

Tufts Health Plan Medicare Preferred

Medicare Supplement Policy

Tufts Medicare Preferred Supplement 1 Plan

IMPORTANT NOTES ABOUT THIS POLICY

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your *Policy*, you may return it to *Tufts Health Plan Medicare Preferred* at: **705 Mount Auburn Street; Watertown; MA 02472-1508**. If you send the *Policy* back to us within 30 days after you receive it, we will treat the *Policy* as if it had never been issued and return all of your payments.

RIGHT TO CONTINUE COVERAGE

You have the right to continue your coverage under this *Policy*, provided that:

- you pay your *Premiums* on time; and
- you do not make any material misrepresentations to *Tufts Health Plan Medicare Preferred*.

OUR RIGHT TO CHANGE YOUR BENEFITS OR PREMIUMS

Tufts Health Plan Medicare Preferred will change your benefits automatically to coincide with:

- any changes in the applicable *Medicare* Part A and B *Deductibles* and *Copayments*;
- any changes required under Massachusetts law regarding mandated benefits. We may change your *Premiums* to correspond with these mandated benefit changes, if: approved by the Massachusetts Commissioner of Insurance; and in accordance with statutory or regulatory requirements.

TUFTS  Health Plan
Medicare Preferred

**705 Mount Auburn Street
Watertown, MA 02472-1508**

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Tufts Health Plan Medicare Preferred Address And Telephone Directory:

TUFTS HEALTH PLAN MEDICARE PREFERRED

705 Mount Auburn Street
Watertown, Massachusetts 02472-1508.

Hours:

Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m.
(From October 15 – February 14, representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.)
After hours and on holidays, please leave a message and a representative will return your call on the next business day.

IMPORTANT PHONE NUMBERS:

Emergency Care:

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

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

Medicare:

Contact your local Social Security office or visit the Web site at: www.medicare.gov.

Customer Relations Department:

Call for general questions, including benefit questions, and information regarding eligibility for enrollment and billing. 1-800-701-9000.

Services for Hearing Impaired Members:

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

Telecommunications Device for the Deaf (TTY):

If you have access to a TTY phone, call: 1-800-208-9562. You will reach Customer Relations.

Massachusetts Relay (MassRelay):

1-800-720-3480.

***Tufts Health Plan Medicare Preferred* Address and Telephone Directory**, Continued:

IMPORTANT ADDRESSES:

Appeals and Grievances Department:

If you need to call us about a concern or appeal, contact Customer Relations at 1-800-701-9000. To submit your Appeal or Grievance in writing, send your letter to:

Tufts Health Plan Medicare Preferred
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9181
Watertown, MA 02471-9181.

Web site:

For more information about us and to learn more about the self-service options that are available to you, please see our Web site at: www.tuftsmedicarepreferred.org.

Tufts Health Plan Medicare Preferred Address And Telephone Directory, Continued:

Translating services for 140 languages:

Interpreter and translator services related to administrative procedures are available to assist *Members* upon request. For information, please call Customer Relations.

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為您提供協助。如需要這些服務，請打電話給「Tufts 健康計劃顧客聯絡部」。

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

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

ພວກເຮົາມີບໍລິການນາຍພາສາແລະການແປເອກະສານທາງດ້ານວິທີດຳເນີນການທຸລະການໄວ້ ບໍລິການທ່ານ. ກະລຸນາໂທຫາພະແນກບໍລິການລູກຄ້າຂອງແຜນສຸຂະພາບທັຟສ Tufts, ຖ້າຕ້ອງການບໍລິການເຫລົ່ານີ້.

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

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

1-800-701-9000.

TTY: Telecommunications Device for the Deaf:

1-800-208-9562.

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Benefit Schedule:

Important Note: This section provides basic information about your benefits under this plan. Please see the table below, as well as Chapter 3, for specific information, including certain benefit restrictions and limitations (for example, visit, day, and dollar maximums). Please see the current version of your *Medicare* handbook, which describes the services covered under *Medicare* Part A and Part B. In addition, see all of the sections in this *Tufts Health Plan Medicare Preferred Medicare Supplement Policy*.

Medicare Pays...	Tufts Medicare Preferred Supplement 1 Pays...	You Pay...*	Page
Ambulance Services:			
<i>Medicare</i> benefits in full, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	28.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued:

Medicare Pays...	Tufts Medicare Preferred Supplement 1 Pays...	You Pay...*	Page:
Autism spectrum disorders – diagnosis and treatment:			
<p>When covered by <i>Medicare</i>, <i>Medicare</i> benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. <p>When not covered by <i>Medicare</i>: Nothing.</p>	<p>For rehabilitative or habilitative care (including applied behavioral analysis):</p> <p>When not covered by <i>Medicare</i>:</p> <ul style="list-style-type: none"> ▪ Benefits in full. <p>For prescription medications:</p> <ul style="list-style-type: none"> ▪ Nothing. You must have Medicare Part D coverage. <p>For psychiatric and psychological care: See “Treatment for <i>Biologically-based Mental Disorders</i>” later in this section.</p> <p>Therapeutic care: See “Short Term Rehabilitation Therapy (Physical, Occupational & Speech-Language)” later in this section.</p>	<p>When covered by <i>Medicare</i>:</p> <ul style="list-style-type: none"> ▪ Nothing. <p>When not covered by <i>Medicare</i>:</p> <ul style="list-style-type: none"> ▪ Nothing, for rehabilitative or habilitative care. ▪ All charges for all other services. ▪ 	29.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued:

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	<i>Page:</i>
Blood services – Inpatient:			
<p><i>Medicare</i> benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The blood deductible. <p>This deductible is for the first 3 pints of un-replaced blood during a calendar year.</p>	<ul style="list-style-type: none"> ▪ The blood deductible. 	<ul style="list-style-type: none"> ▪ Nothing. 	30.
Blood services – Outpatient:			
<p><i>Medicare</i> benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The blood deductible; ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The blood deductible; ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	30.
Cardiac Rehabilitation:			
<p><i>Medicare</i> benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	31.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued:

Medicare Pays...	Tufts Medicare Preferred Supplement 1 Pays...	You Pay...*	Page:
Chemotherapy:			
<p>Medicare benefits on an Inpatient basis as described under <i>Hospital Medical and Surgical Care – Inpatient:</i></p> <ul style="list-style-type: none"> ▪ Medicare benefits on an <i>Outpatient</i> basis as described under <i>Hospital Medical and Surgical Care – Outpatient.</i> 	<p>As described under <i>Hospital Medical and Surgical Care – Inpatient:</i></p> <ul style="list-style-type: none"> ▪ As described under <i>Hospital Medical and Surgical Care – Outpatient.</i> 	<p>As described under <i>Hospital Medical and Surgical Care – Inpatient:</i></p> <ul style="list-style-type: none"> ▪ As described under <i>Hospital Medical and Surgical Care – Outpatient.</i> 	31.
Chiropractor Services:			
<p>Medicare benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	31.
Diabetic Supplies and Services:			
<p>When covered by Medicare: Medicare benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. <p>When not covered by Medicare:</p> <ul style="list-style-type: none"> ▪ Nothing. 	<p>When covered by Medicare:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. <p>When not covered by Medicare:</p> <ul style="list-style-type: none"> ▪ Nothing. 	<p>When covered by Medicare:</p> <ul style="list-style-type: none"> ▪ Nothing. <p>When not covered by Medicare:</p> <ul style="list-style-type: none"> ▪ All charges. 	31.
Diagnostic Tests, X-rays and Clinical Laboratory Services:			
<p>Medicare benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	31.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued:

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	Page:
Dialysis (Kidney) Services and Supplies:			
<i>Medicare</i> benefits in full, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	31.
Durable Medical Equipment and Prosthetic Devices:			
<i>Medicare</i> benefits in full, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	32.
Enteral Formulas, Low Protein Food Products:			
<p>When covered by <i>Medicare</i>, <i>Medicare</i> benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. <p>When not covered by <i>Medicare</i>:</p> <ul style="list-style-type: none"> ▪ Nothing. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; The Part B <i>Coinsurance</i>. <p>When not covered by <i>Medicare</i>: benefits in full</p> <ul style="list-style-type: none"> ▪ For certain enteral formulas. ▪ For low protein food products up to \$5,000 per calendar year. 	<ul style="list-style-type: none"> ▪ Nothing. <p>When not covered by <i>Medicare</i>:</p> <ul style="list-style-type: none"> ▪ Nothing for certain enteral formulas. • All charges for low protein food products after the <i>Plan</i> pays \$5,000 in a calendar year. 	32.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued:

Medicare Pays...	Tufts Medicare Preferred Supplement 1 Pays...	You Pay...*	Page:
Foreign Travel:			
<ul style="list-style-type: none"> ▪ Nothing for services not covered by <i>Medicare</i> because they were received outside the United States. 	<ul style="list-style-type: none"> ▪ All expenses <i>Medicare</i> would have paid for if services had been received in the United States, plus the remainder of charges. 	<ul style="list-style-type: none"> ▪ Nothing. 	32.
Home Health Care:			
<p>For <i>Medicare</i> covered home visits, <i>Medicare</i> benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	32.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	Page:
Hospice Services:			
<p>When covered by <i>Medicare</i>,</p> <ul style="list-style-type: none"> ▪ <i>Medicare</i> benefits in full for most services. <p>When not covered by <i>Medicare</i>,</p> <ul style="list-style-type: none"> ▪ Nothing. 	<p>When <i>Medicare</i> does not provide benefits in full,</p> <ul style="list-style-type: none"> ▪ The difference between the amount <i>Medicare</i> pays and the <i>Allowed Charge</i>. <p>When not covered by <i>Medicare</i></p> <ul style="list-style-type: none"> ▪ Covered services in full. 	<p>When covered by <i>Medicare</i>,</p> <ul style="list-style-type: none"> ▪ Nothing. <p>When not covered by <i>Medicare</i></p> <ul style="list-style-type: none"> ▪ Nothing. 	33.
<i>Hospital Medical and Surgical Care – Inpatient:</i>			
<p>▶ <i>Medicare</i> benefits in full in a general <i>Hospital</i> facility per benefit period, except:</p> <ul style="list-style-type: none"> ▪ The Part A <i>Deductible</i> for day 1-60; ▪ The Part A <i>Coinsurance</i> for day 61-90; ▪ The Part A <i>Coinsurance</i> for 60 lifetime <i>Reserve Days</i>. 	<p>Per benefit period:</p> <ul style="list-style-type: none"> ▪ The Part A <i>Deductible</i> for day 1-60; ▪ The Part A <i>Coinsurance</i> for day 61-90; ▪ The Part A <i>Coinsurance</i> for 60 lifetime <i>Reserve Days</i>; ▪ <i>Covered Services</i> in full up to an additional 365 days per lifetime after <i>Medicare</i> benefits are used up. 	<p>Per benefit period:</p> <ul style="list-style-type: none"> ▪ Nothing for day 1-90; ▪ Nothing for up to 60 lifetime <i>Reserve Days</i>; ▪ Nothing for <i>Covered Services</i> up to an additional 365 days per lifetime after <i>Medicare</i> benefits are used up; ▪ Then, all charges. 	33.
<p>▶ <i>Medicare</i> benefits in full for physician and other professional provider services, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i> ▪ The Part B <i>Coinsurance</i> 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	33.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	Page:
<i>Hospital Medical and Surgical Care – Outpatient</i> (including Ambulatory Surgical Centers):			
<p>▶ <i>Medicare</i> benefits in full in a general <i>Hospital</i> facility or <i>Ambulatory Surgical Center</i>, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. <p>▶ <i>Medicare</i> benefits in full for physician and other professional provider services, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. ▪ Nothing. 	34.
<i>Medical Care Outpatient Visits by a Physician or Covered Practitioner (Non-physician):</i>			
<p><i>Medicare</i> benefits in full, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	34.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

