *Group* coverage; and (2) agree, on behalf of yourself and your enrolled *Dependents*, to all the terms and conditions of the *Group Contract*, including this *Certificate*.

Notes:

- The validity of the *Group Contract* cannot be contested, except for non-payment of *Premium*, after it has been in force for two years from its date of issue.
- A copy of the *Group's* application will be attached to the *Group Contract* when issued. All statements made by the *Group* or by *Members* in that application shall be deemed representations and not warranties.
- No agent has authority to change the *Group Contract* or waive any of its provisions. In addition, no change in the *Group Contract* shall be valid unless approved by an officer of *Tufts Health Plan* and evidenced by an amendment to the *Group Contract* signed by us. Note, though, that any such amendment that reduces or eliminates coverage must be requested in writing by the *Group* or signed by the *Group*.

Payments for coverage

We will bill your *Group* and your *Group* will pay *Premiums* to us for you. We are 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: Your *Group* may fail to pay the *Premium* on time. If this happens, we 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*" in Chapter 4.

We may change the *Premium*. If the *Premium* is changed, the change will apply to all *Members* in your *Group*.

Changes to this *Certificate*

We may change this *Certificate*. Changes do not require your consent. [Notice of changes in *Covered Services* will be sent to your *Group* at least [30] [60] days before the effective date of the modifications. That notice will: (1) include information regarding any changes in clinical review criteria; and (2) detail the effect of such changes on a Member's personal liability for the cost of such charges.]

An amendment to this *Certificate* describing the changes [will be sent to you. It] 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*. They will not apply just to you.

Notice

Notice to *Members*: When we send a notice to you, it will be sent to your last address on file with us.

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
We may choose to waive certain terms of the *Group Contract*, if applicable. This includes the *Certificate*. This does not mean that we give up our rights to enforce those terms in the future.

When this *Certificate* Is Issued and Effective
This *Certificate* is issued and effective on your *Group Anniversary Date* on or after [January 1, 2012]. It supersedes all previous *Certificates*. We will issue a copy of the *Certificate* to the *Group* and to all *Subscribers* enrolled under this plan.

Appendix A
Glossary of Terms And Definitions

This section defines the terms used in this *Certificate*.

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: A foster child is considered an *Adoptive Child* as of the date of placement for adoption.

Anniversary Date

The date when the *Group Contract* first renews. Then, each successive annual renewal date.

Annual Coverage Limitations

Annual dollar or time limitations on *Covered Services*.

[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. *BCBAs* must also be individually licensed by the Rhode Island Department of Health as a healthcare provider/clinician, and credentialed by *Tufts HP.* 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.]

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, the autism spectrum disorder benefit and this definition only apply to groups of 51 or more*

CareLink

CareLink is an open access benefit plan insured by *Tufts Health Plan*. In Rhode Island and Massachusetts, and its affiliate, Tufts Benefit Administrators, Inc., are responsible for participating provider network contracting and maintenance, certain credentialing, provider services and claims payment, and member services for CareLink *Members*. Connecticut General Life Insurance Company and its affiliates, International Rehabilitation Associates, Inc. and CIGNA Behavioral Health, Inc. provide certain administrative services including participating provider network contracting and maintenance outside of Rhode Island and Massachusetts, medical management, and contracting and maintenance of a behavioral health provider network.

Certificate

This document, and any future amendments, which describes the health benefits under the *Group Contract*.

Child

The following individuals until their 26th birthday:

- The *Subscriber's* or *Spouse's* natural child, stepchild, or *Adoptive Child* who qualifies as a *Dependent* for federal tax purposes; or
- [the *Child* of an enrolled child; or]
- any other *Child* for whom the *Subscriber* has legal guardianship.

Coinsurance

The *Member's* share of costs for *Covered Services* not provided by *Network Providers*. For services provided by a *Non-Network Provider*, the *Member's* share is a percentage of the *Reasonable Charge* [For services provided by a *Network Provider*, the *Member's* share is a percentage of: (1) the applicable Network fee schedule amount for those services and (2) the *Network Provider's* actual charges for those services, whichever is less.]

[Note: The *Member's* share percentage is based on the *Network Provider* payment at the time the claim is paid. It does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.]

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

[Community Hospital]

[Any *Network Hospital* other than a *Tertiary Hospital*.]