Medicare Pays...	Tufts Medicare Preferred Supplement 1 Pays...	You Pay...*	Page:
Mental Health and Substance Abuse:			
▶ Treatment for <i>Biologically-based Mental Disorders</i> (includes substance abuse disorders):			
<p>Medicare benefits in full for <i>Inpatient stay in a general or mental Hospital, except:</i></p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ The Part A <i>Deductible</i> for day 1-60; ▪ The Part A <i>Coinsurance</i> for day 61-90; ▪ The Part A <i>Coinsurance</i> for 60 lifetime <i>Reserve Days</i>. <p>Note: Medicare benefits in a mental <i>Hospital</i> are limited to 190 days per lifetime.</p> <p>Medicare benefits in full for <i>Inpatient physician and other covered professional mental health provider services</i> for as many days as <i>Medically Necessary</i>, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. <p>Medicare benefits in full for <i>Outpatient treatment, except:</i></p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i> ▪ The Part B <i>Coinsurance</i> 	<p><i>Inpatient stay in a general or mental Hospital</i></p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ The Part A <i>Deductible</i> for day 1-60; ▪ The Part A <i>Coinsurance</i> for day 61-90; ▪ The Part A <i>Coinsurance</i> for 60 lifetime <i>Reserve Days</i>; ▪ <i>Covered Services</i> in full up to an additional 365 days per lifetime after Medicare benefits are used up. <p><i>Inpatient physician and other covered professional mental health provider services</i> for as many days as <i>Medically Necessary</i></p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>; ▪ <i>Covered Services</i> in full when benefits provided only by the <i>Plan</i>. <p><i>Outpatient treatment for as many days as Medically Necessary</i></p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>; ▪ Covered in full for covered benefits provided only by the <i>Plan</i>. 	<p><i>Inpatient stay in a general or mental Hospital</i></p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ Nothing for day 1-90; ▪ Nothing for up to 60 lifetime <i>Reserve Days</i>; ▪ Nothing for <i>Covered Services</i> up to an additional 365 days per lifetime after Medicare days are used up; ▪ Then, all charges. <p><i>Inpatient physician and other covered professional mental health provider services</i></p> <ul style="list-style-type: none"> ▪ Nothing for as many days as <i>Medically Necessary</i>. <p><i>Outpatient treatment for as many days as Medically Necessary</i></p> <ul style="list-style-type: none"> ▪ Nothing. 	35-36.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

Medicare Pays...	Tufts Medicare Preferred Supplement 1 Pays...	You Pay...*	Page:
▶ Treatment for non-Biologically-based Mental Disorders not included in previous section:			
<p>Medicare benefits in full for <i>Inpatient stay in a general Hospital</i>, except:</p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ The Part A <i>Deductible</i> for day 1-60; ▪ The Part A <i>Coinsurance</i> for day 61-90; ▪ The Part A <i>Coinsurance</i> for 60 lifetime <i>Reserve Days</i>. 	<p><i>Inpatient stay in a general Hospital</i></p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ The Part A <i>Deductible</i> for day 1-60; ▪ The Part A <i>Coinsurance</i> for day 61-90; ▪ The Part A <i>Coinsurance</i> for 60 lifetime <i>Reserve Days</i>; ▪ <i>Covered Services</i> in full up to an additional 365 days per lifetime** after <i>Medicare</i> benefits are used up. 	<p><i>Inpatient stay in a general Hospital</i></p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ Nothing for day 1-90; ▪ Nothing for up to 60 lifetime <i>Reserve Days</i>; ▪ Nothing for <i>Covered Services</i> up to an additional 365 days per lifetime** after <i>Medicare</i> days are used up; ▪ Then, all charges. 	35-36.
<p>Medicare benefits in full for <i>Inpatient stay in a mental Hospital</i>, except:</p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ <i>The Part A Deductible</i> for day 1-60; ▪ <i>The Part A Coinsurance</i> for day 61-90; ▪ <i>The Part A Coinsurance</i> for 60 lifetime <i>Reserve Days</i>. <p>Note: <i>Medicare</i> benefits in a mental <i>Hospital</i> are limited to 190 days per lifetime.</p>	<p><i>Inpatient stay in a mental Hospital</i></p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ <i>The Part A Deductible</i> for day 1-60; ▪ <i>The Part A Coinsurance</i> for day 61-90; ▪ <i>The Part A Coinsurance</i> for 60 lifetime <i>Reserve Days</i>; ▪ <i>Covered Services</i> up to 120 additional days per <i>Benefit Period</i> (at least 60 days per calendar year) in a mental <i>Hospital</i>, less any days in a mental <i>Hospital</i> already covered by <i>Medicare</i> or the <i>Plan</i> in that <i>Benefit Period</i> or calendar year. 	<p><i>Inpatient stay in a mental Hospital</i></p> <p>Per Benefit Period:</p> <ul style="list-style-type: none"> ▪ Nothing for day 1-90; ▪ Nothing for up to 60 lifetime <i>Reserve Days</i>; ▪ <i>Covered Services</i> up to 120 days per <i>Benefit Period</i> (at least 60 days per calendar year) in a mental <i>Hospital</i>; ▪ Then, all charges. 	35-36.

* Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

**The 365 additional lifetime days are combined for all *Inpatient* stays in general and mental *Hospitals*.

Benefit Schedule – continued

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	Page:
<p>► Treatment for non-Biologically based Mental Disorders not included in previous section (continued):</p>			
<p><i>Medicare</i> benefits in full for <i>inpatient</i> physician and other covered professional mental health provider services for as many days as <i>Medically Necessary</i>, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<p><i>Inpatient</i> physician and other covered professional mental health provider services covered by <i>Medicare</i> and the <i>Plan</i> for as many days as <i>Medically Necessary</i> in a general <i>Hospital</i>:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>; ▪ <i>Covered Services</i> in full for as many days as <i>Medically Necessary</i> in a general <i>Hospital</i> and up to 120 additional days per <i>Benefit Period</i> (at least 60 days per calendar year) in a mental <i>Hospital</i> when covered only by the <i>Plan</i>. 	<p><i>Inpatient</i> physician and other covered professional mental health provider services</p> <p>Nothing for as many days as <i>Medically Necessary</i>.</p>	35-36.
<p><i>Medicare</i> benefits in full for <i>Medically Necessary</i> <i>Outpatient</i> treatment, except:</p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<p><i>Outpatient</i> treatment for as many visits as <i>Medically Necessary</i></p> <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. • <i>Covered Services</i> in full for 24 visits per calendar year when benefits provided only by the <i>Plan</i>. 	<p><i>Outpatient</i> treatment for as many visits as <i>Medically Necessary</i>:</p> <ul style="list-style-type: none"> ▪ Nothing for <i>Medicare</i> and <i>Plan</i> benefits for as many visits as <i>Medically Necessary</i>; • Nothing for up to 24 visits per calendar year when covered only by the <i>Plan</i>. 	35-36.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	<i>Page:</i>
Oxygen and Equipment:			
<i>Medicare</i> benefits in full, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	37.
Podiatry:			
<i>Medicare</i> benefits in full, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	37.
Prescription Drugs – Limited <i>Outpatient</i> Drug Coverage under Part B:			
When covered by <i>Medicare</i>, <i>Medicare</i> benefits in full, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	When covered by <i>Medicare</i>, <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	When covered by <i>Medicare</i>, <ul style="list-style-type: none"> ▪ Nothing. 	37.
Preventive Care:			
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits in full for screening bone mass density testing. 	<ul style="list-style-type: none"> ▪ Nothing. 	<ul style="list-style-type: none"> ▪ Nothing. 	38.
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits in full for diabetes self-management training, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	38.
<ul style="list-style-type: none"> ▪ ► For family planning: <ul style="list-style-type: none"> ▪ Nothing. 	<ul style="list-style-type: none"> ▪ Benefits in full as required by state mandate. 	<ul style="list-style-type: none"> ▪ Nothing. 	38.
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits in full for glaucoma testing, except: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. 	38.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	Page:
Preventive Care – continued:			
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits in full for cardiovascular screening. 	<ul style="list-style-type: none"> ▪ Nothing. 	<ul style="list-style-type: none"> ▪ Nothing. 	38.
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits as follow for routine colorectal cancer screenings: <ul style="list-style-type: none"> ▪ Full benefits for fecal occult blood test, flexible sigmoidoscopy, and colonoscopy. ▪ Barium enema covered, subject to: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. ▪ Nothing. 	39.
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits in full for pelvic and clinical breast exams 	<ul style="list-style-type: none"> ▪ Nothing. 	<ul style="list-style-type: none"> ▪ Nothing. 	39.
<ul style="list-style-type: none"> ► Medicare benefits in full for a PAP smear test every two years. 	<ul style="list-style-type: none"> ▪ In full for an annual routine PAP smear test each calendar year (covered in years when Medicare benefits do not cover this test). 	<ul style="list-style-type: none"> ▪ Nothing. 	39.
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits in full for annual screening mammogram. 	<ul style="list-style-type: none"> ▪ Nothing. 	<ul style="list-style-type: none"> ▪ Nothing. 	39.
<ul style="list-style-type: none"> ▪ ► <i>Medicare</i> benefits as follow for annual prostate cancer screenings: <ul style="list-style-type: none"> • Full benefit for annual Prostate specific antigen (PSA) blood test. • Annual digital rectal exam covered, subject to: <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ Nothing. ▪ Nothing. 	39.
<ul style="list-style-type: none"> ▪ ► Medicare benefits in full for a Medicare approved smoking cessation program. 	<ul style="list-style-type: none"> ▪ Nothing. 	<ul style="list-style-type: none"> ▪ Nothing. 	40.

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

Medicare Pays...	Tufts Medicare Preferred Supplement 1 Pays...	You Pay...*	Page:
Preventive Care – continued:			
Medicare benefits in full for a one time physical exam within 12 months after Part B coverage begins.	▪ Nothing.	▪ Nothing.	39.
Medicare benefits in full for an annual wellness exam.	▪ Nothing.	▪ Nothing.	40.
<u>Note:</u> This benefit applies in years following initial Welcome to Medicare physical exam.			
Radiation and X-Ray Therapy:			
Medicare benefits in full, except: ▪ The Part B <i>Deductible</i> ; ▪ The Part B <i>Coinsurance</i> .	▪ The Part B <i>Deductible</i> ; ▪ The Part B <i>Coinsurance</i> .	▪ Nothing.	40.
Second Opinions:			
Medicare benefits in full, except: ▪ The Part B <i>Deductible</i> ; ▪ The Part B <i>Coinsurance</i> .	▪ The Part B <i>Deductible</i> ; ▪ The Part B <i>Coinsurance</i> .	▪ Nothing.	40.
Short Term Rehabilitation Therapy (Physical, Occupational & Speech-Language):			
Medicare benefits in full, except: ▪ The Part B <i>Deductible</i> ; ▪ The Part B <i>Coinsurance</i> .	▪ The Part B <i>Deductible</i> ; ▪ The Part B <i>Coinsurance</i> .	▪ Nothing.	40.
Skilled Nursing Facility Services:			
Medicare benefits per Benefit Period: ▪ in full for day 1-20; ▪ For day 21-100, in full, except for the Part A <i>Coinsurance</i> ; ▪ Nothing for day 101-365; ▪ Nothing for day 366 and beyond.	Per Benefit Period: ▪ Nothing. ▪ The Part A <i>Coinsurance</i> . ▪ \$10 per day in a <i>Skilled Nursing Facility</i> participating with <i>Medicare</i> ##; ▪ \$8 per day in a <i>Skilled Nursing Facility</i> not participating with <i>Medicare</i> ##; ▪ Nothing.	Per Benefit Period: ▪ Nothing. ▪ Nothing. Remaining cost. ▪ All costs.	40.
# You must meet <i>Medicare</i> requirements, including: • having been in a <i>Hospital</i> at least 3 days; and having entered a <i>Medicare</i> -approved facility within 30 days after having left the <i>Hospital</i> ; or • having been in a <i>Hospital</i> at least 3 days; and transferred to the facility within 30 days after having left the <i>Hospital</i> .			