Community Residence

Any home or other living arrangement which is established, offered, maintained, conducted, managed, or operated by any person for a period of at least 24 hours, where, on a 24-hour basis, direct supervision is provided for the purpose of providing rehabilitative treatment, habilitation, psychological support, and/or social guidance for three or more persons with substance abuse or *Mental Disorders,* or persons with developmental disabilities or cognitive disabilities such as brain injury. Examples include, but are not limited to, group homes, halfway homes, and fully-supervised apartment programs. Semi-independent living programs, foster care, and parent deinstitutionalization subsidy aid programs are not considered *Community Residences* under this *Certificate.*

Contract Year

The 12-month period determined by the *Group* in which benefit limits, *Deductibles*, *Out-of-Pocket Maximum,* and *Coinsurance* are calculated under this plan. A *Contract Year* can be either a calendar year or a plan year.

- Calendar year: Coverage based on a calendar year runs from January 1st through December 31st within a year.
- Plan year: Coverage based on a plan year runs during a period of 12 consecutive months that are not a calendar year (As an example, a plan year can run from July 1st in one calendar year through June 30th in the following calendar year).

For more information about the type of *Contract Year* that applies to your plan, call Member Services. You can also contact your employer.

[Copayment]

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

[**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 we will pay. They must be:

- described in Chapter 3 of this *Certificate.* (They are subject to the "Exclusions from Benefits" section in Chapter 3.); and
- *Medically Necessary*.

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

[Note: *Covered Services* do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any *Provider*, *Member*, service, supply or medication.]

Custodial Care

- Care provided primarily to assist in the activities of daily living. Examples include 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) provided to a *Member* at a facility licensed by the state to perform surgery. The *Member* must be expected to depart the same day, or in some instances, within 24 hours. Also called "Ambulatory Surgery" or "Surgical Day Care".

[**Deductible**

For each [calendar year] [*Contract Year*], the amount paid by the *Member* for [certain] *Covered Services* [not provided by a *Network Provider*] before any payments are made under this *Certificate*. [(Any amount paid by the *Member* for a *Covered Service* rendered during the last [0-12] months of a [calendar year] [*Contract Year*] shall be carried forward to the next [calendar year's] [*Contract Year's*] *Deductible*.)] [*Copayments* do not count toward the *Deductible*.] See "Benefit Overview" at the front of this *Certificate* for more information.] [Note: The amount credited towards the *Member's Deductible* is based on the *Network Provider* negotiated rate at the time the services are rendered. It does not reflect any later adjustments, payments, or rebates that are not calculated on an individual claim basis.]

Dependent

The *Subscriber's Spouse*, *Child*, [*Domestic Partner,*] 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.

Directory of Health Care Providers
A separate booklet which lists Network physicians. It also lists their affiliated *Network Hospital(s)*, and certain other *Network Providers*. Note: This directory is updated from time to time to reflect changes in *Network Providers*. For information about the *Providers* listed in the *Directory of Health Care Providers*, you can call [*CareLink* Member Services.] [Or, you check our web site at **www.tuftshealthplan.com]**.

Disabled Dependent
The *Subscriber's* or *Spouse's* natural child, stepchild, or *Adoptive Child* of any age who:
- is medically determined to have a physical or mental impairment which can be expected to result in death or can be expected to last for a period of not less than 12 months; and
- who is financially dependent on the *Subscriber*.

Domestic Partner
[An unmarried *Subscriber's* individual partner of the same or opposite sex who:
- [is at least 18 years of age;
- is not married;
- has not been married (or has not been in a prior domestic partner relationship) for at least the prior [0-12] consecutive months;
- is not related to the *Subscriber* by blood; and
- meets the eligibility criteria described in Chapter 2.]

The *Subscriber* and the *Domestic Partner* must:
- share a mutually exclusive and enduring relationship;
- have shared a common residence for [[0-12] prior consecutive months] and intend to do so indefinitely;
- be financially interdependent;
- be jointly responsible for their common welfare; and
- be committed to a life partnership with each other.

Note: Roommates who do not satisfy the above criteria, parents and siblings of the *Subscriber* cannot qualify as *Domestic Partners*.]

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 our 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 (This includes 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 we have 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. The *Group* is your agent. It is not *Tufts Health Plan's* agent.

Group Contract
The agreement between *Tufts Health Plan* and the *Group* under which:

- we agree to provide *Group* coverage; and
- the *Group* agrees to pay a *Premium* to us on your behalf.

The *Group Contract* includes this *Certificate* and any amendments.

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

In-Network Level of Benefits
The level of benefits that a *Member* receives when *Covered Services* are provided by a *Network Provider*. See Chapter 1 for more information.

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.

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, this *CareLink* plan uses *Medical Necessity* Guidelines. These Guidelines are:

- developed with input from practicing physicians in the *Network Contracting Area*;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- evidence-based, if practicable.

Member
A person enrolled in *Tufts Health Plan* under the *Group Contract*. Also referred to as “you”.

Mental Disorders

Any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization and that substantially limits the life activities of the person with the illness. *Mental Disorders* do not include tobacco and caffeine in the definition of substance. In addition, *Mental Disorders* do not include: mental retardation, learning disorders, motor skills disorders, communication disorders, and mental disorders classified as "V" codes.

Network Contracting Area

The geographic area within which we have developed or arranged for a network of *Providers* to afford *Members* with adequate access to *Covered Services*.

Note: For information about *Providers* in the *Network Contracting Area*, call [Member Services] [or check our Web site at **www.tuftshealthplan.com]**.

Network Hospital

A hospital which has an agreement either with *Tufts Health Plan* directly or with a *provider* network with whom we have a contract to provide certain *Covered Services* to *Members*. *Network Hospitals* are independent. They are not owned by *Tufts Health Plan*. *Network Hospitals* are not *Tufts Health Plan's* agents or representatives, and their staff are not *Tufts Health Plan's* employees. *Network Hospitals* are subject to change.

Network Provider

A *Provider* who has an agreement either with *Tufts Health Plan* directly or with a provider network with whom we have a contract to provide *Covered Services* to *Members*. *Network Providers* are located throughout the *Network Contracting Area*.

Non-Network Provider

A *Provider* who does not have an agreement either with *Tufts Health Plan* directly or with a provider network with whom we have a contract to provide *Covered Services* to *Members*.

Observation

The use of hospital services to treat and/or evaluate a condition that should result in either a discharge within twenty-three (23) hours or a verified diagnosis and concurrent treatment plan. At times, an observation stay may be followed by an *Inpatient* admission to treat a diagnosis revealed during the period of *Observation.*

Open Enrollment Period

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*.

Out-of-Network Level of Benefits

The level of benefits that a *Member* receives when *Covered Services* are not provided by a *Network Provider*. See Chapter 1 for more information.

Outpatient

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

- a *Provider's* office;

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

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

[Out-of-Pocket Maximum]

[The maximum amount of money paid by a *Member* during a [calendar year] [*Contract Year*] for [certain] *Covered Services* [which are not provided by a *Network Provider*]. The *Out-of-Pocket Maximum* consists of [*Copayments,*] [the *Deductible*] [and] [*Coinsurance*]. It does not include [*Copayments*], or costs for health care services that are not *Covered Services* under the *Group Contract*.]

See "Benefit Overview" for detailed information about your *Out-of-Pocket Maximum*.

[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 Behavioral Analyst (BCBA)* who is a licensed health care clinician. As required by Rhode Island law, Board-Certified Assistant Behavioral Analysts (BCaBAs) are considered *Paraprofessionals.]*

FILING NOTE TO RI DEPARTMENT OF BUSINESS REGULATION: *In accordance with RI General Laws 27.18-71, the autism spectrum disorder benefit and this definition only apply to groups of 51 or more*

[Pre-Existing Condition]

[A condition which had during the six months immediately preceding your *Effective Date*, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received. Pregnancy is not considered a pre-existing condition.]

Premium

The total monthly cost of *Individual* or *Family Coverage* that [the *Group* pays] [is paid] to *Tufts Health Plan*.

Precertification

CareLink's process of verifying authorization required for *Inpatient* admissions and transfers. *Precertification* is not a guarantee of payment. See Chapter 1 for further information.

[Primary Care Provider]

[A *Network Provider* who is a general practitioner, family practitioner, nurse practitioner, internist, pediatrician, or obstetrician/gynecologist who provides primary care services.]

Prior Authorization

A process we use to decide if a health care service or supply qualifies as a *Covered Service* and is *Medically Necessary*. We recommend that you get prior authorization before obtaining care for certain *Covered Services*. *Covered Services* for which we suggest prior authorization include a "(PA)" notation in the "Benefit Overview" section of this document. This process is handled by *Tufts Health Plan's* [Chief Medical Officer] or someone we designate. For services you receive at the *In-Network Level of Benefits*, your *Network Provider* is responsible for obtaining *prior authorization*.