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Benefit Schedule – continued

<i>Medicare Pays...</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	<i>Page:</i>
Surgery as an <i>Outpatient</i>:			
<i>Medicare</i> benefits in full, except : <ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	<ul style="list-style-type: none"> ▪ The Part B <i>Deductible</i>; ▪ The Part B <i>Coinsurance</i>. 	▪ Nothing.	40.
Additional Covered Services Provided by the <i>Plan</i> (for benefits not covered under Parts A and B of <i>Medicare</i>):			
<i>Description of Covered Service:</i>	<i>Tufts Medicare Preferred Supplement 1 Pays...</i>	<i>You Pay...*</i>	<i>Page:</i>
<ul style="list-style-type: none"> ▪ <u>Fitness and Nutritional Counseling Benefit</u> 	All charges up to a maximum benefit of \$150 per calendar year.	All costs, after the maximum benefit of up to \$150 per calendar year is reached	41

*Benefits for *Covered Services* are provided based on the *Allowed Charge*. You may have to pay any amount over the *Allowed Charge*.

Discounts and savings – Preferred Extras:

In addition to your covered benefits, as a *Member* you may take advantage of Preferred Extras - discounts on a variety of health products, services, and treatments. Current examples include:

• **Fitness Discounts:**

- ❖ Curves® - 50% discount on initiation fees; one month free membership after 12 consecutive monthly membership payments.
- ❖ Fitness Together – Free initial fitness evaluation; 10% discount on personal training packages of 36 sessions or more.
- ❖ Local Fitness Clubs – 20% discount on an annual membership, with no initiation fees; \$3 copayment per visit for up to 5 visits per month. You are also eligible for a \$150 reimbursement towards fitness club membership each year.

• **Health Products & Services:**

- ❖ Lasik Surgery - 15% discount on retail price, or 5% off the promotional price, of LASIK and PRK laser vision correction.
- ❖ ChooseHealthy.com™ – Free shipping and up to 40% discount on over 2,400 dietary supplements, homeopathic remedies, diet and sports nutrition, yoga and fitness activities, personal body care, books, audio videos, DVDs, and more.
- ❖ Home Instead Senior Care – \$100 one-time credit on non-medical home care services.

• **Mind & Body:**

- ❖ Massage Therapy - 25% discount on usual and customary fee or pay \$15 per 15 minutes of massage therapy, whichever is less.
- ❖ Acupuncture – 25% discount on usual and customary fee.
- ❖ Wellness Programs – 30% discount on a variety of health and wellness seminars and programs.

• **Nutritional Services:**

- ❖ Nutritional Counseling - 25% discount on unlimited visits with registered dietitians and licensed nutritionists.
- ❖ Weight Watchers® – Free registration and complete reimbursement for successful completion of the traditional Weight Watchers program; \$10 discount on Weight Watchers Deluxe At Home Kit.

These discounts and savings may change over time without notice to Members. To check on current Preferred Extras, call Customer Relations at the number listed on your Member ID card, or go to www.tuftsmedicarepreferred.org.

Chapter 1

How Your Plan Works

Overview:

Introduction: Welcome to the *Tufts Health Plan Medicare Preferred Medicare Supplement Plan* (“the *Plan*”). We are pleased you have chosen us. We look forward to working with you to help you meet your health care needs. Your satisfaction with us is important to us. If you have questions, please call Customer Relations at 1-800-701-9000. We will be happy to help you.

This *Plan* provides coverage to supplement your *Medicare* benefits. The *Plan* is designed to add to your existing *Medicare* coverage (Parts A and B of the Original *Medicare* Program), subject to the terms, conditions, exclusions and limitations of *Medicare* eligible services.

Under the *Plan*, coverage is also provided for certain services which are not covered under *Medicare*. Those services are described in the “Covered Services” section of Chapter 3.

Benefits under the *Plan*:

The *Plan* covers only the services and supplies described as *Covered Services* in Chapter 3. There are **no pre-existing condition limitations** under the *Plan*. You are eligible to use your benefits as of your *Effective Date*.

Overview, Continued:

Your Policy: This book, called your *Policy*, will help you find answers to your questions about *Tufts Health Plan Medicare Preferred Medicare Supplement Plan* benefits. We certify that you have the right to services and supplies described in this *Policy* which are

- eligible for coverage under *Medicare*; or
- eligible for coverage under the *Plan*, when *Medically Necessary*.

The benefits described in this *Policy* are consistent with the requirements of Massachusetts law. Your benefits will be updated automatically when required by Massachusetts law. *Medicare* is the **primary insurer** for *Medicare*-covered services and the *Plan* is the **secondary insurer**.

Coverage for *Medicare*-covered services under the *Plan* will be subject to the terms, conditions, exclusions, and limitations of eligible services and supplies under the Original *Medicare* Plan. That coverage is subject to change per *Medicare's* guidelines. This *Policy* is not intended as a full explanation of *Medicare's* benefits. Information and guidelines established for *Medicare* by the federal Centers for *Medicare* and Medicaid Services may be obtained:

- by contacting your local Social Security office; or
- via the internet on the official *Medicare* Web site at www.medicare.gov.

Also, refer to your *Medicare* handbook for questions pertaining to the *Medicare* portion of your health care under the *Plan*.

Note that words with special meanings appear as italicized words in this *Policy*. Those words are defined in the Glossary in Appendix A.

Calls to Customer Relations:

The *Tufts Health Plan Medicare Preferred* Customer Relations Department is committed to excellent service.

Calls to Customer Relations may, on occasion, be monitored to assure quality service.

Canceling appointments

If you must cancel an appointment with any *Provider*:

- always provide as much notice to the *Provider* as possible (at least 24 hours), and
- if your *Provider's* office charges for missed appointments that you did not cancel in advance, the *Plan* will not pay for the charges.

Member Identification Card:

Introduction: The *Plan* gives each *Member* a Member identification card (Member ID).

Membership Identification Number: If you have any questions about your Member ID, please call Customer Relations at 1-800-701-9000.

Reporting errors: When you receive your Member ID, check it carefully. If any information is wrong, call us at 1-800-701-9000.

Using your card: Your Member ID is important because it identifies your health care plan. Remember to:

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

Identifying yourself as a Tufts Health Plan Medicare Preferred Member: When you receive services, you must tell the office staff that you are a *Tufts Health Plan Medicare Preferred Member*.

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

Utilization Management:

Introduction When services are eligible for benefits under Part A or Part B of *Medicare*, *Medicare* determines whether those services are *Medically Necessary*. *Tufts Health Plan Medicare Preferred* will rely upon the determination made by *Medicare* for those services.

For *Covered Services* provided under this *Plan* only, we will determine whether the services are *Medically Necessary*. This section describes the utilization management program used by us to make those determinations.

Utilization management We have a utilization management program. Its purpose is to control health care costs by evaluating whether health care services provided to *Members* under this *Plan* only (and not by *Medicare*) are: *Medically Necessary*; and provided in the most appropriate and efficient manner. Under this program, we sometimes engage in prospective, concurrent, and retrospective review of health care services.

We use prospective review to determine whether proposed treatment is *Medically Necessary* before that treatment begins. Prospective review is also referred to as “Pre-Service Review”.

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

Retrospective review is used to evaluate care after the care has been provided. In some circumstances, we engage in retrospective review to more accurately determine the appropriateness of health care services provided to *Members*. It is also referred to as “Post-Service Review”.

IMPORTANT NOTE: *Members* can call Customer Relations at 1-800-701-9000 to determine the status or outcome of utilization review decisions.

Type of Review:	Timeframe for Determinations:
Prospective (Pre-Service):	Within 2 working days of receiving all necessary information, but no later than 15 days from receipt of the request.
Concurrent:	Determination is made prior to treatment being reduced or terminated to allow you to appeal the determination.
Retrospective (Post-Service):	30 days.

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.

Utilization Management, continued:

Specialty case management:

For *Covered Services* provided under this *Plan* only, 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
- monitor the *Member's* treatment and progress.

We may contact that *Member* and his or her *Provider* to discuss a treatment plan and establish short and long term goals. The 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 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:

- serious heart or lung disease;
- cancer;
- certain neurologic diseases;
- AIDS or other immune system diseases;
- certain mental health conditions, including substance abuse;
- severe traumatic injury.

When You Need *Emergency Care*:

Guidelines for receiving covered *Emergency care*:

Follow these guidelines when you need *Emergency care* within the United States.

- If needed, call 911 for emergency medical assistance. If 911 services are not available in your area, call the local number for emergency medical services.
- Go to the nearest emergency medical facility.

Information Resources for *Members*:

Obtaining information about *Tufts Health Plan Medicare Preferred*:

The following information about us is available from the Massachusetts Department of Public Health's Office of Patient Protection:

- A list of sources of independently published information assessing member satisfaction and evaluating the quality of health care services offered by *Tufts Health Plan Medicare Preferred*.
- The percentage of premium revenue spent by us for health care services provided to *Members* for the most recent year for which information is available.
- A report that details the following information for the previous calendar year:
 - the total numbers of filed grievances, grievances denied internally, and grievances withdrawn before resolution; and
 - the total number of external appeals pursued after exhausting the internal grievance process, as well as the resolution of all those external appeals.

How to obtain this information:

You can obtain this information about us by contacting the Massachusetts Department of Public Health's Office of Patient Protection in the following ways:

- Call 1-800-436-7757.
- Write a letter to the Office. Address it to

Department of Public Health;
Office of Patient Protection;
250 Washington Street, 2nd Floor;
Boston, MA 02108.
- Send a fax to the Office. Fax # 1-617-624-5046.
- View information at the Office's Web site. Go to <http://www.state.ma.us/dph/opp/>.

Chapter 2

Eligibility

Eligibility:

Eligibility rules:

You are eligible as a *Member* only if you meet the following criteria:

- You are eligible for *Medicare* Parts A and B and enrolled in *Medicare* Part B as either:
 - a person who is age 65 or older; or
 - a person who is disabled*, under age 65, and receiving Social Security disability benefits.

*Note: If you are under age 65, you may only enroll in this plan if the disability that made you eligible for *Medicare* is a condition other than end-stage renal disease.

- You are not enrolled in any other individual *Medicare* supplement plan.

Proof of eligibility:

Tufts Health Plan Medicare Preferred may ask you for proof of your eligibility or continuing eligibility. You must provide us with proof when asked. This may include proof of:

- residence; and
- *Medicare* enrollment.

Effective Date of coverage

Your coverage starts on the first day of the month following our receipt of a completed enrollment application.

Chapter 3

Covered Services:

Introduction: The “*Covered Services*” section of this chapter describes the health care services and supplies that qualify as *Covered Services* under this *Policy*. Read this section to understand your coverage under *Tufts Health Plan Medicare Preferred Medicare Supplement* (“the *Plan*”). In addition, this chapter explains the services and supplies excluded under this *Policy*. For more information, see the “Exclusions from Benefits” section at the end of this chapter.

In general, the *Plan* only provides coverage for benefits eligible for payment under *Medicare* Parts A and B. As a result, you should see the most recent version of your *Medicare* handbook. That document will explain to you the benefits, exclusions, and restrictions under your *Medicare* Parts A and B coverage.

Covered Services:

Ambulance Services: Once *Medicare* provides coverage, *Tufts Health Plan Medicare Preferred Medicare Supplement* provides coverage up to the *Allowed Charge* for:

- *Medicare*-approved transportation in an ambulance to an emergency medical facility for treatment of an *Accident* or for *Emergency* medical care.
- Other *Medically Necessary* ambulance transportation approved by *Medicare*.

Covered Services, Continued:

Autism spectrum disorders – diagnosis and treatment

Coverage is provided, in accordance with Massachusetts law, for the diagnosis and treatment of autism spectrum disorders. Autism spectrum disorders include any of the pervasive developmental disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and include:

- autistic disorder;
- Asperger's disorder; and
- pervasive developmental disorders not otherwise specified.

Coverage is provided for the following *Covered Services*:

- habilitative or rehabilitative care, which are professional, counseling, and guidance services and treatment programs that are necessary to develop, maintain, and restore the functioning of the individual. These programs may include, but are not limited to, applied behavioral analysis (ABA) supervised by a *Board-Certified Behavior Analyst (BCBA)*. For more information about these programs, call the *Tufts Health Plan* Mental Health Department at 1-800-208-9565;
- psychiatric and psychological care, covered under your "Mental Health and Substance Abuse Services benefit", as a *Biologically-based Mental Disorder* – see page 35; and
- therapeutic care (including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers), covered under your "Short term rehabilitation therapy" benefit.

Notes:

- Prescription medications to treat autism spectrum disorders are covered under *Medicare* Part D. You will need to enroll in *Medicare* Part D to receive coverage for these drugs. Call Customer Relations for information about enrolling in *Medicare* Part D.
- For the purposes of this benefit, ABA includes the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. [
- To the extent that habilitative and rehabilitative services are covered by the *Plan*, prior approval by *Tufts Health Plan* is required for these services. Please call Customer Relations for information on how to obtain this approval.]

Covered Services, Continued:

Blood services – Inpatient:

The *Plan* provides coverage for the *Inpatient* blood deductible under *Medicare* Part A. This “deductible” is the cost of the first three pints of blood you use in a calendar year as an *Inpatient* in a *Hospital* or *Skilled Nursing Facility*.

Note: The *Inpatient* blood deductible will only apply to you if the *Hospital* or *Skilled Nursing Facility* has to purchase the blood for you for your *Inpatient* admission. In this case, this deductible will be waived if you either replace the blood yourself or have it donated by another party.

See also “Blood services – *Outpatient*” below. You are only responsible for paying one blood deductible under *Medicare* Part A or Part B per calendar year.

Blood services – Outpatient:

The *Plan* provides coverage for the *Outpatient* blood deductible under *Medicare* Part B. This “deductible” is the cost of the first three pints of blood you use in a calendar year as an *Outpatient* at a *Hospital*.

Note: The *Inpatient* blood deductible will only apply to you if the *Hospital* has to purchase the blood for you for your *Outpatient* services. In this case, this deductible will be waived if you either replace the blood yourself or have it donated by another party.

See also “Blood services – *Inpatient*” above. You are only responsible for paying one blood deductible under *Medicare* Part A or Part B per calendar year.

Covered Services, Continued:

Cardiac Rehabilitation Services:	Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for <i>Medicare</i> -approved <i>Outpatient</i> cardiac rehabilitation services.
Chemotherapy Services:	Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for <i>Inpatient</i> and <i>Outpatient</i> chemotherapy for cancer patients.
Chiropractor Services:	Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for manual manipulation of the spine. This benefit must be furnished: (1) by a chiropractor and (2) to correct a subluxation of the spine.
Diabetic Services and Supplies:	<p>Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for certain <i>Medicare</i>-approved Part B diabetes supplies. These supplies include such items as: blood sugar (glucose) test strips; blood sugar monitors (glucometers); lancet devices and lancets; glucose control solutions for checking test strip and monitor accuracy; therapeutic shoes or inserts for <i>Members</i> with severe diabetic foot disease.</p> <p><u>Notes:</u></p> <ul style="list-style-type: none">• Part B diabetes supplies are covered under the “<i>Durable Medical Equipment</i>” benefit.• The following diabetes-related drugs and supplies are not covered by either <i>Medicare</i> or this <i>Plan</i>: insulin (unless used with an insulin pump); insulin pens; syringes; needles; alcohol swabs; or gauze. Insulin and certain medical supplies used to inject insulin, such as syringes, gauze, and alcohol swabs are covered under <i>Medicare</i> Part D. You will need to enroll in <i>Medicare</i> Part D to receive coverage for these drugs and supplies.• Call Customer Relations for information about enrolling in <i>Medicare</i> Part D.
Diagnostic Tests, X-Rays and Clinical Laboratory Services:	Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for <i>Medicare</i> -approved <i>Outpatient</i> diagnostic tests, x-rays, and clinical laboratory services.
Dialysis (Kidney) Services and Supplies:	Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for <i>Medicare</i> -approved <i>Outpatient</i> maintenance dialysis treatment services and self-dialysis training, as well as certain home dialysis treatment services.

Covered Services, Continued:

Durable Medical Equipment and Prosthetic Devices:	Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for <i>Medicare</i> -approved <i>Durable Medical Equipment</i> and prosthetic devices.
Enteral Formulas and Food Products:	<p>The <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for the following formulas and food products:</p> <ul style="list-style-type: none">• Enteral formulas for home use for treatment of malabsorption caused by: Crohn's disease; ulcerative colitis; gastroesophageal reflux; gastrointestinal motility; chronic intestinal pseudo-obstruction; and inherited diseases of amino acids and organic acids. The <i>Plan</i> covers these formulas in full up to their <i>Allowed Charge</i>.• Food products modified to be low protein when <i>Medically Necessary</i> to treat inherited diseases of amino acids and organic acids. Note that <i>Medicare</i> does not cover these food products. The <i>Plan</i> covers these products up to a maximum of \$5,000 per calendar year. You are responsible for paying any additional charges for these products in a calendar year.
Foreign Travel:	<p><i>Medicare</i> generally does not cover services that you receive while traveling outside of the United States and its territories. For more information on this topic, please refer to your <i>Medicare</i> handbook.</p> <ul style="list-style-type: none">• For services that Medicare would have covered if you received them in the United States, the <i>Plan</i> provides benefits for both:<ul style="list-style-type: none">• the <i>Covered Services</i> listed in this <i>Policy</i>; and• the benefits that <i>Medicare</i> normally provides that are listed in this <i>Policy</i>.• For the few services that Medicare covers outside of the United States, the <i>Plan</i> only provides benefits for the <i>Covered Services</i> listed in this <i>Policy</i>. <p><u>Note:</u> The <i>Plan</i> will not pay for any services if you establish residency outside of the United States or its territories.</p>
Home Health Care:	<p>Once <i>Medicare</i> provides coverage, the <i>Plan</i> provides coverage up to the <i>Allowed Charge</i> for <i>Medicare</i>-approved home health care services.</p> <p><u>Note:</u> The <i>Plan</i> also provides coverage up to the <i>Allowed Charge</i> for <i>Durable Medical Equipment</i> required as part of <i>Medicare</i>-approved home health care services. This coverage is provided once <i>Medicare</i> provides benefits for this equipment.</p>

Covered Services, Continued:

Hospice Services:

If *Medicare* does not provide either full benefits or any benefits for hospice care services, the *Plan* provides coverage up to the *Allowed Charge* for the following hospice care services required for a terminally-ill person (a person with a life expectancy of six months or less) under Massachusetts law:

- the following services when they are either provided or arranged by a hospice care provider: physician services; nursing care provided by or supervised by a registered professional nurse; social work services; volunteer services; home health aide services; counseling services; *Durable Medical Equipment*; and drugs;
- respite care (care for the terminally ill person to provide relief to the family or other person providing primary care to that person); and
- bereavement counseling services for the *Member's* family.

Hospital, Medical and Surgical Care – Inpatient:

(including care for *Biologically-based Mental Disorders*)

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for all *Medicare*-approved *Inpatient* days during a *Benefit Period*. This *Tufts Health Plan Medicare Preferred Medicare Supplement* coverage is provided on:

- the 1st 60 days of a *Benefit Period*;
- the 61st through 90th day of a *Benefit Period*; and
- the 60 lifetime *Medicare Reserve Days*.

Once you have used up all of your *Medicare Reserve Days*, the *Plan* provides coverage up to the *Allowed Charge* for an additional 365 lifetime *Inpatient* days. These additional days are only covered for semi-private room and board charges.

Covered Services, Continued:

Hospital, Medical and Surgical Care – Outpatient: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Medicare*-approved *Outpatient Hospital* and medical care including: physician services; *Outpatient* medical services and supplies; physical and speech therapy; diagnostic tests; and *Durable Medical Equipment*.

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Outpatient* surgical care provided in a *Medicare*-approved facility (for example, a general *Hospital* or an ambulatory surgical center).

Human organ transplants: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Medicare*-approved human organ transplants.

- *Medicare* Part A provides coverage under certain conditions and only at *Medicare*-approved facilities for transplants of: the heart; lung; kidney; pancreas; intestine; and liver.
- *Medicare* Part B provides coverage for cornea and bone marrow transplants.

For more information about this coverage under *Medicare* Part A and Part B, see your *Medicare* handbook or contact *Medicare*.

Medical Care Outpatient Visits by a Physician or Covered Practitioner (Non-physician): Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Medicare*-approved medical care used to diagnose or treat an illness or injury such as:

- office, home, or clinic visits;
- medical nutrition therapy services;
- hormone replacement therapy for peri and post-menopausal women;
- follow-up medical care following an *Accidental* injury or an *Emergency*.

Covered Services, Continued:

Mental Health and Substance Abuse Services:

The *Plan* provides coverage for:

- Services to diagnose or treat *Biologically-based Mental Disorders*.
- Treatment of *Rape-related Mental or Emotional Disorders*.
- Services to diagnose or treat other *Mental Disorders*.

Biologically-based Mental Disorders (including substance abuse and alcoholism) and Rape-related Mental or Emotional Disorders:

The *Plan* provides coverage up to the *Allowed Charge* for *Biologically-based Mental Disorders* and *Rape-related Mental or Emotional Disorders* as follows:

- Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for all *Medicare*-approved *Inpatient* days during a *Benefit Period*. This *Tufts Health Plan Medicare Preferred Medicare Supplement* coverage is provided on:
 - the 1st 60 days of a *Benefit Period*;
 - the 61st through 90th day of a *Benefit Period*; and
 - the 60 lifetime *Medicare Reserve Days*.