To request prior authorization, please call us. For mental health services, call our Mental Health Department at 1-800-208-9565. For all other *Covered Services*, call our Member Services Department at 1-800-682-8059. For more information about our prior authorization process, call Member Services or check our Web site at **www.tuftshealthplan.com**.

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, licensed nurse midwives, certified registered nurse anesthetists, certified registered 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, tobacco treatment specialists, licensed speech-language pathologists, licensed marriage and family therapists; and licensed audiologists.

We will only cover services of a *Provider*, if those services are listed as *Covered Services* and within the scope of the *Provider's* license.

Reasonable Charge

The lesser of:

- the amount charged by the *Non-Network Provider*; or
- the amount that we determine to be reasonable. We decide that amount based on nationally accepted means and amounts of claims payment. These means and amounts include, but are not limited to: Medicare fee schedules and allowed amounts; CMS medical coding policies, AMA CPT coding guidelines; nationally recognized academy and society coding; and clinical guidelines.

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

Review Organization

The term Review Organization refers to an entity to which *Tufts Health Plan* has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include physicians, registered graduate nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Skilled

A type of care which is *Medically Necessary*. This care 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.

Spouse also includes the spousal equivalent of the *Subscriber* who is the registered *Domestic Partner,* civil union partner, or other similar legally recognized partner of the *Subscriber* who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Subscriber

The person:

- who is [employed by the *Group*] [a person eligible to be a *Subscriber* under the *Group*];
- 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 a *Group Contract*.

[Tertiary Hospital]

[Each of the following hospitals:

- [Beth Israel Deaconess Medical Center (Boston, MA);]
- [Boston Medical Center (Boston, MA);]
- [Brigham & Women's Hospital (Boston, MA);]
- [Children's Hospital (Boston, MA);]
- [Dana-Farber Cancer Institute (Boston, MA);]
- [Lahey Clinic (Burlington, MA);]
- [Mary Hitchcock Memorial Hospital (Hanover, NH);]
- [Massachusetts Eye & Ear Infirmary (Boston, MA);]
- [Massachusetts General Hospital (Boston, MA);]
- [New England Baptist Hospital (Boston, MA);]
- [Rhode Island Hospital, including Hasbro Children's Hospital (Providence, Rhode Island);]
- [Tufts-New England Medical Center (Boston, MA);]
- [UMass Memorial Medical Center (Worcester, MA).]]

Tufts Health Plan

(TIC) which is authorized to offer POS and PPO products. TIC has entered into an agreement with Tufts Benefit Administrators, Inc. (TBA) for TBA to administer the health benefits and make available a network of *Providers* described in this *Certificate*.

Both TIC and TBA do business under the name *Tufts Health Plan*. *Tufts Health Plan* is also called "we", "us", and "our".

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; sudden extreme anxiety; a cut that needs stitches but is not actively bleeding; 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

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. 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 (EBSA).
- 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).
- 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] [includes] a preexisting condition exclusion.

ERISA Rights, continued

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.

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. contact a *CareLink* Member Services at 1-866-352-9114 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 claims: 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, we will respond to you within 72 hours after receipt of the claim. If we determine 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. We 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 we have already approved an ongoing course of treatment for you and considers reducing or terminating the treatment, we 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, we 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.

PROCESSING OF CLAIMS FOR PLAN BENEFITS, continued

Types of claims, continued

[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, we will respond to you within 72 hours for an urgent request and within 15 days for a non-urgent request after receipt of the claim. If we determine that an extension is necessary for a non-urgent request 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 us to make a determination, we will notify you within 15 days and describe the information that you need to provide to us. You will have no less than 45 days from the date you receive the notice to provide the requested information.

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, we will respond to you within 30 days after receipt of the claim. If we 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 us to make a determination, we will notify you within 30 days and describe the information that you need to provide to us. 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.]

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 physician 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 right 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 tthat the spouse, son, daughter, ro 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.

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/esa/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[1] 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.

You are receiving this Notice as a member of CareLink[SM]. Tufts Health Plan and CIGNA HealthCare[2] have joined together to offer CareLink.

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.

NOTICE OF PRIVACY PRACTICES, continued

How We Use and Disclose Your PHI, continued

- **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.

How We Use and Disclose Your PHI, continued

- **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*.

NOTICE OF PRIVACY PRACTICES, continued

Your Individual Rights, continued

- **Right to This Notice:** You have a 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 866-352-9114 ~~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.