Once you have used up all of your *Medicare Reserve Days*, the *Plan* provides coverage up to the *Allowed Charge* for an additional 365 lifetime *Inpatient* days. These additional days are only covered for semi-private room and board charges.

Note: These limits also apply to all other *Inpatient* stays. For more information, see the benefit description for “*Hospital Medical and Surgical Care - Inpatient*” earlier in this chapter.

- Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Inpatient* services provided by a physician specializing in psychiatry or a psychologist. If *Medicare* does not provide coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Inpatient* services provided by a physician specializing in psychiatry, a psychologist, or a clinical specialist in psychiatric and mental health nursing. The *Plan* provides this coverage for as many days as are *Medically Necessary*.
- Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Outpatient* services provided by a mental health care provider. If *Medicare* does not provide coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Inpatient* services provided by a physician specializing in psychiatry, a psychologist, a licensed independent clinical social worker, a clinical specialist in psychiatric and mental health nursing, or a licensed mental health counselor. The *Plan* provides this coverage for as many visits as are *Medically Necessary*.

Note: Coverage of other, non-mental health treatment of autism and autism spectrum disorders is described under “Autism spectrum disorders – diagnosis and treatment” earlier in this chapter.

Covered Services, Continued:

Mental Health and Substance Abuse Services:

(continued)

All other *Mental Disorders*:

The *Plan* provides coverage up to the *Allowed Charge* for all other (non-*Biologically-Based*) *Mental Disorders*:

- Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for all *Medicare*-approved *Inpatient* days during a *Benefit Period*. The *Plan* coverage is provided on:
 - the 1st 60 days of a *Benefit Period*;
 - the 61st through 90th day of a *Benefit Period*; and
 - the 60 lifetime *Reserve Days*.

Once you have used up all of your *Reserve Days*, the *Plan* provides coverage up to the *Allowed Charge* for an additional 365 lifetime *Inpatient* days. These additional days are only covered for semi-private room and board charges.

Note: These limits also apply to all other *Inpatient* stays. For more information, see the benefit description for “*Hospital Medical and Surgical Care - Inpatient*” earlier in this chapter.

The *Plan* provides coverage up to the *Allowable Charge* under this benefit for:

- Up to 120 days per *Benefit Period* (but covered for at least 60 days per calendar year). This may occur when your *Inpatient* days are covered by *Medicare* or the *Plan* during a *Benefit Period* (or in the same calendar year).
- Up to a total of 365 lifetime *Inpatient* days.
- Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Outpatient* services provided by a physician specializing in psychiatry or a psychologist. If *Medicare* does not provide coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Inpatient* services provided by a physician specializing in psychiatry, a psychologist, or a clinical specialist in psychiatric and mental health nursing. The *Plan* provides this coverage for up to 24 visits per calendar year.

Intermediate Mental Health Care Services:

In certain instances, you may need *Covered Services* that are more intensive than *Outpatient* services (but not requiring a 24-hour *Inpatient Hospital* admission). Both *Medicare* and the *Plan* cover these intermediate mental health care services. As a result, *Medicare* will decide whether this care is *Medically Necessary* for you. These services include, but are not limited to: intensive *Outpatient* programs; acute residential; and partial *Hospital* programs.

Covered Services, Continued:

- Oxygen and Equipment:** Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for
- the rental of oxygen equipment; and
 - oxygen contents and supplies for the delivery of oxygen.
- Podiatry:** Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for:
- Treatment of injuries and diseases of the feet (such as hammer toe and spurs).
 - Routine foot care* for members with certain medical conditions affecting the lower limbs.
- *For information about foot care related to diabetes, see "Diabetes Services and Supplies" in this Benefit Schedule.
- Prescription drugs – Limited Outpatient drug coverage under Medicare Part B:** Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for a limited number of *Outpatient* prescription drugs covered under *Medicare* Part B. Some examples include certain drugs in the following categories:
- osteoporosis drugs;
 - injectable drugs given by a licensed medical practitioner;
 - oral cancer drugs; and
 - oral anti-nausea drugs.

For more information about this Part B benefit, see your *Medicare* handbook or contact *Medicare*.

Note: This *Plan* **does not** pay for most prescription drugs. You pay the full cost for most prescription drugs. In order to receive the full prescription drug benefits available through *Medicare*, you need to enroll in *Medicare* Part D coverage.

Covered Services, Continued:

Preventive Care Services:

Bone mass density testing:

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Medicare*-approved bone mass density testing. This testing is provided to: identify bone mass; determine bone quality; or detect bone loss.

For more information, see your *Medicare* handbook or contact *Medicare*.

Diabetes self-management training:

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Outpatient* self-management training and educational services, including medical nutrition therapy, used to diagnose or treat: insulin-dependent diabetes; non-insulin dependent diabetes; or gestational diabetes.

Family planning:

The *Plan* provides coverage up to the *Allowed Charge* for the following family planning services:

- Consultations, examinations, procedures and medical services, which are related to the use of all contraceptive methods that have been approved by the United State Food and Drug Administration (USFDA).
- The injection of birth control drugs, including a prescription drug obtained from the *Provider* during an office visit.
- Genetic counseling.
- Insertion of implantable contraceptives, including levonorgestrel implants. Coverage includes the implant system as well.
- Intrauterine devices (IUDs), diaphragms, and any other USFDA-approved contraceptive methods, when these contraceptives are obtained from the *Provider* during an office visit.

Glaucoma testing:

Medicare provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for one glaucoma test every 12 months. This coverage is for *Members* that *Medicare* decides to be at high risk for glaucoma.

Medical nutrition therapy:

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Medicare*-approved medical nutritional therapy services for *Members* with diabetes or kidney disease.

Cardiovascular screening:

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for screenings once every five years to test a Member's cholesterol, lipid, and tryglyceride levels.

Covered Services, Continued:

Preventive Care Services – continued:

Colorectal cancer screenings:

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for the following colorectal cancer services:

- Fecal-occult blood test: one test per year for *Members* age 50 or older.
- Flexible Sigmoidoscopy: one test every four years for *Members* age 50 or older.
- Colonoscopy: one test every two years for *Members* determined by *Medicare* to be at high risk for developing colorectal cancer.
- Barium Enema: one test every four years for *Members* age 50 or older.

Pelvic and clinical breast exams and routine cytology (PAP) smear tests:

Medicare-covered exams and tests: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for one gynecological exam (including a routine pap smear) every two years. This coverage is provided every year for a *Member* that *Medicare* determines to be at high risk for developing cervical or vaginal cancer.

Non-Medicare-covered exams and tests: If *Medicare* does not provide coverage for a routine cytological exam (pap smear) per calendar year, the *Plan* provides full coverage up to the *Allowed Charge* for that exam.

Annual screening mammograms

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for mammograms as follows:

- One baseline mammogram for a *Member* between ages 35 and 39.
- One routine mammogram each calendar year for a *Member* age 40 or older.

Note: The *Plan* also provides coverage up to the *Allowed Charge* for *Medically Necessary* diagnostic mammograms. For more information, see “Laboratory Tests, X-Rays, and Other Diagnostic Tests” earlier in this chapter.

Annual prostate cancer screening:

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for the following routine prostate cancer screenings:

- Digital rectal exam: one exam per year for *Members* age 50 or older.
- Prostate specific antigen (PSA) blood test: one test per year for *Members* age 50 or older.

Note: The *Plan* may also provide coverage up to the *Allowed Charge* for additional prostate cancer screenings determined by *Medicare* to be *Medically Necessary*.

Routine physical exam (one-time):

Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for a one-time “Welcome to *Medicare*” routine physical exam.

Note: *Medicare* covers this exam when a *Member* receives it within 12 months after enrolling in *Medicare* Part B.

Covered Services, Continued:

Preventive Care Services – continued:

Annual wellness exam: *Medicare* provides coverage for an annual wellness exam. This benefit applies in years following the initial one-time “Welcome to *Medicare*” physical exam.

Smoking cessation program: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for a *Medicare*-approved smoking cessation program. This coverage includes up to 8 face-to-face visits in a 12-month period for a *Member* who has **not** been diagnosed with an illness caused or complicated by tobacco use.

Radiation and X-Ray Therapy: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for radiation and x-ray therapy.

Second Opinions: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for: (1) an *Outpatient* second opinion regarding your medical care; or (2) a second surgical opinion. Coverage may also be provided for a third opinion, when the second opinion is different from the initial opinion.

Short Term Rehabilitation Therapy: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Outpatient* short term rehabilitation therapy. This coverage includes: physical therapy; occupational therapy; and speech therapy.

Also, the *Plan* provides coverage for *Medically Necessary* services required to diagnose and treat speech, hearing, and language disorders.

Skilled Nursing Facility Services: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Skilled Nursing Facility* services. This coverage is provided through the 100th day in a *Benefit Period*. After that, the *Plan* provides coverage as follows:

- *Medicare*-covered services for 101st through 365th day in a *Benefit Period*: The *Plan* pays **\$10 per day** for each of these days.
- *Non-Medicare*-covered services for 101st through 365th day in a *Benefit Period*: the *Plan* pays **\$8 per day** for each of these days.

Note: *Medicare* and the *Plan* both provide coverage for *Skilled Nursing Facility* services, when a *Member’s Inpatient* stay in such a facility meets *Medicare’s* rules. One example of these rules is *Medicare’s* requirement for the *Member* to: (1) be an *Inpatient* in a *Hospital* for at least three days; and then (2) transferring to the *Skilled Nursing Facility* within 30 days after leaving that *Hospital*.

Surgery as an Outpatient: Once *Medicare* provides coverage, the *Plan* provides coverage up to the *Allowed Charge* for *Medicare*-approved *Outpatient* surgery.

Covered Services, Continued:

Women's Health and Cancer Rights Act Coverage:

The *Plan* provides coverage up to the *Allowed Charge* for breast reconstruction in connection with a mastectomy. This includes the following services:

- 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).

Additional Covered Services Provided by the *Plan*

(for benefits not covered under Parts A and B of *Medicare*):

- Fitness and Nutritional Counseling benefit: Covers up to a total of \$150 per calendar year towards membership fees and/or exercise classes for a Member enrolled in a qualified health club or fitness facility and/or covered nutritional counseling sessions with a licensed nutritional counselor or registered dietician.

Important notes about this benefit:

- A qualified health club or fitness facility provides cardiovascular and strength training exercise equipment on site. Examples include traditional health clubs, YMCAs, YWCAs and community fitness centers.
- This benefit does not cover fees paid to non-qualified health clubs or fitness facilities, including but not limited to, martial arts centers; gymnastics facilities; country clubs; social clubs; facilities providing only yoga, pilates, aerobics, golf, tennis, swimming or other sports activity.
- For more information about this benefit, call Customer Relations.

Discounts and savings – Preferred Extras:

In addition to your covered benefits, as a *Member* you may take advantage of Preferred Extras - discounts on a variety of health products, services, and treatments. Current examples include:

• **Fitness Discounts:**

- ❖ Curves® - 50% discount on initiation fees; one month free membership after 12 consecutive monthly membership payments.
- ❖ Fitness Together – Free initial fitness evaluation; 10% discount on personal training packages of 36 sessions or more.
- ❖ Local Fitness Clubs – 20% discount on an annual membership, with no initiation fees; \$3 copayment per visit for up to 5 visits per month. You are also eligible for a \$150 reimbursement towards fitness club membership each year.