[1] *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.
[2] "CIGNA" or "CIGNA HealthCare" refer to various subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries, including Connecticut General Life Insurance Company and not by CIGNA Corporation. "CIGNA" is a registered service mark, and "CARELINK" is a service mark, licensed for use by CIGNA Corporation and its subsidiaries. ©2007 CIGNA. All rights reserved

SERFF Tracking #:	*THPC-129022561*	***State Tracking #:***		***Company Tracking #:***	*2013-RI-130*

State:	*Rhode Island*	***First Filing Company:***	*Tufts Associated Health Maintenance Organization, Inc., ...*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*		
Product Name:	*RI 2014 Rate Review Process - TAHMO & TIC LG*		
Project Name/Number:	*RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*		

Supporting Document Schedules

Bypassed - Item:	A&H Experience
Bypass Reason:	N/A to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Certification - Life & A&H
Bypass Reason:	N/A to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum - A&H Rate Revision Filing
Bypass Reason:	n/a to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Health Insurance Checklist
Bypass Reason:	Checklist not applicable to this rate filing submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Premium Rate Sheets - Life & A&H
Bypass Reason:	n/a to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications

SERFF Tracking #:	*THPC-129022561*	***State Tracking #:***		***Company Tracking #:***	*2013-RI-130*

State:	*Rhode Island*	***First Filing Company:***	*Tufts Associated Health Maintenance Organization, Inc., ...*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*		
Product Name:	*RI 2014 Rate Review Process - TAHMO & TIC LG*		
Project Name/Number:	*RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*		

Bypass Reason:	N/A to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	N/A to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	N/A to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	N/A to this submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	N/A to this submission
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Filing Materials - 2014 LG Rate Trend Factor Submission

SERFF Tracking #:	*THPC-129022561*	***State Tracking #:***		***Company Tracking #:***	*2013-RI-130*

State:	*Rhode Island*	***First Filing Company:***	*Tufts Associated Health Maintenance Organization, Inc., ...*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*		
Product Name:	*RI 2014 Rate Review Process - TAHMO & TIC LG*		
Project Name/Number:	*RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*		

Comments:	Attached are materials for the 1/1/14 Large Group Rate Review Process filings for Tufts Associated Health Maintenance Organization, Inc. (TAHMO) and Tufts Insurance Company (TIC). For any questions about this submission, please contact Jennifer Stevenson, Analytic Manager, at 617-972-9400, ext. 3748.
Attachment(s):	2013 Rate Review Process OHIC.pdf Actuarial Memorandum (Large Group) Final.pdf 2013 Rate Review Process OHIC.xlsx
Item Status:	
Status Date:	

SERFF Tracking #:	*THPC-129022561*	***State Tracking #:***		***Company Tracking #:***	*2013-RI-130*

State:	*Rhode Island*	***First Filing Company:***	*Tufts Associated Health Maintenance Organization, Inc., ...*
TOI/Sub-TOI:	*H16G Group Health - Major Medical/H16G.002A Large Group Only - PPO*		
Product Name:	*RI 2014 Rate Review Process - TAHMO & TIC LG*		
Project Name/Number:	*RI 2013 Rate Review Process - TAHMO & TIC LG/2013-RI-130*		

Attachment 2013 Rate Review Process OHIC.xlsx is not a PDF document and cannot be reproduced here.

Rhode Island Individual, Small and Large Group Rate Filing Template Part I

Part 1. Historical Information

Experience Period for Developing Rates

From	To
01/01/2012	12/31/2012

Utilization/Experience Data by Quarter (Experience Period only)

A. Incurred Data

Quarter	End Date	IP Days	Member Months	Earned Premium	Incurred Claims Total	Incurred Claims IP	Incurred Claims OP	Incurred Claims Primary Care	Incurred Claims Other M/S	Incurred Claims Rx	Capitation	Claims not Otherwise categorized (explain)	Loss Ratio	Quality Improvement Expense*	Other Cost Containment Expense*	Other Claim Adjustment Expense*	Other Operating Expense*	Investment Income Credit	Commissions	Contribution to Reserves
1 (Oldest)	03/31/2012	349	14,456	$5,746,414	$4,699,944	$993,967	$1,077,429	$303,786	$1,421,561	$897,259	$5,943	$0	83.4%	$92,084	$65,335	$72,254	$429,763	N/A	$157,787	$229,248
2	06/30/2012	261	18,027	$7,041,927	$5,572,855	$918,686	$1,419,142	$408,708	$1,814,727	$1,003,365	$8,226	$0	80.8%	$113,637	$82,199	$88,635	$540,078	N/A	$191,203	$453,322
3	09/30/2012	283	18,614	$7,264,818	$6,856,890	$2,049,015	$1,619,453	$423,669	$1,798,239	$957,154	$9,360	$0	96.0%	$117,577	$84,729	$91,817	$556,827	N/A	$198,549	($641,573)
4	12/31/2012	581	27,490	$11,269,395	$10,298,000	$2,469,203	$2,812,748	$709,056	$2,965,335	$1,331,500	$10,157	$0	92.9%	$172,023	$126,116	$133,607	$827,982	N/A	$285,680	($574,014)
5																				
6																				
7																				
8																				

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

B. Allowed Data

Quarter	End Date	Allowed Claims Total	Allowed Claims IP	Allowed Claims OP	Allowed Claims Primary Care	Allowed Claims Other M/S	Allowed Claims Rx	Capitation	Claims not Otherwise categorized (explain)
1 (Oldest)	03/31/2012	$5,648,130	$1,022,497	$1,265,813	$375,261	$1,807,605	$1,171,011	$5,943	$0
2	06/30/2012	$6,460,953	$942,088	$1,576,964	$475,106	$2,180,879	$1,277,689	$8,226	$0
3	09/30/2012	$7,665,635	$2,077,214	$1,762,488	$485,967	$2,126,727	$1,203,880	$9,360	$0
4	12/31/2012	$11,519,702	$2,528,552	$3,103,384	$794,611	$3,410,048	$1,672,950	$10,157	$0
5									
6									
7									
8									

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3- Analysis of Expenses and/or to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1

Part 2. Prospective Information

A. Trend Factors for Projection Purposes (Annualized)

	IP	OP	Primary Care	Other M/S	Rx	Capitation	Claims not Categorized	Weighted Total
Total	5.2%	6.5%	2.7%	5.8%	9.7%			6.2%
Price Only	3.5%	3.7%	1.7%	1.8%	8.1%			3.7%
Utilization	1.6%	2.6%	1.0%	3.9%	1.5%			2.4%
Other**								
Other**								
Other**								
Weights	19.9%	25.2%	10.4%	27.4%	17.1%			**100.0%**

** All elements should add or compound to the total. If anything is to be reported as "Other" please provide a description.

B. The following items for the period to which the rate filing applies:

	Average % Rate Increase	Expected Pure Medical Cost Ratio	Expected Contribution to Reserves %	Quality Improvement Expense %*	Other Cost Containment Expense %*	Other Claim Adjustment Expense %*	Other Operating Expense %*	Average Commissions %*	Investment Income Credit %	Premium Tax %
TAHMO	9.5%	85.6%	0.0%	1.6%	1.0%	1.1%	4.2%	2.5%	0.0%	4.0%
TIC	10.1%	85.2%	0.0%	1.6%	1.0%	1.1%	4.1%	2.0%	0.0%	4.7%

* These categories should conform generally to the reporting in the NAIC statement Underwriting & Investment Exhibit Part 3 - Analysis of Expenses and to the Supplemental Health Care Exhibit, Lines 6.3 and 8.1
The sum of the expenses, commissions, contributions to reserves, investment income credit, taxes and the medical loss ratio should be 100%.

C. Average Rate Increase Components

The following items should reconcile to the Weighted Average Percent Rate Increase for the year:

	Price	Utilization, Mix	Total
Hospital Inpatient Price	0.6%	0.3%	0.9%
Hospital Outpatient	0.8%	0.6%	1.4%
Primary Care	0.2%	0.1%	0.2%
Med/Surg Other Than Primary Care	0.4%	0.9%	1.3%
Pharmacy	1.2%	0.2%	1.4%
Administrative Expense (Aggregated)			1.0%
Contribution to Reserves			0.0%
Taxes and Assessments			2.8%
Legally Mandated Changes			N/A
Other*			1.0%
Total			10.0%

* Accounts for differences between trend application method and Part C component break out method, as well as expected demographic changes

Rate Template Part IV: Administrative Costs Request

1. Please provide 2012 Actual and 2014 proposed individual, small and large group administrative costs on a per member per month (PMPM) basis, allocated among the National Association of Insurance Commissioners (NAIC) financial statement administrative cost categories. Please explain any significant changes from the financial filing for 2012 (increases/decreases of more than 5% in a particular category).