• **Health Products & Services:**

- ❖ Lasik Surgery - 15% discount on retail price, or 5% off the promotional price, of LASIK and PRK laser vision correction.
- ❖ ChooseHealthy.com™ – Free shipping and up to 40% discount on over 2,400 dietary supplements, homeopathic remedies, diet and sports nutrition, yoga and fitness activities, personal body care, books, audio videos, DVDs, and more.
- ❖ Home Instead Senior Care – \$100 one-time credit on non-medical home care services.

• **Mind & Body:**

- ❖ Massage Therapy - 25% discount on usual and customary fee or pay \$15 per 15 minutes of massage therapy, whichever is less.
- ❖ Acupuncture – 25% discount on usual and customary fee.
- ❖ Wellness Programs – 30% discount on a variety of health and wellness seminars and programs.

• **Nutritional Services:**

- ❖ Nutritional Counseling - 25% discount on unlimited visits with registered dieticians and licensed nutritionists.
- ❖ Weight Watchers® – Free registration and complete reimbursement for successful completion of the traditional Weight Watchers program; \$10 discount on Weight Watchers Deluxe At Home Kit.

These discounts and savings may change over time without notice to Members. To check on current Preferred Extras, call Customer Relations at the number listed on your Member ID card, or go to

www.tuftsmedicarepreferred.org.

Limitations on Benefits:

Dental Care Services:

Dental care is not covered under this *Plan*. One exception is for dental care covered by *Medicare*. *Medicare* does not cover routine dental care or most dental procedures such as: cleanings; fillings; tooth extractions; dentures; dental plates; or other dental devices. *Medicare* Part A will pay for certain dental services that you get when you are in the *Hospital*. *Medicare* Part A may pay for *Hospital* stays if you need to have *Emergency* or complicated dental procedures (even when the dental care is not covered). For more information, see your *Medicare* handbook or contact *Medicare*.

Exclusions from Benefits:

List of exclusions: *Tufts Health Plan Medicare Preferred* 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.
- *Custodial Care*.
- Services related to non-covered services.
- A drug, device, medical treatment or procedure (collectively "treatment") that is *Experimental or Investigative*.

This exclusion does not apply to:

- bone marrow transplants for breast cancer; or
- patient care services provided pursuant to a qualified clinical trial

which meet the requirements of Massachusetts law.

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

- Drugs, medicines, materials or supplies for use outside the *Hospital* or any other facility, except as described earlier in this chapter.
- The following exclusions apply to services provided by the relative 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).

Exclusions from Benefits, Continued:

List of exclusions (continued)

- Services, supplies, or medications required by a third party which are not otherwise *Medically Necessary*. Examples of a third party are: employer; insurance company; school; or court.
- Services for which you are not legally obligated to pay or services for which no charge would be made if you had no health plan.
- Care for conditions for which 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.
- Facility charges or related services if the procedure being performed is not a *Covered Service*.
- Cosmetic (meaning to change or improve appearance) surgery, procedures, supplies, medications or appliances, except as provided earlier in this chapter.

Note: Breast reconstruction is covered when following a *Medically Necessary* mastectomy, as described in "Women's Health and Cancer Rights Act Coverage" earlier in this chapter.

- Human organ transplants, except as described earlier in this chapter.

Exclusions from Benefits, Continued:

**List of
exclusions
(continued):**

- Any service, supply, or procedure performed in a non-conventional setting (including, but not limited to: spas/resorts; therapeutic programs; camps; and clinics).
- Hearing aids.
- Methadone treatment or methadone maintenance related to substance abuse disorders.
- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet.

Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a *Member* with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the *Member's* treating doctor, and the shoes and inserts:

- are prescribed by a *Provider* who is a podiatrist or other qualified doctor; and
- are furnished by a *Provider* who is a podiatrist, orthotist, prosthetist, or pedorthist.

This exclusion also does not apply to routine foot care for *Members* diagnosed with diabetes.

Chapter 4

When Coverage Ends

Overview:

**Intro-
duction:** This chapter tells you when coverage ends.

**Reasons
coverage
Ends:** Coverage ends when any of the following occurs:

- you lose eligibility because:
 - you no longer are eligible for *Medicare* Parts A and B; and
 - you are enrolled in *Medicare* Part B (please refer to your *Medicare* handbook for events that can change your *Medicare* coverage); or
- you fail to pay your *Premium* when due; or
- you choose to drop coverage; or
- material misrepresentation.

When a *Member* is No Longer Eligible:

**Loss of
eligibility:** Your coverage ends on the date you no longer are eligible for *Medicare* Parts A and B and enrolled in *Medicare* Part B.

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

**You choose
to drop
coverage** Coverage ends if you decide that, for any reason, you no longer want coverage. You may do this at any time by notifying us. You can choose to end your coverage as of the date you contact us or at a future date you elect. You must pay *Premiums* up through the day your coverage ends.

When a *Member* is Entitled to Medicaid:

If you become eligible for Medicaid (under Title XIX of the Social Security Act), you may request that we suspend your benefits and *Premiums* under this *Tufts Health Plan Medicare Preferred Medicare Supplement Policy*. You may continue this suspension of benefits and *Premiums* for up to 24 months. To do this, you must notify us within 90 days after you become entitled to Medicaid.

Once we have received this notice from you, we will refund to you any *Premiums* you had paid beyond your effective date under Medicaid coverage. Note the following, though, about any *Premium* refund we may send you:

- We will deduct from that amount any payments we made for coverage under the *Plan* **after** your Medicaid coverage became effective.
- The amount of those payments we make under the *Plan* during that time period may be more than the amount we collect from you in *Premiums*. If this occurs, it is our right to collect the difference from you.

If you suspend your coverage in this way, and then later lose your entitlement to Medicaid, we will reinstate your *Policy*. To do this, you must notify us within 90 days after you lose your Medicaid coverage. In this event, you will need to reimburse us the amount of *Premiums* for the time period dating back to when you lost entitlement to Medicaid.

Once we have reinstated your *Policy*, you will be covered under the *Plan* as of that date. You will not wait to receive benefits, including those for treatment of a pre-existing condition. Your coverage under the *Plan* will be the same, or very similar to, your coverage prior to your entitlement to Medicaid. In addition, your *Premiums* will be at the same level they would have been if you had not suspended your coverage under the *Plan*.

Membership Termination for Material Misrepresentation:

Policy: We may terminate your coverage for making a material misrepresentation to us. If your coverage is terminated for this reason, we may not allow you to re-enroll for coverage with us under any other plan (such as individual plan or an employer group plan).

Acts of material misrepresentation: Examples of material misrepresentation include:

- false or misleading information on your application;
- receiving benefits for which you are not eligible; or
- allowing someone else to use your Member ID.

Date of termination: If we terminate your coverage for material misrepresentation, your coverage will end as of your *Effective Date* or a later date chosen by us.

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

If the *Premium* is not enough to pay for that care, we may, at our option:

- 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.

If the *Premium* is more than is needed to pay for *Covered Services* you received after your termination date, we will refund the excess to you.

Voluntary and Involuntary Disenrollment Rates for *Members*:

Voluntary and Involuntary Disenrollment Rates for *Members*:

As required by Massachusetts law, *Tufts Health Plan Medicare Preferred* conducts an annual disenrollment study. Annually, the study looks at the reasons *Members* leave us, in order to track voluntary and involuntary disenrollment rates.

- **Voluntary Disenrollment Rate:** The number of *Members* we disenrolled because they ceased to pay *Premiums*. This is the voluntary disenrollment rate. For 2010, less than one percent of *Members* voluntarily disenrolled by ceasing to pay their *Premiums*.
- **Involuntary Disenrollment Rate:** The number of *Members* that we disenrolled because of fraud or acts of physical or verbal abuse. This is the involuntary disenrollment rate. For 2010, less than one percent of *Members* were involuntarily disenrolled as a result of fraud or abuse.

For additional information about the voluntary and involuntary disenrollment rates among our *Members*, you can call Customer Relations at 1-800-701-9000.

Termination of the *Individual Contract*:

End of *Tufts Health Plan Medicare Preferred's* and *Member's* relationship:

Coverage will terminate if the relationship between you and *Tufts Health Plan Medicare Preferred* ends for any reason, including

- your *Individual Contract* with us terminates;
- you fail to pay *Premiums* on time; or
- we stop operating.

Obtaining a Certificate of Creditable Coverage:

Certificates of Creditable Coverage will be mailed to each *Member* upon termination in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting Customer Relations at 1-800-701-9000.

Chapter 5

Member Satisfaction:

Important Notes about Appeals and Grievances:

- In many instances, we will ask you to direct your initial concern to *Medicare*. This is because *Medicare* will make the primary determination on your health care benefits. Information is available: by contacting your local Social Security office or; on the official *Medicare* Web site at: www.medicare.gov.
- The *Member* Satisfaction Process described below applies to you when we determine that a service is *Medically Necessary* under this *Plan* only (and **not** under *Medicare*).

Member Satisfaction Process:

Tufts Health Plan Medicare Preferred has a multi-level *Member* Satisfaction process including:

- Internal Inquiry;
- *Member* Grievances Process;
- Internal *Member* Appeals; and
- External Review by the Office of Patient Protection.

Send all grievances and appeals to us at the following address:

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

All calls should be directed to Customer Relations at: 1-800-701-9000.

Internal Inquiry:

Call Customer Relations to discuss concerns you may have regarding your healthcare. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be resolved within three (3) business days or if you tell Customer Relations that you are not satisfied with the response you have received from us, we will send you a letter describing any options you may have. Those options may include the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accord with the timelines outlined below.

We maintain records of each inquiry made by a *Member* or by that *Member's* authorized representative. The records of these inquiries and the response provided by us are subject to inspection by: the Commissioner of Insurance; and the Department of Public Health.

Member Satisfaction Process, Continued:

Member Grievance Process:

A grievance is a formal complaint about actions taken by us or a *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. If you choose to file a grievance verbally, please call Customer Relations. 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; and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern (including: relevant dates; any applicable medical information; and *Provider* names); and
- any supporting documentation.

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 “Internal *Member* Appeals” below.

Member Satisfaction Process, Continued:

Administrative Grievances: An administrative grievance is a complaint about: a *Tufts Health Plan Medicare Preferred* employee, department, policy, or procedure; or about a billing issue involving us.

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

Member Satisfaction Process, Continued:

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

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

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

“Reconsideration:” If you are not satisfied with the result of the Clinical Grievance review process, you may request a “reconsideration”. If you so choose, your concerns will be reviewed by a clinician who was not involved in the initial review process. Upon request for a reconsideration, your concerns will be reviewed within thirty (30) calendar days. You will be notified in writing of the results of the review.

Member Satisfaction Process, Continued:

Internal Member Appeals:

An appeal is a request for a review of a: denial of coverage for a service or supply that has been reviewed and denied by *Tufts Health Plan Medicare Preferred* based on medical necessity (an adverse determination) or; a denial of coverage for a specifically excluded service or supply. Our Appeals and Grievances Department will review all of the information submitted upon appeal, taking into consideration your benefits as detailed in this *Policy*.