	2012 Actual			2014 Proposed			% Change		
	Individual	Small Group	Large Group	Individual	Small Group	Large Group	Individual	Small Group	Large Group
Total Estimated Member Months		8,656	78,923		8,060	109,960		-6.9%	39.3%
Total Estimated Premiums ($pmpm)		$403.47	$399.83		$456.59	$457.21		13.2%	14.4%
Total General Administrative Expense ($pmpm)		$38.30	$38.46		$50.78	$48.25		32.6%	25.5%
Total Cost Containment Expense ($pmpm)		$9.84	$9.13		$10.67	$9.87		8.5%	8.1%
Total Other Claim Adjustment Expense ($pmpm)		$9.17	$8.52		$9.95	$9.20		8.5%	8.1%
Total Admin Expense ($pmpm)		$57.31	$56.10		$71.40	$67.32		24.6%	20.0%
Breakdown of General Administrative Expense ($ pmpm)									
a. Payroll and benefits		$2.86	$2.66		$3.10	$2.87		8.5%	8.1%
b. Outsourced Services (EDP, claims etc.)		$0.31	$0.29		$0.33	$0.31		8.5%	8.1%
c. Auditing and consulting		$6.95	$6.45		$7.54	$6.97		8.5%	8.1%
d. Commissions		$9.08	$10.56		$13.05	$9.78		43.8%	-7.4%
e. Marketing and Advertising		$1.75	$1.63		$1.90	$1.76		8.5%	8.1%
f. Legal Expenses		$0.03	$0.03		$0.03	$0.03		8.5%	8.1%
g. Taxes, Licenses and Fees		$11.90	$11.57		$19.08	$20.73		60.4%	79.2%
h. Reimbursements by Uninsured Plans		$0.00	$0.00		$0.00	$0.00		N/A	N/A
i. Other Admin Expenses		$5.43	$5.29		$5.74	$5.80		5.8%	9.8%

* We have elected, again, not to reflect the actual projected administrative charges in our RI business, but rather, have assumed the administration charges of a fully mature block of business. This results in some otherwise unexpected rates of change for administrative charges.

2. Please provide actual 2008-2012 fully insured commercial administrative costs in accordance with the following table. This should be consistent with the annual statement filings to OHIC for adminisrative costs, providing additional detail on the components of administrative costs using the categories defined by the NAIC financial statement and as allocated to commercially insured business only. Specifically, the information provided should agree with the "Exhibit of Premiums, Enrollment and Utilization" and the "Analysis of Operations by Line of Business" schedules included in the annual statements on file with OHIC, Where there are variances, a reconciliation and explanation should be provided.

Fully Insured Commercial Administrative Cost History (Comprehensive Column)

	2008	2009	2010	2011	2012
Total Premiums		**13,585,944**	**23,938,084**	**22,887,475**	**35,048,439**
Total General Administrative Expense		2,122,289	2,620,440	2,259,427	3,366,739
General Admin Exp. Ratio		15.62%	10.95%	9.87%	9.61%
Total Fully Insured Member Months		**37,616**	**63,963**	**57,541**	**87,579**
General Administrative Expense ($pmpm)		$56.42	$40.97	$39.27	$38.44
Breakdown of General Administrative Expenses ($ pmpm)					
a. Payroll and benefits		$3.37	$2.49	$2.76	$2.69
b. Outsourced Services (EDP, claims etc.)		$0.01	$0.01	$0.09	$0.29
c. Auditing and consulting		$5.92	$4.93	$7.54	$6.53
d. Commissions		$17.44	$16.38	$14.23	$10.41
e. Marketing and Advertising		$2.52	$1.72	$1.66	$1.65
f. Legal Expenses		$0.08	$0.11	$0.16	$0.03
g. Taxes, Licenses and Fees		$7.22	$8.25	$8.63	$11.60
h. Reimbursements by Uninsured Plans		$0.00	$0.00	$0.00	$0.00
i. Other Admin Expenses		$19.85	$7.07	$4.21	$5.30
Cost Containment Expense		$200,430	$544,401	$563,731	$805,693
Other Claim Adjustment Expense		$263,773	$521,528	$431,602	$751,536
Total Self Insured Member Months for all affiliated companies doing business in RI		227,388	0	1,324	16,278

Actuarial Memorandum

Tufts Associated Health Maintenance Organization, Inc. and Tufts Insurance Company
Rhode Island Large Group – Trend Development

The purpose of this actuarial memorandum is to file trend factors for Tufts Health Plan (THP) large group plans to be effective January 1, 2014.