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 to file an internal appeal. Appeals may be filed either verbally or in writing. If you would like to file a verbal appeal, call a Customer Relations Representative who will: document your concern; and forward it to an Appeals and Grievances Analyst. To accurately reflect your concerns, you may want to: put your appeal in writing; and send it to the address provided at the beginning of this section. Your explanation should include:

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

Appeals Timeline:

- If you file your appeal in writing, within five (5) business days after receiving your letter, we will: notify you in writing that your letter has been received and; provide you with the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your appeal.
- If you file your appeal verbally within forty-eight (48) hours we will send you a written confirmation of our understanding of your concerns. We will also include the name, address, and telephone number of the Appeals and Grievances Analyst coordinating the review of your appeal.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) day internal inquiry process or earlier if you notify us that you are not satisfied with the response you received during the internal inquiry process.
- Within 30 calendar days of receipt, we will: review your appeal; make a decision; and send you a decision letter.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between: you or your authorized representative; and us.

This extension may be necessary if: we are waiting for medical records that are necessary for the review of your appeal; and have not received them. The Appeals and Grievances Analyst handling your case will notify you in advance if an extension may be needed. Also, a letter will be sent to you confirming the extension.

Member Satisfaction Process, Continued:

When Medical Records are Necessary:	If your appeal requires the review of medical records you will receive a form that you will need to sign which authorizes your <i>Providers</i> to release to us medical information relevant to your Appeal. You must sign and return the form before we can begin the review process. If you do not sign and return the form to us within thirty (30) calendar days of the date you filed your appeal, we may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal, which are in our possession and control.
Who Reviews Appeals?	If the appeal involves a medical necessity determination, an actively practicing physician in the same or similar specialty as typically treats the medical condition, and who did not participate in any of the prior decisions on the case will take part in the review. In addition, a Committee made up of Managers and Clinicians from various <i>Tufts Health Plan Medicare Preferred</i> departments will review your appeal. A Committee within the Appeals and Grievances Department will review appeals involving non-covered services.
Appeal Response Letters:	<p>The letter you receive from us will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on medical necessity) will include: the specific information upon which the adverse determination was based; 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; notification of the steps for requesting external review by the Office for Patient Protection; and the titles and credentials of the individuals who reviewed the case. Please note that requests for coverage of services that are specifically excluded in your <i>Policy</i> are not eligible for external review.</p> <p>An appeal not properly acted on by us within the time limits of Massachusetts law and regulations, including any extensions made by mutual written agreement between you or your authorized representative and us, shall be deemed resolved in your favor.</p>

Member Satisfaction Process, Continued:

Expedited Appeals:

We recognize that there are circumstances that require a quicker turnaround than the 30 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. Should you feel that your request meets the criteria cited above, you or your attending physician should contact Customer Relations. Under these circumstances, you will be notified of our decision within seventy-two (72) hours after the review is initiated. If your treating physician (the physician responsible for the treatment or proposed treatment) certifies that the service being requested is *Medically Necessary*; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal grievance process, you will be notified of our decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for *Durable Medical Equipment (DME)* that we determined was not *Medically Necessary*, you will be notified of our decision within less than forty-eight (48) hours of the receipt of certification. If you are an *Inpatient* in a *Hospital*, we will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at our expense through the completion of the Internal Appeals Process. The only services which will continue to be covered are those which: (1) were originally authorized by us; and (2) which were not terminated pursuant to a specific time or episode-related exclusion.

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

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

Member Satisfaction Process, Continued:

Conference (Walk-in) Appeals: If the case involves an adverse determination (*Medical Necessity* determination), you or your representative may also appear in person or by conference call to present your appeal. This is an opportunity for you to present additional information to the Committee that may be better communicated in person. If you would like to present your appeal in person, you must request this option. A Member Appeals Analyst will contact you to schedule a date and time to appear. You will have approximately twenty minutes to address the Committee. The Committee will not make a decision while you are present. However, the Member Appeals Analyst will notify you of a decision after it has been made.

If You are Not Satisfied with the Appeals Decision:

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

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

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

(continued on next page)

Member Satisfaction Process, continued:

External Review by The Office of Patient Protection (cont.):

You or your authorized representative may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a physician, that delay in the providing or continuation of health care services, that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review. Your cost for an external review by the Office of Patient Protection is \$25.00. This payment should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that the payment of the fee would result in an extreme financial hardship to you. We will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill us the amount established pursuant to contract between the Department and the assigned external review agency minus the \$25 fee which is your responsibility.

You, or your authorized representative, will have access to any medical information and records relating to your appeal, in our possession or under our control.

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

The decision of the review panel will be binding on us. If the external review agency overturns a *Tufts Health Plan Medicare Preferred* decision in whole or in part, we will send you a written notice within five (5) business days of receipt of the written decision from the review agency. This notice will:

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

Please note, if you are not satisfied with our member satisfaction process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care or the Department of Public Health's Office of Patient Protection at:

Department of Public Health, Office of Patient Protection.
250 Washington Street, 2nd Floor, Boston, MA 02108.
Phone: 1-800-436-7757 / Fax: 1-617-624-5046.
Internet: www.state.ma.us/dph/opp

Limitation on Actions:

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

Chapter 6

Other Plan Provisions:

Subrogation:

Tufts Health Plan Medicare Preferred's
right of
subrogation:

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

- your own or someone else's auto or homeowner's insurer, or
- the person who caused your illness or injury.

In that case, if *Tufts Health Plan Medicare Preferred* pays or will pay for the costs of health care services given to treat your illness or injury, we have the right to recover those costs in your name, with or without your consent, directly from that person or company. This is called our right of subrogation. 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"). Our coverage is secondary to Med Pay benefits. If we pay benefits before Med Pay benefits have been exhausted, we may recover the cost of those benefits as described above.

Workers' compensation:

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

If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. *Tufts Health Plan Medicare Preferred* will not provide coverage for any injury or illness for which it determines that benefits are available under: any workers' compensation coverage or equivalent employer liability; or indemnification law.

If we pay for the costs of health care services or medications for any work-related illness or injury, 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, please contact Customer Relations.

Subrogation, Continued:

***Tufts Health
Plan Medicare
Preferred's***
**right of
reimburse-
ment:**

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

**Assignment of
benefits:**

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

Member
cooperation:

You agree:

- to notify us of any events which may affect our rights of recovery under this section, such as:
 - injury resulting from an automobile accident, or
 - job-related injuries that may be covered by workers' compensation;
- to cooperate with us by:
 - giving us information and help, and
 - signing documents to help us get reimbursed;
- that we may:
 - investigate,
 - request and release information which is necessary to carry out the purpose of this section to the extent allowed by law, and
 - do the things we decide are appropriate to protect our rights of recovery.

**Subrogation
Agent:**

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

Coordination of Benefits:

Benefits under other plans:	<p>You may have benefits under other plans for <i>Hospital</i>, medical, dental or other health care expenses.</p> <p>We <i>have</i> a coordination of benefits program (COB) that prevents duplication of payment for the same health care services. We will coordinate benefits payable for <i>Covered Services</i> with benefits payable by other plans, consistent with state law.</p>
Primary and secondary plans:	<p>We will coordinate benefits by determining:</p> <ul style="list-style-type: none">• which plan has to pay first when you make a claim; and• which plan has to pay second. <p>We will make these determinations according to applicable state law.</p>
Right to receive and release necessary information:	<p>When you enroll, you must include information on your membership application about other health coverage you have.</p> <p>After you enroll, you must notify us of new coverage or termination of other coverage. We may ask for and give out information needed to coordinate benefits.</p> <p>You agree to provide information about other coverage and cooperate with our COB program.</p>
Right to recover overpayment:	<p>We may recover, from you or any other person or entity, any payments made that are greater than payments it should have made under the COB program. We will recover only overpayments actually made.</p>
For more information:	<p>For more information about COB, call Customer Relations: 1-800-701-9000.</p>

Use and Disclosure of Medical Information:

We mail a separate “Notice of Privacy Practices” to all *Members* to explain how we use and disclose your medical information. If you have questions or would like another copy of our “Notice of Privacy Practices”, call Customer Relations: 1-800-701-9000. Information is also available on our Web site at: www.tuftsmedicarepreferred.org

Coverage for Pre-existing Conditions:

Your coverage under this *Policy* is not limited with respect to pre-existing conditions. A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before your *Effective Date*.

Circumstances Beyond *Tufts Health Plan Medicare Preferred's* Reasonable Control:

Circumstances beyond our reasonable control: We 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 *Providers*.

Individual Contract:

Acceptance of the terms of the *Individual Contract:* By signing and returning the membership application form, you apply for *Individual* coverage and agree to all the terms and conditions of the *Individual Contract*, including this *Policy*.

Payments for Coverage: We will bill you and you will pay your *Premiums* to us. We are not responsible if you fail to pay the *Premium*.

Note: If you fail to pay the *Premium* on time, we may cancel your coverage in accordance with this *Policy* and applicable state law.

We may change the *Premium*. If the *Premium* is changed, the change will apply to all *Members* enrolled in this *Plan* and not just you.

Individual Contract, Continued:

Changes to this Policy:

Tufts Health Plan Medicare Preferred may change this *Policy*. Changes will be consistent with state and federal law and do not require your consent. Notice of changes in *Covered Services* will be sent to you at least 60 days before the effective date of the modifications and will:

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

An amendment to this *Policy* describing the changes will be sent to you and will include the effective date of the change. Changes will apply to all benefits for services received on or after the *Effective Date* with one exception.

Exception: A change will not apply to you if you are an *Inpatient* on the effective date of the change until your discharge date.

Note: If changes are made, they will apply to all *Members* enrolled in this product, not 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 us: *Members* should address all correspondence to:

Tufts Health Plan Medicare Preferred
705 Mount Auburn Street
P.O. Box 9181
Watertown, MA 02471-9181.

Enforcement of terms:

We may choose to waive certain terms of the *Policy*, if applicable. This does not mean that we give up its rights to enforce those terms in the future.

When this Policy is Issued and Effective:

This *Policy* is issued and effective on your *Effective Date* on or after January 1, 2012 and supersedes all previous *Policies*.

Appendix A

Glossary of Terms:

Terms and Definitions:

Term/definition table: The table below defines the terms used in this *Policy*.

Term:	Definition:
Accident.	<p>Injury or injuries for which benefits are provided means accidental bodily injury sustained by the <i>Member</i> which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while his or her coverage is in force under this plan.</p> <p>Note: Injuries shall not include injuries for which benefits are provided or available under:</p> <ul style="list-style-type: none"> • any workers' compensation, employer's liability or similar law; • motor vehicle no-fault plan; • or other motor vehicle insurance-related plan; <p>unless prohibited by law.</p>
Allowed Charge.	<p>The expense used to determine payment of <i>Plan</i> benefits listed in this <i>Policy</i>.</p> <ul style="list-style-type: none"> • <u>For a service eligible for coverage under <i>Medicare</i></u>: This means the payment amount <i>Medicare</i> establishes for that service. See your <i>Medicare</i> handbook, or contact <i>Medicare</i>, for more information. • <u>For a service that qualifies as a <i>Covered Service</i> under this <i>Plan</i> only</u>: This means the <i>Provider's</i> actual charge for that service.