Claims Trend Development:
Since THP's claims experience in Rhode Island (RI) is not sufficiently credible to support the development of RI trend factors, we used the same methodology in developing 2014 trends as what was used in our previous filings. The utilization trends are based on Massachusetts utilization trends, which are developed using 36 months of historical utilization experience in over 40 different service categories. Utilization trends are adjusted for changes in mix of service, demographics and business mix. The medical unit cost trends are based on the existing Rhode Island provider contracts and a best estimate of unit cost increases for those provider contracts that are still outstanding. The Rhode Island Rx unit cost trend is the same as the Massachusetts Rx unit cost trend since our Rx contract does not differ by state.

The proposed 2014 trend factors below reflect the utilization trend underlying the most recent Massachusetts emerging experience. Calendar year 2014 unit cost trends are based on the most updated Rhode Island provider contracts. THP's overall 2014 annual claim trend is 6.2%. The proposed 2014 annual trend factors are:

	IP	OP	Primary Care	Other M/S	Rx	Weighted Total
Total	5.2%	6.5%	2.7%	5.8%	9.7%	6.2%
Price Only	3.5%	3.7%	1.7%	1.8%	8.1%	3.7%
Utilization	1.6%	2.6%	1.0%	3.9%	1.5%	2.4%

Pharmacy:
The trends shown above integrate differential trend assumptions for generic and brand drugs, taking into account the anticipated movement of drugs among tiers. To the extent that information from our PBM or from our own independent research projects significant changes in generic drug launches compared to prior years, these are also taken into account. Our trends for 2014 have not been adjusted for significant changes in drug launches.

General Administrative Expense:
As in prior filings, given THP's low membership level in RI, we have elected not to reflect the actual projected administrative charges for our RI business in our rates. Rather, we have assumed the administrative expenses of a fully mature block of business.

On a per member per month basis, changes in administrative charges by expense category are projected to range from -7.4% to +9.8%, excluding taxes. Where the actual distribution of administrative expenses in the experience period (2012) does not match the projected distribution, the rates of change by category are higher or lower than the premium increase. The proposed 2014 administrative expense percentages, excluding taxes, are:

	Quality Improvement Expense %	Other Cost Containment Expense %	Other Claim Adjustment Expense %	Other Operating Expense %	Average Commissions %	Investment Income Credit %
TAHMO	1.6%	1.0%	1.1%	4.2%	2.5%	0.0%
TIC	1.6%	1.0%	1.1%	4.1%	2.0%	0.0%

Taxes and Fees imposed on the Issuer:
In addition to the administrative charges referenced above, the Patient Centered Outcome Research Institute (PCORI) assessment fee and the Patient Protection and Affordable Care Act (PPACA) tax, to be paid in CY 2014 based on CY 2013 premiums are included in premium rates effective on or after January 1, 2014. The PCORI fee is $2 per member per year. The PPACA tax is estimated at 0.7% for TAHMO, which is a not for profit company, and 1.3% for TIC. These taxes and fees are in addition to the premium taxes charged by Rhode Island, which are 2.00% for TAHMO and 2.28% for TIC.

Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program:
The $5.25 PMPM contribution to the Federal Transitional Reinsurance Program is incorporated into our rates for 2014. Since reinsurance payments apply solely to the individual market, there are no recoveries anticipated from the reinsurance program in 2014 to offset the fee.

Premium Rate Increase Development:
To develop manual rates for each month of 2014, the December 2013 manual rate excluding retention is trended to January 2014 by applying 1/12 of the annual trend. The general administrative expenses, taxes and fees are added to calculate a manual rate for January 2014. This manual rate is trended forward by 1/12 of the annual trend to calculate the rates for subsequent months.

The initial premium rate increases are developed by comparing the manual rate for each month to the manual rate for the same month in the previous year. The aging of THP's covered population is projected to increase premiums by 1.1%, so we have added this into the premium rate increases shown in the filing.

The components of the premium rate increases are:

Component	TAHMO	TIC
Trend Increase	6.1%	6.1%
New Taxes & Fees	2.1%	2.7%
Aging	1.1%	1.1%
Total Increase	9.5%	10.1%

I certify that the proposed trend factors were developed using sound actuarial assumptions and methodologies.

Jennifer Stevenson, F.S.A., M.A.A.A.
Analytic Manager
Tufts Health Plan
May 15, 2013