Terms and Definitions, Continued:

Term:	Definition:
Benefit Period.	<p>The way that <i>Medicare</i> measures your use of <i>Hospital</i> and <i>Skilled</i> nursing facility services:</p> <ul style="list-style-type: none"> • A <i>Benefit Period begins</i> the day you receive <i>Covered Inpatient Services</i> in a <i>Hospital</i> or <i>Skilled Nursing Facility</i>. • The <i>Benefit Period ends</i> when you have not received <i>Covered Inpatient Services</i> in a <i>Hospital</i> or <i>skilled</i> nursing care for 60 days in a row. • If you go into the <i>Hospital</i> after one <i>Benefit Period</i> has ended, a new <i>Benefit Period</i> begins. • You must pay the <i>Inpatient Hospital Deductible</i> for each <i>Benefit Period</i>. • There is no limit to the number of <i>Benefit Periods</i> you can have.
Biologically-based Mental Disorders.	<p>The following Mental Disorders:</p> <ul style="list-style-type: none"> • schizophrenia; • schizoaffective disorder; • major depressive disorder; • bipolar disorder; • paranoia and other psychotic disorders; • obsessive-compulsive disorder; • panic disorder; • delirium and dementia; • affective disorders; • eating disorders; • post-traumatic stress disorders; • autism; • substance abuse disorders; and • any other mental disorders added by the Commissioners of the Department of Mental Health and the Division of Insurance.
Board-Certified Behavior Analyst (BCBA).	<p>A Board-Certified Behavior Analyst (BCBA) meets the qualifications of the Behavior Analyst Certification Board (BACB) by achieving a master's degree, training, experience, and other requirements. A BCBA professional conducts behavioral assessments, designs and supervises behavior analytic interventions, and develops and implements assessment and interventions for Members with diagnoses of autism spectrum disorders. BCBA's may supervise the work of Board-Certified Assistant Behavior Analysts and other Paraprofessionals who implement behavior analytic interventions.</p>

Terms and Definitions, Continued:

Term:	Definition:
Coinsurance.	An amount you must pay as your share of the cost of <i>Medicare</i> Covered Services after you pay any <i>Medicare Deductibles</i> . Coinsurance is usually a percentage (for example, 20%), rather than a set amount.
Covered Services.	<p>The services and supplies for which <i>Tufts Health Plan Medicare Preferred</i> will pay under this <i>Policy</i>. They must be:</p> <ul style="list-style-type: none"> • described in Chapter 3; • for <i>Medicare</i>-approved services, obtained by a <i>Provider</i> who accepts assignment from <i>Medicare</i>; and • except for preventive care, <i>Medically Necessary</i>. <p><u>Note:</u> <i>Covered Services</i> do not include any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any <i>Provider</i>, <i>Member</i>, service, supply, or medication.</p>
Custodial Care.	<ul style="list-style-type: none"> • Care given primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety; • care given primarily for maintaining the <i>Member's</i> or anyone else's safety, when no other aspects of treatment require an acute <i>Hospital</i> level of care; • services that could be given by people without professional skills or training; or • routine maintenance of colostomies, ileostomies, and urinary catheters; or • adult and pediatric day care. <p>In cases of mental health care, <i>Inpatient</i> care given primarily:</p> <ul style="list-style-type: none"> • for maintaining the <i>Member's</i> or anyone else's safety, or • for the maintenance and monitoring of an established treatment program, <p>when no other aspects of treatment require an acute <i>Hospital</i> level of care.</p> <p><u>Note:</u> <i>Custodial Care</i> is <u>not</u> covered by <i>Tufts Health Plan Medicare Preferred</i>.</p>

Terms and Definitions, Continued:

Term:	Definition:
Deductible.	The amount you must pay for health care, before <i>Medicare</i> begins to pay for <i>Medicare</i> covered services. There is a <i>Deductible</i> for each <i>Benefit Period</i> for Part A, and each year for Part B. These amounts can change every year.
Durable Medical Equipment.	<p>Devices or instruments of a durable nature that:</p> <ul style="list-style-type: none"> • 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 <i>Member</i> and are first eligible for <i>Covered Services</i> .
Emergency.	<p>An illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:</p> <ul style="list-style-type: none"> • 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); • 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 <i>Hospital</i> before delivery, or a threat to the safety of the Member or her unborn child in the event of transfer to another <i>Hospital</i> before delivery. <p>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.</p>

Terms and Definitions, Continued:

Term:	Definition:
Experimental or Investigative.	<p>A service, supply, treatment, procedure, device, or medication (collectively “treatment”) is considered <i>Experimental or Investigative</i> if any of the following is true:</p> <ul style="list-style-type: none"> • 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.
Hospital.	<p>A hospital, as defined by <i>Medicare</i>, which is authorized for payment by <i>Medicare</i> and licensed to operate as a hospital in the state where it operates.</p>
Individual Contract.	<p>The agreement between <i>Tufts Health Plan Medicare Preferred</i> and you under which:</p> <ul style="list-style-type: none"> • we agree to provide Individual Coverage to you; and • you agree to pay a <i>Premium</i> to us on your behalf. <p>The Individual Contract includes this <i>Policy</i> and any amendments.</p>

Terms and Definitions, Continued:

Term:	Definition:
Inpatient.	<p>A patient who is:</p> <ul style="list-style-type: none"> • admitted to a <i>Hospital</i> or other facility licensed to provide continuous care; and • classified as an <i>Inpatient</i> for all or a part of the day on the facility's <i>Inpatient</i> census.
Medically Necessary.	<ul style="list-style-type: none"> • For a service eligible for coverage under <i>Medicare</i>: This means “medically necessary” as determined by <i>Medicare</i>. See your <i>Medicare</i> handbook or contact <i>Medicare</i> for more information. • For a service that qualifies as a <i>Covered Service</i> under this <i>Tufts Health Plan Medicare Preferred Medicare Supplement Policy</i> only: This term has the following meaning: <ul style="list-style-type: none"> A service or supply that is consistent with generally accepted principles of professional medical practice as determined by whether that service or supply: <ul style="list-style-type: none"> • Is the most appropriate available supply or level of services for the <i>Member</i> 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 <i>Medically Necessary Services</i>, <i>Tufts Health Plan Medicare Preferred</i> uses Clinical Coverage Guidelines which are: <ul style="list-style-type: none"> • developed with input from practicing physicians; • developed in accordance with the standards adopted by national accreditation organizations; • updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and • evidence-based, if practicable.

Terms and Definitions, continued:

Term:	Definition:
Medicare.	Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
Medicare-approved Amount.	<p>The amount a <i>Physician</i> or supplier that accepts assignment can be paid by <i>Medicare</i>.</p> <ul style="list-style-type: none"> • It includes what <i>Medicare</i> pays and any <i>Deductible</i>, <i>Coinsurance</i>, or <i>Copayment</i> that you pay. • It may be less than the actual amount a doctor or supplier charges.
Member	<p>A person who:</p> <ul style="list-style-type: none"> • enrolls in the <i>Plan</i>; • signs the membership application form; and • in whose name the <i>Premium</i> is paid to us. <p>Also, referred to as “you.”</p>
Mental Disorders.	Psychiatric illnesses or diseases listed as <i>Mental Disorders</i> in the latest edition, at the time treatment is given, of the <u>American Psychiatric Association's Diagnostic and Statistical Manual: Mental Disorders</u> regardless of whether the cause of the illness or disease is organic.
Outpatient.	<p>A patient who receives care other than on an Inpatient basis. This includes services provided in:</p> <ul style="list-style-type: none"> • a physician's office; • an <i>Ambulatory Surgical Center</i>; and • an Emergency room or <i>Outpatient</i> clinic.
Paraprofessional.	As it pertains to the treatment of autism and autism spectrum disorders, a <i>Paraprofessional</i> is an individual who performs applied behavior analysis (ABA) services under the supervision of a <i>Board-Certified Behavior Analyst (BCBA)</i> .
Physician.	<p>As defined by <i>Medicare</i>, an individual licensed under state law to practice:</p> <ul style="list-style-type: none"> • medicine; or • osteopathy.

Terms and Definitions, Continued:

Term:	Definition:
Plan.	The <i>Tufts Health Plan Medicare Preferred Medicare Supplement</i> option described in this <i>Policy</i> .
Policy.	This document, and any future amendments, which describes the <i>Plan</i> in which you have enrolled. This <i>Policy</i> is the agreement for the coverage under the <i>Plan</i> between: you; and <i>Tufts Health Plan Medicare Preferred</i> .
Premium.	The total monthly cost of <i>Individual Coverage</i> which the <i>Member</i> pays to <i>Tufts Health Plan Medicare Preferred</i> .
Provider.	<p>A health care professional or facility licensed in accordance with applicable law. <i>Providers</i> do not have to contract with <i>Tufts Health Plan Medicare Preferred</i> in order to offer services for the benefits listed in this <i>Policy</i>.</p> <p>The types of <i>Providers</i> covered under the <i>Plan</i> include, but are not limited to: <i>Ambulatory Surgical centers; Hospitals; physicians; certified nurse midwives; certified registered nurse anesthetists; nurse practitioners; optometrists; podiatrists; psychologists; licensed mental health counselors; licensed independent clinical social workers; and Skilled Nursing Facilities.</i></p> <p>The <i>Plan</i> will only cover services of a <i>Provider</i>, if those services are:</p> <ul style="list-style-type: none"> • listed as <i>Covered Services</i>; and • within the scope of the <i>Provider's</i> license. <p><u>Important Note – Providers outside of Massachusetts:</u> No coverage is available under this <i>Plan</i> for services obtained by the following types of <i>Providers</i> outside of Massachusetts:</p> <ul style="list-style-type: none"> • clinical specialists in psychiatric and mental health nursing; • licensed independent clinical social workers (for <i>Covered Services</i> under this <i>Plan</i> only); • licensed mental health counselors; and • psychologists (for <i>Covered Services</i> under this <i>Plan</i> only).
Rape-related Mental or Emotional Disorder.	<p>A mental or emotional disorder related to a <i>Member</i> who is a victim of rape or assault with intent to commit rape.</p> <p>Rape-related Mental or Emotional Disorders are covered when the costs for treatment exceed the maximum amount awarded under applicable Massachusetts law.</p>

Terms and Definitions, Continued:

Term:	Definition:
Reserve Days.	Sixty days that <i>Medicare</i> will pay for when you are put in a <i>Hospital</i> for more than 90 days of <i>Medicare</i> covered services. These 60 Reserve Days can be used only once during your lifetime. For each lifetime Reserve Day, <i>Medicare</i> pays all covered costs except for a daily <i>Coinsurance</i> amount.
Sickness.	An illness or disease of a Member for which expenses are incurred after the <i>Effective Date</i> and while the insurance is in force. Note: Sicknesses shall not include sicknesses for which benefits are provided or available under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, or other motor vehicle insurance-related plan, unless prohibited by law.
Skilled.	A type of care which is <i>Medically Necessary</i> and must be provided by, or under the direct supervision of, licensed medical personnel. Skilled care is provided to achieve a medically desired and realistically achievable outcome.
Skilled Nursing Facility.	A <i>Medicare</i> -certified <i>Skilled Nursing Facility</i> with the staff and equipment to provide: skilled nursing care and/or skilled rehabilitation services; and other related health services.
Tufts Health Plan Medicare Preferred.	Tufts Insurance Company (TIC), a Massachusetts corporation d/b/a Tufts Health Plan <i>Medicare Preferred</i> . Also referred to as: "we;" "us;" or "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. <u>Note:</u> Care is not considered <i>Urgent Care</i> if it is rendered: <ul style="list-style-type: none"> • after the <i>Urgent</i> condition has been treated and stabilized; • and the <i>Member</i> is safe for transport.